

# Care Quality Commission

## Inspection Evidence Table

### Oakham Medical Practice (1-572959716)

Inspection date: 29 November 2022

Date of data download: 18 November 2022

**Overall rating: Good**

We have rated the practice as good overall.

At our previous inspection in April 2022, we rated the practice as inadequate overall and the service was placed into special measures. When we returned to review progress in November 2022, we observed many positive changes and improvements. Some workstreams remained ongoing as part of a longer-term plan to achieve sustainable outcomes, but we saw that a clear plan was in place to achieve this.

## Safe

## Rating: Requires improvement

At our previous inspection in April 2022, we rated the practice as requires improvement for providing safe services. This was because:

- There was insufficient monitoring of patients being prescribed high-risk medicines.
- We identified some medication reviews which were overdue and incomplete.
- Safety alerts were not always being acted on appropriately.
- We found an out of date oxygen cylinder which had not been removed.

Following the inspection in November 2022, the practice remains rated as requires improvement in the safe key question. This was because:

- We identified some concerns in respect of medicines management via our remote clinical searches, although there was significant improvement noted since our previous inspection.
- We required further assurance that safety alerts were being fully acted upon with evidence being available to reflect this.

### Safety systems and processes

**The practice had 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.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our previous inspection in April 2022, we found that some staff had not received up-to-date safeguarding training relevant to their role. In November 2022, we found that all staff had completed the appropriate safeguarding training.</li> <li>The practice demonstrated an effective and thorough process in ensuring safeguarding was a key part of patient care. Staff demonstrated clear awareness of their responsibilities around reporting incidents if they suspected a concern. The practice had safeguarding policies which were regularly reviewed, and staff were aware of how to access these policies.</li> <li>Child safeguarding meetings were held every 6 weeks. Vulnerable adults were reviewed at the monthly practice multi-disciplinary meeting.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our inspection in April 2022, we observed that the practice was not able to provide evidence staff had received appropriate immunisations in line with national guidance. When we returned to the practice in November 2022, we saw the practice team had undertaken significant efforts to collate the evidence of staff vaccinations. There were a few gaps which the practice was in the process of following up with individual staff members; this mostly related to staff who had been employed for a number of years but we were assured that any new starters now provided the necessary evidence as part of their recruitment, and if any gaps were evident these were followed up with the individual or via occupational health.</li> <li>The practice had also produced a comprehensive staff immunisation policy. This outlined how the provider would ensure that staff received the immunisations appropriate to their role to protect themselves and others, as well as to ensure the efficient continuity of the service.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022	Y
There was a fire procedure. Date of fire risk assessment: February 2022	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

- We saw certificates to evidence that medical equipment was calibrated annually, and portable appliance testing of electrical items was completed on a yearly basis. This had last been completed in January 2022.
- Comprehensive safety checks and testing were in place to ensure the safety of the building. This included regular electrical and gas reviews.
- Fire safety policies were in place and evidence was provided of a completed fire risk assessment. All staff had completed fire safety training, and fire marshals had undertaken additional training for the role. Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures. We saw a fire drill had been completed and recorded in April 2022, and learning points were identified as a result of this.
- The practice had assessments in place for the safe control of hazardous substances (COSHH).

## 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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 11.11.2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• In addition to the comprehensive infection control audit, we were provided with separate audits pertaining to sharps bins and clinical waste management. When an issue was identified for improvement, actions were taken, staff were made aware, and this was kept under review at subsequent audits.</li> <li>• There were a range of infection prevention and control policies available for reference including Legionella management. There was a documented record of regular checks to assess for Legionella.</li> <li>• We observed that all staff had completed relevant infection control training for their role.</li> </ul>	

## Risks to patients

### There were 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.	Y
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Explanation of any answers and additional evidence:

- The previous inspection highlighted that the practice had lost a number of staff in the preceding 12 months. At this inspection, we found that staffing levels were more stable, but recruitment was ongoing for a number of clinical and non-clinical vacant posts. There were some difficulties with retaining staff in the patient service team (covering reception duties) due to untoward interactions from a small number of patients who were not able to get the appointment they wanted.
- At our previous inspection in April 2022, we found that some staff had not completed sepsis or sepsis awareness training; however in November 2022 staff training records showed all staff were up to date with this training.
- We observed that an auto consultation template had been developed for non-clinical staff to complete when dealing with a potential deteriorating or acutely unwell patient. The template incorporated signs of sepsis and elements of the National Early Warning Scores (NEWS2). This ensured any potential red flags were identified and prioritised for clinical review, and also provided documented evidence of actions undertaken by the non-clinical staff. We identified this as good practice which should be considered for wider sharing.

## 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.	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.	Y
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

Explanation of any answers and additional evidence:

- Notes summarising was kept up to date.
- The practice had a system in place to ensure all test results and information relating to patients received were acted on appropriately and in a timely manner. On the day of the inspection, there was no backlog in managing incoming pathology results.
- The practice had a system in place for the management of referrals under the two-week wait process (for suspected cancer diagnosis) supported by a safety netting process. Data demonstrated that the practice performed above local and national figures in terms of the numbers of referrals that went on to receive treatment for a cancer diagnosis.

## Appropriate and safe use of medicines

## The practice did not have always systems for the appropriate and safe use of medicines, including medicines optimisation

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 Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.74	0.79	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	11.3%	10.4%	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)	5.00	5.06	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	118.7‰	113.5‰	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)	0.47	0.51	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.7‰	4.9‰	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
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.	Y

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
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.	Y
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.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• Since our previous inspection, the practice had developed their own auto-consultation templates for each high-risk medicine category to ensure that all the necessary checks were completed when prescribing. This was a recent initiative and would take some time to become fully embedded, but we observed that this was a notable development which in the longer-term could be shared with others as best practice.</li> <li>• At our previous inspection, the remote clinical searches identified some concerns in relation to the monitoring of patients prescribed high-risk medicines. When this was reviewed at our inspection in November 2022, we observed that changes had been implemented and the overall process for safe medicines management was improved. However, we identified some areas requiring further work: <ul style="list-style-type: none"> <li>➤ We reviewed 5 sets of patient records where there was an indication of high prescribing of short acting relieving inhalers. We observed that 2 of the 5 patients had received over 20 of the short-acting inhalers in the last 12 months, demonstrating that their condition was not being effectively managed. We observed that 3 of these 5 patients required greater optimisation of their asthma management.</li> <li>➤ We observed 1 patient with asthma was prescribed a medicine on repeat prescriptions which can worsen asthmatic symptoms, and this had not been identified during a medicines review.</li> </ul> </li> </ul>	



Medicines management	Y/N/Partial
<p>➤ Our remote review of patients with a long-term condition also suggested that improvements were needed in asthma management. Our search identified 88 patients with asthma who have had 2 or more courses of rescue steroids in the last 12 months. We looked at 5 randomly selected patient records from this number, and this highlighted that 4 patients required some sort of clinical review of their condition.</p> <p>These issues were highlighted to the practice who they told us they would ensure these patients were reviewed, and they would review their overall approach to asthma management.</p> <ul style="list-style-type: none"> <li>• Following our last inspection, it was highlighted that there had been some confusion regarding the roles and oversight of pharmacy staff working for the Primary Care Network (PCN) and this had impacted on medicines management. In November 2022, this had been largely resolved and systems had been strengthened to ensure these were more streamlined and effective. This included a plan to standardise protocols across the PCN as a future development. There was also improved oversight of the pharmacy provision and input to the practice.</li> <li>• The practice also directly employed a pharmacist, and also hosted a PCN pharmacist who developed protocols and pathways and undertook medicines audits and safety alert reviews. The pharmacists undertook structured patient medicine reviews, and provided scheduled slots for more detailed medicine reviews if other prescribing clinicians did not have time to complete this during a standard consultation.</li> <li>• In April 2022 we found an out of date oxygen cylinder in an emergency medical bag used for home visits. At our November 2022, we found that this bag was no longer used. The practice held emergency medicines and equipment in the practice and in the minor injuries unit they ran at the hospital next door. We found that both were well-maintained and checked regularly, and they contained the appropriate medicines which were all in date.</li> <li>• We observed vaccine fridge manually recorded temperature logs and noted one reading that was out of range, recorded on 23 November 2022. No reason was recorded for this on the log but the data logger download showed the fridge was out of range for less than 15 minutes and this was due to it being opened and closed for vaccines. We were told that data loggers were routinely downloaded weekly as a secondary check for vaccine fridge temperatures. The manual logs should be completed with a supporting rationale if the temperatures vary outside the permitted range.</li> <li>• We observed that the practice had reviewed antibiotic prescribing and the rate of prescribing broad spectrum antibiotics had reduced from 13% to 11.3% in line with the local average. The practice informed us that they usually waited for the type of infection to be confirmed prior to prescribing antibiotics to ensure the medicines prescribed were appropriate for the condition.</li> </ul>	

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y

There was evidence of learning and dissemination of information.	Y
Number of events recorded since last inspection (1 May 2022 to 29 November 2022):	39
Number of events that required action:	38
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a procedure for recording significant events, acting and sharing information and learning outcomes as a team.</li> <li>There was a process to determine the severity of the incident and the action required.</li> <li>There was an open culture in which all safety concerns raised were discussed and learning was used to make improvements. All staff were encouraged to report incidents.</li> <li>The practice had a system in place to ensure learning from incidents was shared through various meetings and general cascade of information via email and on the practice software package.</li> </ul>	

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

Event	Specific action taken
A concern was reported by the ambulance service to the CQC regarding the safe care of a patient who had abnormal results when tests were done at the practice.	The practice ensured all clinical staff undertook ECG training as a mandatory training module. An auto-consultation template was developed for reception staff to use to identify potential emergency presentations and to escalate these to the duty doctor immediately.
A member of the team found some medicines returned by a patient in a consulting room drawer. They had been placed there by a locum.	The medicines were handed over the practice management team to be returned to the pharmacy for disposal. The procedure to deal with returned medicines was reinforced to all staff and locums.
A patient attended the practice to have sutures removed following treatment at the hospital. However, not all the sutures were removed due to deep closure and skin overgrowth.	The practice wound protocol was revised. The practice contacted secondary care to ask them to document the number of stitches to be removed in their discharge information in future to ensure there was absolute clarity on what needed to be done.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw that that the practice had a process in place for a clinician to review safety alerts, but the provider was unable to evidence that all relevant safety alerts had been acted upon and responded to.</li> <li>As part of our remote searches, we reviewed 5 patients who were prescribed 2 different medicines which, when combined, created a potential increased risk of cardiovascular problems. This had been highlighted by a Medicines and Healthcare products Regulatory Agency (MHRA) alert. We saw that 4 patients had been reviewed and their medicines had been changed in line with guidance; the other patient's medicine was also changed but was then reverted back to the original medicine as they were not able to tolerate the alternative. An alert was placed on the patient record although it was not documented that each patient was aware of the risk of the combination of medicines, and that they accepted this risk.</li> </ul>	



- We looked at a safety alert relating to a named medicine used primarily for pain relief. This was a historic alert from 2016 which stated that the dosage should be increased when patients with specific rheumatology conditions have insufficient pain relief, but then reduced to a lower strength once the patient was clinically stable. The practice had identified a small cohort of patients being prescribed this medicine at the higher dosage, but we could not see documented evidence that these patients had been reviewed.

Following our inspection, the practice told us that they had audited the medicine specified in the safety alert and set up an auto consultation template to ensure regular reviews of these patients in the future. They confirmed that all patients were currently being managed in line with the safety alert guidance but acknowledged that they could improve the review process.

- The practice also confirmed that they were undertaking a project to inform all their prescribing clinicians of historic safety alerts to check their awareness. They would then use this information to review in a clinical meeting as a learning event, undertake any audits this project highlighted as being a priority, and repeat this process annually for alerts received in the preceding 12 months as a means of ongoing assurance.
- We saw a copy of the recently updated and approved practice safety alert protocol

## Effective

## Rating: Good

At our previous inspection in April 2022, we rated the practice as inadequate for providing effective services. This was because:

- We identified gaps in staff training and appraisals.
- We found that patients' treatment was not always being regularly reviewed and updated.
- DNACPR forms were not always fully completed.

In November 2022, we saw that improvements had been made and that sustainable changes were in place supported by managerial oversight. The practice is now rated as good for providing effective services.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
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 prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Clinical meetings were held on a weekly basis, and a medicines management meeting was held each month.</li></ul>	

### Effective care for the practice population

#### Findings

- The practice identified older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Annual health checks were offered to patients over 75 years of age. This included a 30 minute telephone call structured medicine review by the pharmacist for those aged 75 or over, or those patients being prescribed 10 or more medicines.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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 93% had been completed (the remaining patients declined to attend).
- 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 allocated a dedicated session for each GP weekly to review complex cases and ensure that appropriate care was in place.
- 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, and referred them to appropriate services to support their needs.
- The practice worked with health and social care colleagues to assess and monitor the physical health of people with mental illness, severe mental illness, and personality disorder. The practice planned to use a GP registrar, or to recruit a mental health specialist clinician, to lead on this in house in the near future. A visiting mental health practitioner saw patients at the practice for lower level support including counselling.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with guidance to optimise their care. The practice planned to review its overall approach to asthma management.
- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. GPs led a structured 30 minute annual review for patients with dementia, heart failure and rheumatoid arthritis.
- For patients with the most complex needs, clinicians worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice demonstrated they had effective processes to identify patients with commonly undiagnosed conditions, for example atrial fibrillation, diabetes, chronic obstructive pulmonary disease (COPD), dementia, and hypertension. We saw that prevalence rates were higher than other local practices in all common long-term conditions apart from peripheral arterial disease.
- The practice also had high rates of patients with cancer and patients identified as end of life. Services were tailored to meet these patients' individual needs.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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)	99	100	99.0%	Met 95% WHO based target
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)	117	120	97.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	117	120	97.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	117	120	97.5%	Met 95% WHO based target
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)	138	144	95.8%	Met 95% WHO based target

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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice performed well in respect of childhood immunisations. Systems supported a good uptake of vaccinations with follow up for those who did not engage.</li> </ul>

Cancer Indicators	Practice	SICBL 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	72.4%	N/A	80% Target	Below 80% target

64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	64.0%	65.5%	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)	72.4%	70.9%	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)	62.9%	58.2%	55.4%	No statistical variation

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.

#### Any additional evidence or comments

- The practice was trying to encourage attendance for cervical screening. Appointments were available on a Saturday as part of the PCN's extended access service. The practice was also considering how it could offer additional appointments to their own registered patients for continuity.

#### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	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.	Y
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

- The practice had a programme of scheduled audits covering a wide range of internal processes, oversight of clinical performance, and clinical effectiveness.
- We were provided with examples of recently completed audits. This included a two cycle audit on patients being prescribed high dose opioids. This highlighted that medicines were appropriate and being regularly monitored.

#### Any additional evidence or comments

- There were audits to review the prescribing quality of independent prescribers based on a national competency framework. We saw the most recent one from October 2022 demonstrated high standards of prescribing.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
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> <ul style="list-style-type: none"> <li>At our previous inspection in April 2022, we identified gaps in staff training. When we returned to the practice in November 2022, we found that all staff were up to date with the practice's mandatory training schedule. This was closely monitored by the practice management team to ensure that when updates were required, staff completed these in a timely fashion.</li> <li>Staff told us they had protected time to complete their allocated learning. In order to address the backlog of training modules identified at the last inspection, staff were offered overtime to do the training in their own time at home.</li> <li>The previous inspection identified that many staff appraisals were out of date. By the time we returned to the practice in November 2022, we found that all staff appraisals had been completed. We observed a sample of these and saw that these were of good quality with personal objectives and they included the identification of learning needs. Line managers undertook the appraisal and these were sent to the partners upon completion for review and sign off. The practice told us they intended to further develop these by aligning them with practice business objectives in the future.</li> <li>We saw that the appraisal process included the discussion of any complaints and significant events that the individual staff member had been involved with. This was in recognition of the impact this may have on the individual and the appraisal was being used as an opportunity to reflect on what had happened, what learning this had produced, as well as to bring closure and assurance for the staff member. There were plans to introduce 360 degree appraisals for all staff from next year. Managers had received training in appraisal since our previous inspection which demonstrated the provider's commitment to improve.</li> <li>We saw examples of how new staff competencies were assessed. All staff we asked told us they were well supported by managers and colleagues when they started their roles, with opportunities to shadow and to be observed whilst acquiring experience in the role.</li> <li>Staff told us they were mostly able to access informal supervision, rather than via a structured and documented approach. However, the recent review of how team meetings worked afforded more opportunities for discussion for each cohort of staffing.</li> </ul>	



- The practice was aware that more staff were needed to be able to effectively deliver the level of service required. At the time of our inspection, the practice were advertising for 2 administration posts, 2 receptionists, 3 advanced practitioners and 2 salaried GPs.
- The practice had access to additional specialist staff through their PCN, for example: a first contact physiotherapist, a mental health practitioner, and pharmacy support.

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice hosted monthly multi-disciplinary meetings to review their most vulnerable cohort of patients. A quarterly meeting was also held to review end of life patients with the palliative care nurses.</li> <li>• The practice team looked after a number of local nursing care homes and each had an allocated GP who visited the home to undertake a weekly ward round. Visits could be arranged at additional times to accommodate more acute needs, including those residents requiring end of life care.</li> </ul>	

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice performed well in delivering blood pressure checks to 84% of patients aged over 45 without a long-term condition.</li> </ul>	

## Consent to care and treatment

**The practice 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.	Partial
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> <li>Following our previous inspection, the practice had reviewed that all DNACPRs held on patient records were appropriately signed. An audit in November 2022 had demonstrated that 100% of the sample of 25 randomly selected DNACPRs included an appropriate clinician's signature.</li> <li>At the inspection in November 2022, we reviewed a random sample of DNACPRs and were assured that these were being signed by an appropriate clinician. We observed that 1 record did not have a completed section pertaining to mental capacity for a patient with dementia, nor had there been any documentation of discussion with care home staff or relatives as part of a best interests assessment. A GP partner informed us that they would undertake further audits of the DNACPRs but rather than focusing on signatures, they intended to review specific parameters such as mental capacity assessments and reviews.</li> </ul>	

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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

### National GP Patient Survey results

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
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 (01/01/2022 to 30/04/2022)	79.5%	86.0%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	77.0%	84.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	87.3%	93.7%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	46.8%	72.5%	72.4%	Variation (negative)

### Any additional evidence or comments

- We saw examples of how staff cared for patients during our inspection. For example, we saw a receptionist help an older patient to arrange an appointment with the nurse straight away so they did not have to come back.
- We spoke with 3 patients who all provided positive feedback about team members and described a good experience in obtaining an appointment.

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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>• A patient survey was planned for early 2023. This would build on the areas of lower performance identified in the national 2022 GP patient survey to review how changes were impacting upon patient experience.</li> </ul>

## 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

## National GP Patient Survey results

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
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 (01/01/2022 to 30/04/2022)	88.6%	90.5%	89.9%	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 easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	323 (2.3%). This figure reflects that the practice had a good system to identify carers.
How the practice supported carers (including young carers).	<p>The practice had an identification of carers policy and this included a summary of the support offered to carers:</p> <ul style="list-style-type: none"> <li>• The offer of an annual health check</li> <li>• Referral to the RISE team for support, if requested to help promote general physical and mental well-being. This PCN led team included a social prescriber, and is an initiative provided in conjunction with the county council to help people identify their health priorities, and make changes to improve their health and wellbeing.</li> <li>• The provision of a face-to-face Admiral Nurse (specialist dementia nurse) clinic once a month, for carers of those patients with dementia.</li> <li>• Discussion about carers' needs took place as appropriate in multi-disciplinary meetings and palliative care meetings</li> <li>• Access to the priority line telephone number to use for the person they care for in case of any urgent needs.</li> <li>• Provision of the annual flu vaccination which could be given at the home of any housebound patient they cared for.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• Condolence cards were sent to the family of a bereaved patients and provided with information on support available.</li> </ul>

## Privacy and dignity

### The practice respected respect 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

# Responsive

Rating: Good

## Responding to and meeting people's needs

At our previous inspection in April 2022, we rated the practice as requires improvement for providing responsive services.

Following the inspection in November 2022, the practice is rated as Good in the responsive key question.

## 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: <ul style="list-style-type: none"><li>A PCN member of staff had been acting as a care coordinator and translator for members of the Ukrainian community who had moved into the area to escape the war. This individual worked with the practice to support patient registrations and access to health care services, including immunisations and screening programmes. The new patient registration form was available in Ukrainian.</li></ul> Evidence to demonstrate compliance with the Accessible Information Standard included: <ul style="list-style-type: none"><li>All staff were allocated mandatory training on the Accessible Information Standard.</li><li>A hearing loop was available for patients who were hard of hearing.</li><li>The television screen in the waiting area had written information and audible videos.</li><li>Translators or British Sign Language support could be booked to attend face to face appointment with patients. Language line was offered to patients via telephone.</li><li>Alerts were placed on records for any patients that need accessible information, for example, if a patient was deaf and therefore needed to be collected from the waiting area by the clinician.</li><li>All practice-produced posters were in calibri font, in line with British Dyslexia Association's recommendation.</li><li>Information sent to patients with a learning disability was available in easy-read format.</li><li>The practice planned to amend all outgoing correspondence to calibri font size 12 as a project for next year.</li></ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm



Thursday	8am to 6.30pm
Friday	8am to 6.30pm
GP/ANP Appointments available:	
Monday	8.30am to 12.30pm/2.00pm to 6.30pm
Tuesday	8.30am to 12.30pm/2.00pm to 6.30pm
Wednesday	8.30am to 12.30pm/2.00pm to 6.30pm
Thursday	8.30am to 12.30pm/2.00pm to 6.30pm
Friday	8.30am to 12.30pm/2.00pm to 6.30pm
<ul style="list-style-type: none"> <li>Patients can obtain additional appointments in the evening and weekends via a local enhanced access service. This is provided onsite on Wednesdays 6.30pm-8.00pm and remotely on Fridays 6.30pm-8.00pm.</li> <li>The minor injuries unit at Rutland Memorial Hospital ran by practice staff opened Monday to Friday 8.30am to 6.30pm. Outside of GP opening times, an urgent care service, managed by another organisation, opened from 6.30pm to 9pm on weekdays, and from 9am to 7pm at weekends and bank holidays.</li> </ul>	

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

- The practice was commissioned to provide a minor injuries unit which was held next door at the Rutland Memorial Hospital. This was open between 8.30am and 6.30pm Monday to Friday. This was open to all patients, and not just those registered with the practice. This provided another access option for patients with a minor injury.
- The activity at the minor injuries unit was variable. We were told that staff working in the unit helped with seeing patients for the practice when they had capacity to do so.
- The practice provided blood test appointments. Not all practices in the region provided this service, but the practice wanted to ensure the service was available for their patients as a rural location in order to reduce lengthy travels to the hospital. The practice had recently increased the number of blood tests by reducing the appointment length from 10 to 7.5 minutes. The practice told us they did approximately 1,000 blood tests each month, 14% of which were undertaken on behalf of secondary care to ensure patients were seen close to home.
- Patients had a usual GP who supported them in whatever setting they lived to ensure continuity.
- The practice was responsive to the needs of older patients and offered home visits and urgent and longer appointments for those with enhanced needs.
- A named GP was allocated to each care home assigned to the practice. Weekly ward rounds were arranged in each home, and additional visits were undertaken for more acute presentations.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Nurse appointments were available for school age children outside of school hours so that they did not need to take time off.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. All infants aged 2 or under would be seen by a GP or ANP on the day.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

- An orthopaedic consultant visited the practice weekly to see patients with lower limb skeletal disorders. The practice arranged x-rays prior to this consultation. This promoted secondary care access for a rural community who would otherwise need to travel to a hospital. It also helped to reduce the time for referrals to be added onto a surgical waiting list.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise 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	N
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	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> <ul style="list-style-type: none"> <li>• Telephone systems had been reviewed and updated in the previous 2 years in recognition of difficulties with telephone access. However, this remained a significant issue for patients as many remained dissatisfied with access, and there was a continued need to reinforce messages about access to the local population.</li> <li>• Vacancies in the reception and administration team created some difficulties in providing sufficient cover for incoming calls. The practice was actively trying to recruit to these posts.</li> <li>• We looked at the practice's appointment system and saw that there were a range of appointments provided to offer flexibility. Patients could arrange an appointment in person, by telephone, or online. A range of appointments could be booked online including those with a GP or ANP and for cervical screening, long term condition reviews, B12 injections, INRs (to review blood clotting), diabetic foot checks, and blood pressure checks. Repeat medicine requests could also be arranged online.</li> <li>• There was a facility on the practice website to submit an online consultation form which would be reviewed by a clinician to determine any follow up actions required within 3 working days. There had been over 400 online consultations in the last month.</li> <li>• On the day of the inspection, we saw that there were appointments available to accommodate any acute presentations on the day, the next pre-bookable GP or ANP appointment was available in one week's time, and a nurse appointment in 10 days. Same day appointments were available at the minor injuries unit held at Rutland Memorial Hospital.</li> <li>• We saw that 30 mins appointments were available for patients with complex needs including end of life care. There had been 60 of the 30 minute appointments provided in the last month. This slightly reduced the availability of appointments but was validated by the need to allow time to meet the needs of the practice's most vulnerable patients.</li> <li>• Priority patients (for example, those with end of life needs) were provided with an alternative number to contact the practice to ensure they would be responded to promptly.</li> </ul>	

- A&E attendance rates at 201.6‰ and were below the local and national averages of 244.4‰ and 312.4‰. Higher A&E attendance rates may be an indicator of poor access.
- Information sheets were available in reception to describe the different ways patients could access an appointment at the practice and at the minor injuries unit. These also provided direct telephone contacts for the mental health crisis team, counselling, physiotherapy and the drug and alcohol service.
- DNA (did not attend) rates were higher than local averages. This impacted on access for other patients.

### National GP Patient Survey results

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
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 (01/01/2022 to 30/04/2022)	19.1%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	34.0%	56.2%	56.2%	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 (01/01/2022 to 30/04/2022)	26.8%	52.7%	55.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	60.4%	72.8%	71.9%	No statistical variation

### Any additional evidence or comments

- There was a significant issue regarding some patients' interpretation of what constituted reasonable access to appointments. The CQC had received a large number of patient concerns regarding telephone access and interactions with reception staff, and equally the practice had received many official complaints in respect of the same issue.
- Difficulties had led to the reception being closed earlier in the year. This was re-opened fully over a phased 3 month period. This was undertaken as a means of protecting reception staff from hostilities being experienced on some occasions. By the time of our inspection, the reception was fully open.
- Integrated Care Board (ICB) data demonstrated that the practice was providing comparable, and in some cases higher, levels of access than demographically similar practices. The data showed that 45% of patients contacting the practice were booked and had a same-day consultation, and this rose to 87.5% in 7 working days.

Source	Feedback
Patient interviews	We saw reception staff deal with two different patients professionally to resolve their requests, even though they were not treated respectfully by the patients.
NHS website	There had been 18 reviews posted on the NHS website, 11 of them in the last 12 months. The 2 most recent postings of the 11 from the last year were highly complementary about the practice, highlighting the online consultation service and staff being helpful and caring. There were 4 mixed comments and 4 negative postings; the negative comments largely related to being able to access an appointment, poor interactions with the patient services team and communication.
Observations	We heard a receptionist providing contact details for the mental health crisis team for a patient who required immediate mental health support.
Online reviews	We saw the practice scored 2.5 out of a maximum 5 star rating based on 67 reviews on an internet review site. Comments were mixed, some patients highlighting good care whilst others were negative, mostly about appointment availability.
Healthwatch	Healthwatch monitored patient feedback and found that there had been an improvement in patient experience in the period 2021-22, compared to the preceding year. There had also been some positive feedback received.

## Listening and learning from concerns and complaints

### Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received since previous inspection in April 2022 (1 May 2022 - 29 November 2022)	56
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice continued to receive high numbers of complaints, many of which related to access. Similarly the CQC had received a high volume of enquiries from patients over the last 12 months; this amounted to 36 in total and made the practice a significant outlier compared to the majority of GP practices in Leicestershire and Rutland. The most consistent concern related to access.</li> </ul>	

### Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint received about a staff member's attitude during a telephone call	Training in telephone etiquette and dealing with conflict arranged. All appropriate staff completed customer care training.

Complaint about a procedure received and the chaperone arrangements that were in place.	<p>The practice chaperone policy was updated to reflect the concerns of the patient.</p> <p>The procedure was reviewed from the individual patient's perspective and changes were made to how this would be improved during any subsequent attendance for the same procedure.</p>
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## Well-led

**Rating: Good**

At our previous inspection in April 2022, we rated the practice as inadequate for providing well-led services. This was because:

- Governance processes were insufficient to effectively identify and minimise risk.

Following the inspection in November 2022, the practice is now rated as good in the well-led key question.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We found that leaders had been proactive in their response to the outcome of our previous inspection. Partners and managers had worked extensively to try and address the concerns that were identified.</li> <li>• After the inspection in 2022, the partners had commissioned an experienced practice business consultant to provide advice and guidance to the practice to promote further and sustainable improvement. We saw this had been successful and added additional expertise to drive improvement, whilst also supporting the existing practice management team and partners throughout a difficult period. The consultant had developed an extensive work plan in response to concerns observed at our previous inspection and had also included other issues which needed wider review supported by effective future planning arrangements.</li> <li>• Since the previous inspection, the practice had also sought assistance from the Royal College of General Practitioners (RCGP) and a quality improvement forward plan had been produced. However, this was only received just prior to our inspection although we saw it mirrored the work that the practice was already undertaking.</li> <li>• Partners and managers met on a weekly basis. We saw an example of how an effective set of actions were drawn up after each meeting which were subsequently reviewed at the following meeting.</li> <li>• The practice worked with other local practices as part of the Rutland Health Primary Care Network.</li> <li>• The practice had engaged with their commissioner, Leicester, Leicestershire and Rutland Integrated Care Board (LLRICB) to respond to the findings at the last inspection. This included taking part in a rapid quality review meetings involving all stakeholders to openly discuss issues and consider how these were being addressed or mitigated.</li> <li>• As part of future planning and sustainability, the practice was considering the potential for diversifying the partnership from its traditional GP focus.</li> <li>• The partners were supporting one of the practice managers to undertake a nationally accredited training course for practice managers.</li> </ul>	



## 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice mission statement said, "We are committed to provide quality and compassionate, patient centred care to all of our patients".</li> <li>The practice had developed a set of values and had a vision which was available on the practice website.</li> <li>The partners were in the process of developing a business plan as a basis for future development. A facilitated 'away day' for partners was being planned to focus on strategic planning.</li> <li>Feedback from some staff questionnaires indicated that staff did not always feel involved in the development of any future planning for the practice.</li> </ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A member of the practice team was identified as a mental health first aider. There were a small number of these across the PCN practices and notices were displayed in staff areas with their contact details. These roles were intended as a source of support for staff experiencing difficulties and needing support and signposting.</li> <li>All of the patient services team had undertaken training in customer service, telephone etiquette, conflict resolution and emotional resilience to help them accommodate more challenging telephone conversations.</li> </ul>	

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

Source	Feedback
Staff feedback and staff questionnaires	<p>We received 25 staff questionnaires from staff that were distributed the week before our inspection. We also held interviews with staff members and talked with members of the practice team on the day of the inspection. Themes from the feedback included:</p> <ul style="list-style-type: none"> <li>• The vast majority of responses indicated that staff had completed training and had been supported to do so; they had received an appraisal; the team worked well together to help support each other and there was good camaraderie; staff knew how to report incidents and received feedback on any learning points</li> <li>• Some staff highlighted that they felt more staff were needed. However, we were aware that there were vacancies and the practice was trying to recruit into these roles. The vacancies appeared to particularly impact on administrative duties in covering reception, and in providing urgent on the day appointments as three advanced paramedics had left the practice.</li> <li>• The area that received the least favourable feedback was being given clear direction and feedback on work; being valued, and receiving effective communications from partners and managers. However, comments were mixed, and other staff reported positively about these areas.</li> <li>• There was an acknowledgement that staff morale was low due to the significant demands of work which had increased since the pandemic, staff turnover, patient expectations and adverse feedback, and the special measures status.</li> <li>• However, we also found that things were improving and staff provided positive views about the future. Staff were proud of the work they did and mostly enjoyed their roles despite the work pressures. There was a sense of commitment to work with management to improve and achieve goals. The feedback also highlighted good quality care and managers were said to be supportive and approachable. However, staff wanted to be heard more and they had ideas to contribute towards making improvements. The recent review of team meetings should help to develop this.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a software package which enabled them to collate all their evidence for compliance in one place. This also helped set a reminder for reviews. Since the previous inspection, the use of this software had become more embedded and we observed this was working well in November 2022.</li> </ul>	

- The practice had a range of policies and procedures which were regularly reviewed and updated as appropriate. Staff knew how to access these. We saw that policies were comprehensive, well written, clear, and reflected appropriate national guidance.
- There was a programme of regular meetings held at the practice which covered all aspects of staffing and governance. Meetings were recorded so that staff could listen if they were unable to attend. Written action points were developed from each meeting which were kept under review to ensure they were completed, and these were available to the team on the practice software package. Weekly team leader meetings had recently been introduced to discuss key issues with the appropriate cascading of timely information to their own teams.

## Managing risks, issues and performance

### There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had needed to implement their business continuity plan twice just a few weeks before our inspection. This was due to an issue that meant they had to close the minor injuries unit and transfer the service to the practice for continuity, and also on a separate occasion due to an issue when the telephone lines went down. The business continuity plans worked effectively and some minor additions were made to the plan as learning points following the incidents. The patient participation group were also involved to help get messages to patients when the phone lines stopped working.</li> <li>• The practice had set up a portacabin as a safe hub for patients with suspected COVID-19 symptoms, and this was still used to see patients in isolation (if needed) at the time of our inspection. It was now also being used on occasions for other consultations or as an office, but systems were in place to adhere to best practice in infection control processes.</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.	Y
Performance information was used to hold staff and management to account.	Y

Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw that the practice used data provided to review service delivery, for example, benchmarking data provided by their ICB to review their performance on a range of parameters against other local practices and the wider area. Where appropriate, the data was used to plan changes.</li> </ul>	

## 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
Staff are supported to work remotely where applicable.	Y

## 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.	Y
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: <ul style="list-style-type: none"> <li>Regular staff meetings were held. Full team meetings were held at the monthly protected learning sessions as required.</li> </ul>	

- The practice planned to undertake their own staff survey in January 2023. Our interviews with staff highlighted that those working in reception had good suggestions to help improve patients' perceptions of poor access, and the practice told us they would try to ensure their involvement in reviewing how services were delivered.
- A 'Hero of the Month' award had been set up to acknowledge staff service above and beyond their remit. The monthly winner would be put forward for an annual 'Hero of the Year' award.
- The practice had previously had a social media presence but this had been problematic due to how some people were expressing their dissatisfaction about not being able to access an appointment when they wanted one. The practice told us that they were planning to reopen their social media account as a way of communicating with patients, and hoped this would have a more positive impact than previously.

Feedback from Patient Participation Group PPG).

## Feedback

- We spoke with the PPG chair who reported that they had established good foundations for a productive relationship with the practice as a critical friend. Meetings were described as being positive.
- There had previously been difficulties with the PPG relationship, and the group had mostly been rebuilt with new members joining over the last three to four months. This provided an opportunity to review how the PPG worked, and the relaunched PPG had posted their aims and own mission statement on the practice website.
- There were 12 PPG members. The PPG met on their own monthly, and approximately every six weeks with the practice management.
- PPG members had assisted a review of the telephone systems by undertaking a mystery shopper exercise. This resulted in suggestions being made to the partnership which the PPG felt were being considered; for example; a formalised script to be used by all staff when answering incoming patients calls.
- At the time of our inspection, the PPG were arranging information to send out to patients to remind them to order their medicines in time for Christmas. This would be sent as a Christmas message to patients and this would also help promote awareness of the PPG. The PPG planned to build on this to develop a set of frequently asked questions to help patients, and in the longer-term develop a formal PPG newsletter for patients.
- The PPG had also attended 3 Saturday flu clinics at the practice to help welcome patients but also to talk with patients to get feedback and discuss how the PPG worked. The PPG had a tablet to show patients how to book an online consultation.
- The PPG had their own email for patients to contact them directly.

## 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

- There was a strong commitment to learn and improve. We saw that the work undertaken by the practice to develop their own auto-consultation templates to improve patient safety would help deliver improved patient outcomes.
- Learning was applied from significant events and complaints to improve patient experience and outcomes.
- Audit was used to review compliance against standards and best practice, and improvements were made when shortfalls were identified.

#### 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.