

## Inspection Evidence Table

Gordon Street Surgery

(1-551326240)

**Inspection Date: 15 May 2023**

Date of data download: 03/04/2023

## Overall rating: Inadequate

At our last onsite inspection, 30 June 2021, we found that the practice had satisfied most but not all of the requirements of Health and Social Care Act 2014 (HSCA) Regulated Activities (RA) Regulation 17 (Good Governance) requirement notice. Therefore, as the provider had mainly, but not fully, met the Requirement Notice the Care Quality commission (CQC) served, they remained in breach of this regulation.

The last announced review took place on 22 September 2021 to review the warning notice served to Gordon Street Surgery for breaches under Section 29 of the Health and Social Care Act 2008. We served the warning notice on 1 July 2021 and had required the practice to be compliant with Regulation 19(1) and 19 (2) Fit and Proper Persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, by 8 September 2021. We reviewed the breach within Schedule Three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 “all potential and employed staff.” However, we did not review other breaches or re-rate the practice at the 22 September review. Therefore, the ratings from the previous inspection in June 2021 remained, unchanged these ratings were requires improvement overall and inadequate for providing a safe service.

At this inspection on 10 and 15 May 2023 we found that the practice had made improvements in the maintenance of recruitment records, for example, staff had job descriptions for their role and their signed contract reflected their role. However, there remained gaps, for example in two files there was a lack of references, a request was seen by the practice management for a copy of a locum GP’s updated medical indemnity, but this was not seen within the file. This was followed up by the practice manager during the onsite inspection and filed. We found that a clinical staff member had a standard not enhanced disclosure and barring check.

## Safe

## Rating: Requires Improvement

The practice was rated Inadequate in Safe at the last inspection in June 2021. The practice had a sustained breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) Fit and proper persons employed as found in our inspections of the service in August 2019 and June 2021.

We carried out a desk top review of this practice in March 2021 in response to concerns raised by an external stakeholder and found that the practice was additionally in breach of Regulations 12 and 17 of HSCA (RA) Regulations 2014, Safe care and treatment and Good Governance.

At our inspection in June 2021, we found the provider had satisfied the Requirement Notice the Care Quality Commission (CQC) had issued in response to the breach we found in Regulation 12 of HSCA. They had made improvements in several systems and processes to keep people who used the service safe. However, we found that further improvements were still required in identifying the actual cause of significant events and sharing the learning from the events.

During the inspection on 10 and 15 May 2023 we found:

- Staff were not all in receipt of safeguarding training at the level their role required.
- We found on review of the practice fire safety policy that nominated staff had not completed fire marshall training. However, at the time of the onsite inspection visit this training had been completed.
- Recruitment files were well ordered; however, in two files we found a lack of references. In one file, we saw a request made for a copy of a GP's updated medical indemnity, but the update was not held on file. This was put in place during the onsite inspection. The same recruitment record also held a standard, not an enhanced disclosure and barring check.

### Safety systems and processes

**The practice had some 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice staff had access to safeguarding policies on their electronic systems. Additional information was available for staff in respect of Female Genital Mutilation and staff had received Prevent training. (Prevent is about safeguarding individuals from being drawn into terrorism, ensuring those vulnerable to extremist and terrorist narratives are given appropriate advice and support at an early stage). Staff knew who the practice safeguarding lead was and there were clear deputising arrangements in place.</p> <p>Staff informed us that alerts were added to the records of patients and families with a child protection plan in place.</p>	

Not all clinical staff had completed safeguarding training to the levels required, which included the practice nurse and pharmacist. Following our feedback, the new practice manager booked staff onto the next available training.

Ten practice staff had completed chaperone training and the practice maintained an accessible chaperone policy.

Out of hours visits, deaths, hospital admissions or the need for urgent follow-up were sent via their electronic systems to the appropriate services and they reviewed information received from the Out-of-Hours service provider by 9am. The administrator distributed the information received to the GPs and if urgent, brought this to the attention of the duty GP. The administrator updated the out of hours clinical information onto the practice electronic clinical system by 1pm the same day. The GP actioned the information and arranged any required visits, telephone follow-up and information coding. We saw that the practice policy regarding out of hours communication needed to be updated as it did not specify the sharing of safeguarding information when appropriate.

The practice reported that referrals to the safeguarding teams were appropriately made and accepted. The practice manager told us they had in the past tried to reconcile the safeguard registers to ensure accuracy with the safeguard local authority teams, however they were advised by the safeguard teams that this was not possible. There was no evidence seen of the escalation of this matter to find resolution.

The practice told us they were unable to hold regular meetings with health and social care professionals, to discuss all vulnerable adults and children at risk of harm, due to the lack of availability of staff in these roles to attend. The practice told us they contacted health visitors and school nurses when they needed to discuss a concern.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained a recruitment policy revised in March 2023. Recruitment files were well ordered; however, in two files we found a lack of references. In one file, we saw a request made for a copy of a GP's updated medical indemnity, but the update was not held on file. This was put in place during the onsite inspection. The same recruitment record also held a standard, not an enhanced disclosure and barring check.</p> <p>In a four-year period, the practice had recruited 5 practice managers which had added to the practice's staff attrition rates. Staff attrition, in particular, practice managers, as well as nurses and reception staff were discussed with the GP partners. The partners acknowledged difficulty in recruiting to the nursing team and receptionists who had no experience tended to leave if they found the work was not what they had expected.</p> <p>The practice completed a significant event report in response to the recognition of staff attrition following the announcement of the inspection. Staff exit interviews had been completed according to a GP partner however significant event minutes on 25 April 2023 stated otherwise. On discussion with the practice manager whilst onsite, no evidence of exit interviews, recent or past could be located.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: 01/02/2023	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 27/04/2023	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Portable appliance testing (PAT) was completed 09/12/2022. All with the exception of digital scales passed and following this a PAT certificate was issued as all had passed.</li> <li>• Equipment calibration certificate was issued 09/12/2022.</li> <li>• The practice manager completed basic fire awareness training 23/02/2022.</li> <li>• The last fire evacuation drill was completed 01/07/2022.</li> <li>• The practice had a Nominated Fire Officer, a Nominated Deputy Fire Officer but no Nominated Fire Marshals. The practice manager following this feedback booked staff for the appropriate training which was completed prior to our onsite inspection.</li> <li>• Fire extinguisher checks were complete 16/03/2023.</li> <li>• Emergency lighting periodic inspection took place on 24/08/2022.</li> <li>• Landlord Gas safety record which included a service record for boiler, smoke alarms was completed, 24/03/2023.</li> <li>• The practice five year-electrical certificate was dated 07/03/2020.</li> <li>• The practices' Control of Substances Hazardous to Health (COSHH) policy was revised in March 2023 the practice employed an external cleaning company who completed annual COSHH audits.</li> </ul>	

### 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.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control (IPC) audit: 03/03/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Legionella, water hygiene was checked on 08/03/2023 this was subject to a monthly visit.</li> <li>• Fridges for vaccines were last calibrated on 29/11/2022.</li> <li>• The IPC audit was overdue for 2023 however the practice manager following inspection feedback booked an external IPC audit which was due to take place in July 2023.</li> <li>• The practice had very recently appointed an IPC lead with overall responsibility for IPC. The lead had not had any additional training in IPC or completed an IPC audit. They had yet to fully appreciate what was required for this lead role.</li> </ul>	

The practice employed contract cleaners.

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Reception and administration staff provided cover for each other with any absence or sick leave but at times they reported they were short of staff. For example, on the day of our onsite inspection two staff were on sick leave. The practice told us they hoped to recruit more reception staff and there were advertisements for various roles at the practice.</p> <p>The practice GP team were supported by two long term locum GPs, providing 4 and 3.5 hours per week varied according to need and to the extent of the number of sessions identified.</p> <p>The practice employed an advanced nurse practitioner whose appointments included patients over the age of 10 years for minor illness/injury appointments.</p> <p>The practice employed a pharmacist for 18 hours a week who amongst other work completed patient medicine reviews.</p> <p>The practice had required external support for a period of time to their nursing team. Practice nurse support had been provided during periods of shortage of staff for example by a neighbouring practice via the Primary Care Network (PCN). The practice nursing team included two practice nurses, one working 32 hours per week and the other 16 hours per week. The practice had advertised for a practice nurse and a new nurse recruit was due to commence in June 2023 for 15 hours per week.</p> <p>The practice employed a healthcare assistant (HCA) who completed new patient health checks and wellbeing checks, phlebotomy and some injections and vaccinations on patient specific directions authorised by the GP. The appointment system dates reviewed demonstrated that injections and vaccination appointments were booked when the advanced nurse practitioner or other clinical staff were available. The practice also employed a phlebotomist.</p> <p>Staff reported that the locum GP induction system was used for temporary staff including that of nurses and other clinical staff.</p>	

**Information to deliver safe care and treatment.**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <p>Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. However, in 2 of the 5 randomly selected patient records checked to determine the quality of the medicine reviews found there was room for some improvement in the documented content. Details in the patient consultation notes were needed for example to provide context on the type of appointment, phone or face to face as well as a brief notes on the medicine review discussion.</p>	

**Appropriate and safe use of medicines**

**The practice had 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	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.95	0.97	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	9.4%	10.6%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	5.43	5.53	5.24	No statistical variation



capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	105.5‰	129.3‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.72	0.42	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	2.5‰	3.4‰	6.8‰	Variation (positive)

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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes

There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence, including from clinical searches.	
<p>Medicines requiring monitoring are those that are used for treatment of conditions that need regular monitoring to ensure that side effects are kept to a minimum and the risk to patients is low. Patients on rheumatoid arthritis medicines at the practice were monitored within secondary care who also repeat prescribed. The practice held information within the patients electronic records on the medicines prescribed and monitored by secondary care.</p> <ul style="list-style-type: none"> <li>• There were 20 patients prescribed potassium sparing diuretics and our clinical searches suggested that 6 patients were overdue their monitoring. We sampled 5 records and found that 3 out of the 5 were overdue the required monitoring. These findings were shared with the GP partners.</li> <li>• 59 out of 178 patients over the age of 70 who were prescribed a non-steroidal anti-inflammatory drug (NSAID) and were not prescribed a Proton pump inhibitor (PPI) (medicines that work by reducing the amount of stomach acid made by glands in the lining of the stomach). Of the 5 records we sampled we found no concerns.</li> <li>• Our searches identified that 685 patients had been in receipt of a medicine review within the previous 3-month period. We sampled 5 records and found 2 records which had a single line entry regarding the review. This was discussed with the GP partners as information such as the content and context of the review was not documented.</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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	10



Number of events that required action:	10
<p>Explanation of any answers and additional evidence:  The practice maintained a significant event/incident management procedure which was accessible to all staff and was last reviewed in May 2023.</p> <p>The practice had yet to hold a whole practice team meeting, to discuss significant events trend analysis. The practice manager told us this was now planned.</p>	

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

Event	Specific action taken
<p>A nursing staff member during a consultation found that the patient had not been informed of their hospital investigation result until a significant amount of time had passed.</p>	<p>The patient was upset and confused due to delay in being informed of their result. The patient was assured that this would be investigated and followed up as a significant event. The nurse informed the practice manager. The practice manager immediately responded by contacting the hospital to request an update. The patient's results were sent by the hospital and were then scanned onto the practice electronic system and processed. The hospital had acknowledged there had been a system failure, they rectified the failure, contacted the practice and apologised.</p> <p>The practice significant event process was followed and actions to mitigate risk and reduce reoccurrence included:</p> <ul style="list-style-type: none"> <li>• Informing staff to be vigilant, should results be expected but were not received and patients contact the practice for an update, practice staff must be proactive and chase up outstanding results.</li> <li>• The practice as a result of this event built an electronic search for all referrals made to be picked up. The medical secretary reviewed the search outcome on a monthly basis to ensure patients who had been referred, were seen and results forwarded.</li> </ul> <p>The practice established through their root cause analysis that they should not always rely on secondary care to forward the results; they needed to be more proactive.</p> <p>There had yet to be an evaluation on the actions taken.</p>
<p>A patient following a review in secondary care had been subject to a reduction in their medicine dosage.</p> <p>This change was not actioned until the pharmacist was reconciling medicines and reviewed the secondary care letter saved into the patient's electronic record.</p>	<p>The pharmacist was reconciling medicines and noted a patient was prescribed by the practice a higher dose of a medicine than that documented in their secondary care letter.</p> <p>This was reported as a significant event and was subject to investigation. The practice found that the</p>

	<p>secondary care letter was filed as under review by secondary care and not for action by the practice. This was subsequently picked up by the practice pharmacist and rectified. The letter should have been forwarded to the GPs for action and not filed.</p> <p>The practice significant event process was followed and actions to mitigate risk and reduce reoccurrence following a root cause analysis activity included:</p> <ul style="list-style-type: none"> <li>• All letters relating to medication should be sent to the pharmacist or GP.</li> <li>• The practice workflow team were informed.</li> <li>• Staff were reminded that all medicine details were important and should be brought to the attention of a clinician to review.</li> <li>• Workflow team were spoken to and advised to send all letters relating to medicines, whether secondary care prescribing or not, for review to a clinician.</li> <li>• The practice found there was no clarity in the secondary care letter that specifically stated there was a medicine dosage change. However, the practice recognised they should not assume the medicines prescribed were the same as those on the patients' electronic system at the practice until checked.</li> </ul> <p>There had yet to be an evaluation on the actions taken.</p>
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Patients prescribed medicines requiring specific advice and guidance following drug safety alerts such as those from the Medicines and Healthcare products Regulatory Agency had received patient information via the practices software electronic system, AccuRx.</li> <li>• 102 patients were prescribed a Sodium-glucose co-transporter-2 (SGLT2) inhibitors, used for treating type 2 diabetes by helping the kidneys to lower blood glucose levels. We sampled 5 of the 102 records and following discussion the GP partners found all had received the appropriate specific advice and guidance via their systems.</li> </ul>	

## Effective

## Rating: Required Improvement

At our last onsite inspection, 30 June 2021, the practice was rated as Requires Improvement for providing effective services and all six population groups were rated as Requires Improvement. We found:

- Further improvement was needed in the uptake of the cervical screening programme and in the Quality and Outcomes Framework clinical indicators for diabetes; annual asthma care plan reviews; chronic obstructive pulmonary disease (COPD) and blood pressure management.
- Medicine reviews were overdue for some patients. Records reviewed showed that no formal structured reviews were taking place. Clinicians were coding that a medicine review had occurred, but there had only been a discussion about one medicine. The practice usually carried out structured annual medicines reviews for older patients. However, the practice had not completed these during the Covid 19 pandemic and were planning to catch up with medicine reviews.
- The practice had not met the minimum 90% for of the five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators.
- Mental health care plans were reviewed. Care plans were in place for patients being reviewed by the Mental Health Team. However, there were no formal care plans documented for some patients after a mental health review at the practice.
- Not all staff had received dementia training to appropriately support those patients who had dementia. The practice told us they had planned and booked this training.

### **During the inspection 10 and 15 May 2023 we found:**

- Further improvement was needed in the uptake of the cervical screening programme.
- Medicine reviews were completed by the clinical team including the practice pharmacist. During the clinical searches we found two single line entry medicine reviews completed by the GPs which required further detail.
- Four of the 5 childhood immunisation indicators were below the 90% minimum target.
- Information evidenced in the Annual GP Practice Indicators shared by external stakeholders showed the practice had a higher emergency admission figure than those of the local Primary Care Network (PCN).
- Mental health care plans were reviewed.
- Our clinical searches showed that patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.
- The clinical searches showed that 19 out of 280 patients with hypothyroidism had not had a specific monitoring blood test for 18 months. We sampled 5 records and found 4 out of 5 patients were overdue their monitoring.
- Not all staff had received dementia training to appropriately support those patients who had dementia.
- Not all clinical staff had been in receipt of Mental Capacity Act 2005 training.
- Clinical staff appraisal to include a clinician in order to review clinical competency and performance.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
<p>Explanation of any answers and additional evidence:            Information evidenced in the Annual GP Practice Indicators shared by their Integrated Care Board showed the practice had higher emergency admission figures when compared with the local Primary Care Network averages. The practice partners in response highlighted that this was in part during the pandemic and that their patients resided less than one mile from the A&amp;E departments.</p> <ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</li> <li>• The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.</li> <li>• The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</li> </ul>	

- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- New patient health checks, including frailty assessments, were offered to patients over 75 years of age.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice had with the learning disability support team taken action from the previous year's poor uptake of the annual health check offer and the GPs had improved the uptake from 17% to 70%.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.  
Patients with poor mental health, including dementia, were referred to appropriate services. Not all clinical staff had been in receipt of Mental Capacity Act 2005 training.

## Management of people with long term conditions

## Findings

- Our clinical searches suggested that 35 out of 498 asthma patients had been prescribed 2 or more courses of rescue steroids in the last 12 months. We sampled 5 records and found there was an inconsistent approach to the follow up of patients as 3 out of the 5 had had no follow up consultation within 48hrs as recommended by NICE, and one of the 5 patients had not been prescribed an inhaled corticosteroid. Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.
- Our clinical searches suggested that 12 out of 32 patients with chronic kidney disease (CKD) at level 4 or 5 who had not had a specific blood test monitoring in the last 9 months. We sampled 5 records and found 1 patient was overdue their monitoring and 2 patients needed their CKD level updating on the practice electronic system.
- Our clinical searches suggested that 19 out of 280 patients with hypothyroidism had not had a specific monitoring blood test for 18 months. We sampled 5 records and found 4 out of 5 patients were overdue their monitoring.
- Our clinical searches suggested that 67 out of 795 patients with diabetic retinopathy (a complication of diabetes) had a specific blood test result that was greater than 74mmol/l suggesting poor control of their diabetes. We sampled 5 records and found 2 patients were overdue their monitoring, both patients had evidence in their records of multiple appointment invites sent but without patient compliance. Another patient had made no contact nor responded to practice interactions and did not attend for appointments made since 2021. The practice GPs advised they would review whether this patient was still at their address or had moved without informing the practice.
- The practice took part in the National Diabetes Prevention Programme working alongside the Commissioning Business Planning Support Officer, Public Health and Prevention and sent a total of 540 self-referral letters. The practice as part of the PCN received praise for its referral rates alongside two other practices.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	109	120	90.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received	120	146	82.2%	Below 90% minimum



Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	119	146	81.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	124	146	84.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	124	145	85.5%	Below 90% minimum

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

Any additional evidence or comments
<p>Four of the 5 childhood immunisation indicators were below the 90% minimum target.</p> <p>The latest unverified data shared by the Integrated care board showed the percentage of children aged 5 who have received immunisation for measles, mumps and rubella in Quarter 2 of 2022 -2023 was 91.7%.</p> <p>The practice advised the nursing staff had focused on childhood immunisations uptake with additional support from a practice nurse from a neighbouring practice as a member of their Primary Care Network. An additional practice nurse had been recruited to provide an additional 15 hours per week and was due to commence employment in July.</p>

Cancer Indicators	Practice	SICBL average	England	England comparison
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	54.7%	67.0%	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)	57.2%	68.9%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	48.6%	50.7%	54.9%	No statistical variation
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	51.2%	N/A	80.0%	Below 70% uptake

persons aged 50 to 64). (30/09/2022 to 30/09/2022) (UKHSA)				
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**Any additional evidence or comments**

The practice advised the nursing staff had put some measures in place to improve the uptake. An additional practice nurse had been recruited to provide an additional 15 hours per week and was due to commence employment in July.

Unverified data shared by Integrated Care Board showed the uptake for persons aged 25 to 49, as of 13 April 2023 was 50.7% and, for persons aged 50 to 64 uptakes of 70.8%.

The practice advised they had in the past been in contact with local communities to provide information of the benefits of the screening programmes. They had added the risk to their practice risk register for additional monitoring and review.

The practice manager informed us that their Patient Participation Group had offered to support with sharing appropriate up to date practice literature in respect of the screening programmes.

**Monitoring care and treatment**

**The practice had a 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>Medicine audits with regular clinical patient searches were carried out by the practice team. Any resultant required actions in respect of the search findings were completed by the clinical staff.</p> <p>For example, an audit was conducted in April 2023 with the results and recommendations shared in a presentation to the practice team. The audit focused on patients with a diagnosis of chronic kidney disease (CKD) to ensure they had appropriate electronic coding on their systems following patients' blood test results.</p> <p>A review of the audit findings took place, and 14 out of 64 patients required further activity, for example 2 patients had required a follow up GP appointment but this had not happened. As a consequence of the audit, they identified a number of recommendations for improvement, these included:</p> <ul style="list-style-type: none"> <li>Clinicians who interpreted blood results needed to ensure they develop a plan if a particular blood result was below a set figure.</li> </ul>	

- At the patient’s medicine review, the clinician must check the alert on the electronic system for ‘consider CKD’ notice and action accordingly.
- The administration manager to review process for booking patients for blood results.

**Effective staffing**

**The practice was able to demonstrate that most 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.	Yes
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.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Practice nurses reported that they worked to their competencies with GP oversight for example one nurse was undertaking additional training and support for her role and completed annual reviews for diabetes and asthma patients. They had yet to commence Chronic Obstructive Airway Disease patient reviews (COPD the name for a group of lung conditions that cause breathing difficulties) until they felt competent to do so.</p> <p>Clinical staff told us they were able to speak with the GPs when required for additional support for more complex patients.</p> <p>One practice nurse advised they did not fulfil a lead nurse role at the practice as they still required support and additional education in the practice nurse role. The practice manager advised they had recruited a practice nurse for 15 hours who was due to start at the practice in a few months’ time.</p> <p>A neighbouring practice was supporting the practice nursing team nurse each week.</p> <p>One of the GP partners had completed recent competency audits on clinical staff with extended roles for example, the advanced nurse practitioner and pharmacist. This included a random sample of the clinical staff members’ patient consultation and prescribing records and a discussion of any findings or improvements required as part of their competency reviews.</p> <p>Clinical staff we spoke with told us they had been subject to probationary reviews and appraisals including personal development plans and told us they felt supported by the supervising GP. One nurse had had their</p>	

appraisal with a non-clinician, the practice manager advised this was to be rebooked with a clinical staff member.

**Coordinating care and treatment**

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

**Helping patients to live healthier lives.**

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

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

**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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Explanation of any answers and additional evidence:

We found that where a DNACPR decision had been recorded, this identified, where possible the patients views had been sought and respected, we saw that information had been shared with relevant agencies.

The practice maintained a DNACPR policy for staff to refer to which was updated in March 2023.

GPs demonstrated awareness of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and Treatment escalation plans (TEP). These tools offer patients the opportunity to plan their future care and support. This includes medical treatment and resuscitation options, while they have the capacity to do so.

However, not all clinical staff understood consent, best interest decision making or Gillick competency.

## Caring

## Rating: Requires improvement

At the last inspection in June 2021 the practice was rated as requires improvement for providing caring services as the practice national GP Patient Survey results were considerably lower than the national average. The practice had identified less than 1% of its practice population as carers.

At the inspection 10 and 15 May 2023 the practice was rated requires improvement for providing caring services as the practice national GP Patient Survey results remained significantly lower than the national average with a year-on-year decline.

- The practice had no other data to share with the Care Quality Commission to evidence they had listened or acted on the survey results from the 113 patients surveyed in July 2022. Action plans were in place, but none were signed off as completed.
- The practice had completed their own in-house survey which produced improved results to that of the National GP Survey July 2022 but from a smaller sample of patients (26).
- Improvement was required on the practice involvement of and engagement with the patient population to gain feedback in order to monitor and review the service provided.

### Kindness, respect and compassion

**Feedback from patients was mixed with some negative comments about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Partial
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence:	
Patient feedback provided on NHS UK suggested a mixed response to their experience of staff at the practice. This included feedback on staff and access.	

The practice's National GP Survey results (July 2022) demonstrated the practice had lower than the Sub Integrated Care Board Locations (SICBL) and England satisfaction rates in respect of the healthcare professionals, and with receptionists (49% found the receptionists at this GP practice helpful when compared with SICBL of, 85% and England 82%).

Patient feedback	
Source	Feedback
NHS UK	<p>In the last 12 months:</p> <ul style="list-style-type: none"> <li>• 2 x 5-star reviews- 12/07/2022, 12/08/2022</li> <li>• 1x 4 star 13/04/2022</li> <li>• 4 x 1 star 18/4/2022, 18/08/2022, 13/09/2022, 22/2/2023</li> </ul> <p>The less positive patient feedback focused on access and staff attitudes.</p>

### 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	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)	68.8%	82.6%	84.7%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	65.6%	79.6%	83.5%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	83.1%	91.9%	93.1%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	28.5%	67.4%	72.4%	Significant variation (negative)

### Any additional evidence or comments

All 4 of the indicators above were lower or significantly lower than the Sub Integrated Care Board Locations (SICBL) and England averages.

The practice reported one of the lowest percentages in England for patients overall experience of their GP practice (28.5%). These indicators had worsened, for example in 2021 patients overall experience of their GP practice was, 34.3%.



The GP Patient Survey is an independent survey run by Ipsos on behalf of NHS England. There were 113 patient responses to the National GP Survey for Gordon Street Surgery (01/01/2022 to 30/04/2022).

The practice had forwarded a document entitled 'GP Survey Results and Actions' to the CQC. No actions at the time of the inspection had been signed off as taken place or completed.

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

### Any additional evidence

The practice received 26 completed in house patient survey responses. One question asked was that of patient use of the practice on-line appointment booking service, which no patients had used. The practice reported that they realised following the survey this was because they were not releasing online appointments. They rectified this by releasing appointments online.

Of the 26 patients those fairly satisfied or satisfied with the navigation of the phone system was 61%, 31% were dissatisfied/fairly dissatisfied and 8% neither satisfied nor dissatisfied.

Of the 26 patients 50% were satisfied with the practice overall.

The practice action plan included:

They planned to improve patients phone experience by:

- Conducting an audit of phone waiting times and closely monitor.
- Sharing the results of the audit with all staff members for transparency and implement changes.
- A shortened introductory phone message to reduce the amount of time patients wait to get through.
- Recruitment of additional reception staff members to reduce the impact of staff sickness and holidays on staffing levels and therefore phone wait times.

They planned to improve patients' online access by:

- Ensuring on-line appointments are released for patient appointment booking.

They planned to improve patient feedback options by:

- The introduction of different methods of feedback e.g., patient survey, ability for patients to request reviews via text messages and emails if patients consent to this.

They planned to improve the clinician and patient relationship by:

- Finding ways to make patients feel comfortable and understood.

### Involvement in decisions about care and treatment

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

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

Explanation of any answers and additional evidence:

Staff advised they could signpost patients to access easy read and pictorial materials. The practice also used electronic and text messaging services to provide patient information literature.

Source	Feedback
Patient participation group (PPG).	<p>The PPG membership was significantly reduced following the pandemic and also in response to the lack of responsiveness to feedback from the practice. The PPG had yet to see action on previous feedback provided and this had added to the reduction in their membership.</p> <p>The PPG advised they had offered suggestions and support to improve patient telephony access. This had not been taken up at the time offered. They have resubmitted this offer to the new practice manager.</p> <p>The PPG said they felt there was a 'tick box' approach to the PPG input and on occasions neither the practice manager nor the GPs attended meetings.</p> <p>The PPG reported that the community were not happy with the GP practice access or telephone access, that they regularly heard complaints from their communities in this respect. However, once in front of the health professional on the whole patients reported satisfaction with their care.</p> <p>The PPG had suggested the practice produce literature on practice staff roles in order that they could distribute this to the various communities. This would help patients to book to the health professional required. This had yet to come to fruition but had been reiterated to the new practice manager.</p> <p>The PPG reported on the regular change of practice managers and that the practice seemed regularly short of staff in order to meet appointment demands.</p> <p>They reported positively on the repeat prescribing systems at the practice.</p>
Care homes:	<p>The practice told us that the Primary Care Network Care Coordinators had in the past liaised with care home staff and residents as well as the GPs to ensure any actions required were completed including home visit requests, acute enquiries and medicine requests. The practice reviewed the number of interactions in the period between January 2023 and March 2023, which demonstrated, 15 consultations.</p> <p>We spoke with four care home managers or nursing staff. Two care homes reported positive remarks about the practice, they found the practice approachable, friendly and responsive to their patients' needs.</p> <p>Two care homes reported access difficulties and hoped to improve their relationship with the practice, they made suggestions that would improve care and treatment for their residents:</p> <ul style="list-style-type: none"><li>• A direct dial number between the care home and the GP practice had been provided to one care home. They reported that on occasions, they had had no response from the GPs until after 6pm which was too late for them to action for example pharmacy for antibiotics.</li></ul>

	<ul style="list-style-type: none"> <li>• Another used direct email address between the care home and the GP practice. They found the response times variable, and the practice sometimes required a second prompt email.</li> <li>• They reported they used to find the PCN Care Co-Ordinator extremely helpful, but now the funding had gone the Care Co-Ordinator role was not available at this practice.</li> <li>• Another reported on the difficulty in obtaining a GP to attend a multi-disciplinary meeting in respect of one of their patients with poor mental health. They also reported on recent difficulties in obtaining a covert medicine management plan for a patient.</li> </ul>
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### 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	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)	85.0%	88.0%	89.9%	No statistical variation
<b>Any additional evidence or comments</b>				
The practice was slightly lower than the Sub Integrated Care Board Locations (SICBL) and England averages.				
				<b>Y/N/Partial</b>
Interpretation services were available for patients who did not have English as a first language.				Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Yes
Information leaflets were available in other languages and in easy read format.				Yes
Information about support groups was available on the practice website.				Yes
<p>Explanation of any answers and additional evidence:</p> <p>Many staff spoke several languages and the practice used language line interpreters when required for patients whose first language was not English.</p> <p>For patients with deafness, they advised they could arrange sign language interpreting services.</p> <p>Information leaflets seen in the waiting room were in English however the practice website enabled access to information in a variety of languages.</p>				

<b>Carers</b>	<b>Narrative</b>
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Percentage and number of carers identified.	175 patients were recorded as being a carer on the practice carer register representing 1.64% of the practice list.
How the practice supported recently bereaved patients.	The practice sent condolence cards and an offer of a face-to-face appointment with the GP.

### Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
<p>Explanation of any answers and additional evidence:  The reception front desk had a sliding glass panel to enable privacy from the incoming and outgoing calls taken in the office behind the reception area.</p> <p>Some conversations could be heard by those patients queuing at the front desk; however, staff made every effort to minimise the risks, requesting patients respect each other's privacy and maintain a distance when queuing. A room to discuss sensitive issues was available.</p>	

## Responsive

## Rating: Inadequate

At the last inspection June 2021, we rated the practice as Requires Improvement for providing responsive services because:

- The practice results from the national GP Patients Survey were exceptionally low, and the practice had not taken steps to engage proactively with its patients during the Covid-19 pandemic.
- The practice had received a large number of concerns through the NHS website over a 12-month period and had not sought to engage with patients or answer the concerns.

At this inspection, 15 May 2023, we found that the practice results from the National GP Patients Survey in July 2022 remained exceptionally low. The practice had conducted an in-house patient survey. The practice had produced an action plan for each of the surveys, but these had yet to be actioned.

- There had been no improvements made, no action taken as a result of the surveys, inadequate action plans, a lack of engagement with the Patient Participation Group, or the acceptance of the offer of a programme of support in respect of access via the Integrated Care Board.

The practice is therefore rated Inadequate for providing responsive services.

### Responding to and meeting people's needs

**The practice organised and delivered services to meet patients' needs but its services did not always meet patients' expectations/needs.**

	Y/N/Partial

The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
Patients reported negatively on access and availability of appointments as reported through the National GP Survey results, in the practice in-house survey in 2023 and via the Patient Participation Group (PPG).	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 6pm
GP Appointments available: Variable	
<p>The practice manager advised that GP appointment times were variable according to the particular GP.</p> <p>The practice requested patients call at 8am for appointments on the day, if there were no appointments left in the morning, they were asked to call back after 12pm for the afternoon appointment slots.</p> <p>The practice had recently reintroduced their on-line booking system.</p> <p><b>Enhanced Hours:</b> Extra appointments were offered across the whole of East Staffordshire, including evening and weekend appointments. Additionally, an online digital service was available on Sunday mornings where appointments were offered with a GP via the Q Doctor app.</p> <p><b>Out of Hours Service</b> Cover for emergencies were provided by Staffordshire Doctors Urgent Care. The GPs were usually based at Cross Street Clinic, but patients may be asked to attend a different out-of-hours centre. They were available from 6pm until 8am on weekdays and all day on Saturdays, Sundays and Bank Holidays. Patients were requested to ring the emergency number to make an appointment to be seen the same day. Patients who were too unwell to leave their homes may receive a visit at the discretion of the GP.</p> <p><b>NHS 111.</b> In the case of urgent need when the practice was closed patients could contact NHS 111.</p>	

## Access to the service

People were not always 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.	Partial
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Patients reported negatively on access and availability of appointments as noted in the practice in-house survey in 2023, via the Patient Participation Group and through the National GP patient survey results.</p> <p>The percentage of respondents to the National 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) was 9% these results were one of the lowest in England.</p> <p>The Integrated Care Board reported that that practice had chosen not to engage with the Accelerate Programme offer (an access improvement programme). This may have enabled targeted support, advice and guidance for practice improvements.</p>	

## 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	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)	9.0%	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)	14.4%	52.0%	56.2%	Significant variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with	35.3%	52.2%	55.2%	Tending towards



their GP practice appointment times (01/01/2022 to 30/04/2022)				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)	50.2%	70.0%	71.9%	Variation (negative)

### Any additional evidence or comments

All 4 of the indicators above were significantly lower than the Sub Integrated Care Board Locations (SICBL) and England averages.

There was a downward trajectory in results year on year, for example, the percentage of patients who responded positively on the ease to get through to someone at their practice on the phone in 2021 was 18.45%, when compared with the 2022 results of 9%.

The practice forwarded a document entitled 'GP Survey Results and Actions.' No actions at the time of the inspection had taken place or been completed by the practice. An action plan is a document that lists what steps must be taken to achieve a specific goal. It breaks down the goal into actionable steps that can be easily followed and tracked. The practice GP Survey Results and Actions spreadsheet was ineffective, it lacked clear direction as to what activity should be undertaken for improvement, by whom, a timeline for completion, who would be responsible for monitoring its process and it contained no date for evaluation.

In respect of phone access, the practice had added the survey results as an agenda item at the PPG meeting for April 2023. A proposal made by the practice was to liaise with a phone company, add a message onto the practice voicemail when all appointments were taken in order that patients could either hold and speak to receptionist or leave the call. In respect of appointment times, the practice proposed to review clinic times and appointments and for staff to speak to clinicians. There was no documented update as to whether any of these activities had been completed.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There was a total of 26 reviews between May 2021 and April 2023</p> <p>In the last 12 months:</p> <ul style="list-style-type: none"> <li>• 2 x 5-star reviews- 12/07/2022, 12/08/2022</li> <li>• 1x 4 star 13/04/2022</li> <li>• 4 x 1 star 18/4/2022, 18/08/2022, 13/09/2022, 22/2/2023</li> </ul> <p>The less positive patient feedback focused on access and staff attitudes.</p>
Local Healthwatch	<p>The feedback from Healthwatch was that patients enquired on how to register with an alternative practice as told by other patients to avoid the practice.</p> <p>Healthwatch referred any requests of this nature to the allocations team within the Integrated Care Board.</p>
Google reviews-unverified data:	<p>The practice scored 1.3 out of 5 with 168 reviews submitted all of which were unverified. The common themes included access and staff attitudes.</p>

Practice could receive patient feedback via an online form with a link on the practice website.	The practice had an online form to request patient feedback via a link: <a href="http://www.mysurgerywebsite.co.uk/secure/questionnaire.aspx?p=M83010">www.mysurgerywebsite.co.uk/secure/questionnaire.aspx?p=M83010</a>
Practice provided a newsletter	A link to sign up for the newsletter was posted on the practice website.
Practice provided a link to East Staffordshire District Patients Engagement Group	A link to sign up for East Staffordshire District Patients Engagement Group was posted on the practice website.
Local PPG	<p>The PPG advised they had offered suggestions and support to improve patient telephony access. This had not been taken up at the time offered. They have resubmitted this offer to the new practice manager.</p> <p>The PPG reported that their community were not happy with the GP practice access or telephone access, that they regularly heard from their communities complaints in this respect. However, once in front of the health professional on the whole patients reported satisfaction with their care.</p> <p>The PPG had suggested the practice produce literature on practice staff roles in order that they could distribute this to the various communities. This would help patients to book to the health professional required. This had yet to come to fruition but had been reiterated to the new practice manager.</p> <p>The PPG reported positively on the practices improved repeat medicines system by use of the practice email functionality.</p>
Care homes	We spoke with care managers/nurses at the care homes with the who spoke positively about the practice and their patients access to the GP service.
Integrated Care Board (ICB)	<p>Over a period of time, the ICB had discussed and engaged with the practice providers regarding ongoing concerns which had included (but were not limited to):</p> <ul style="list-style-type: none"> <li>• The findings from CQC inspections</li> <li>• National GP survey outcomes (year on year)</li> <li>• Staffing concerns</li> <li>• Patient outcomes through various data sources</li> <li>• Business continuity and sustainability.</li> </ul> <p>Whilst ongoing support has been provided by the ICB primary care team and the ICB GP Support Team, the ICB reports that improvements have lacked sustainability and issues have recurred.</p>

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	9
Number of complaints we examined.	2

Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1
Of the 9 complaints received in the 12-month period 2 were partially upheld, 5 not upheld and 2 upheld. The staff did not routinely record verbal complaints.	

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient bought their children to see a GP and raised a complaint as they had found the GP to be abrupt.	<p>The complainant received acknowledgement on the same day as the complaint was raised.</p> <p>The practice investigated the complaint, and a reply was sent to the complainant.</p> <p>The learning outcome was for the GP to be more considerate and empathetic when communicating with parents.</p>

## Well-led

## Rating: Inadequate

At the last inspection in June 2021, we rated the practice as Requires Improvement for providing well-led services because:

- We found that the practice had satisfied most but not all of the requirements of the Regulation 17 Good Governance Requirement Notice served.
- The practice had commenced work on information governance and was seeking support to improve the significant event policy and process.

At this inspection, 10 and 15 May 2023, the practice was rated Inadequate for providing a well led service.

- Whilst we found the practice had improved its significant event policy and process, it had yet to discuss as a whole practice team any significant event trends or learning outcomes.
- We found that the practice had not satisfied all of the requirements of Regulation 17 Good Governance. Areas previously identified as breaches in regulations remained.
- The overall governance arrangements were ineffective.
- In a 12-month period staff attrition amounted to 8 staff members and in a 4-year period there had been a turnover of 5 practice managers impacting on practice management continuity.
- The practice succession plan was incomplete.
- Staff were unaware of the practice strategy as this had been developed during the inspection.
- The Care Quality Commission had received information of concern from several sources both prior to and during the inspection. Those that were individuals did not wish to be identified. Concerns were raised in respect of culture and leadership.
- The practice culture did not effectively support high quality sustainable care.

- There were gaps seen in the practices governance processes and in assurance systems, such as staff training, staff consent awareness, recruitment and verbal complaint recording.

### Leadership capacity and capability

**Leaders could not always 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.	Yes
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the review in June 2021, we found the practice had a newly appointed a practice manager (May 2021) and although the management arrangements were still quite new, the practice had instigated some improvements.</p> <p>At the inspection 10 and 15 May 2023 we found that there had been further appointments of practice managers all of whom had left the practice, the most recent in April 2023 after approximately 6 months at the practice. It was clear in practice minutes that when the former practice manager was in place, recruitment, succession and workforce planning had been discussed with the partners.</p> <p>The practice had completed a significant event in April 2023 in respect of staff attrition. We discussed with the practice manager and the GP Partners staff turnover at the practice. Eight staff in total had left the practice in a 12-month period, four reception staff, a clinical pharmacist, medical secretary, practice nurse, and practice manager. There were no staff exit interviews evidenced in order that the practice could gain an understanding of the reasons/rationale for staff leaving to put measures in place where applicable to reduce staff turnover.</p> <p>The practice had developed a succession plan which was last reviewed in April 2023; however, the plan had not been completed. For example, there were no identified critical roles. The plan suggested that once the practice had identified critical roles, following their appraisal and personal development systems, they would organise their top candidates for each critical position, categorising those ready for critical role in; 3, 3 to 5 and greater than 5 years.</p>	

### Vision and strategy

**The practice had a 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.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial

Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that the practice mission statement was available in most rooms but there was a lack of awareness of the vision, values and strategy and of staff's role in achieving them.</p> <p>The new practice manager in response to inspection feedback had started to develop a practice risk register and strategy. We were told that staff would be unaware of this and informed us that at the next whole practice meeting this would be cascaded to all staff and a further meeting would be planned.</p>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The Care Quality Commission had received information of concern from several sources both prior to and during the inspection. Those that were individuals did not wish to be identified. Concerns raised included the practice culture and leadership.</p> <p>The practice manager advised that they outsourced their Human Resource (HR) functionality and the practice manager advised they would refer to them for support and advice.</p> <p>Staff told us they had access to the staff handbook provided during their induction period, which included some information for example on disciplinary, grievance and whistleblowing procedures as well as access to policies and procedures held electronically.</p> <p>Staff told us they could raise a grievance, none had. Staff reported they would likely gain support or source information via external sources such as professional unions, or legal agencies rather than to the practice.</p> <p>The practice had nominated a member of staff as their Freedom to Speak Up Guardian and the staff member had recently completed online training for this role. The practice maintained a whistleblowing policy.</p>	

Staff reported on the impact on the practice team on the turnover in practice managers over a period of years and at times a lack of formal handover. Staff advised they did not want to be involved in work politics, they just wanted clarity on who they could go to for advice and guidance in relation to their work.

Staff reported on the isolation felt at times when working autonomously and of the need for regular staff meetings, and communication, not just when the practice was being inspected.

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

Source	Feedback
Staff feedback and staff questionnaires	<p>The theme from staff feedback was of shortage of staff, recruitment and retention, communication, of in-house politics impacting on the practice culture, and a lack of regular whole team meetings.</p> <p>Staff reported that the practice was at times short of staff, receptionists, nurses and GPs. They all were happy to cover for each other when able, but that meant that some things got behind. There was an undocumented approach to manage work backlogs which was co-ordinated/managed by the reception manager.</p> <p>They reported that recruitment was difficult, and in the past, they felt some reception staff had left as the role or practice environment was not what they expected.</p> <p>Due to the lack of staff, it had been difficult to move forward and plan. Any plans discussed with management changed or were lost when the practice managers had left.</p> <p>Staff reported on a lack of communication updates on role changes and a lack of regular whole team meetings other than those arranged as practice learning time events and when being inspected.</p>

**Governance arrangements**

**The overall governance arrangements were at times ineffective. There were clear responsibilities, roles and systems of accountability.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
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
<p>Explanation of any answers and additional evidence:            There were some gaps in the governance processes, for example oversight of:</p>	



- Safeguard training at an appropriate level for their clinical role
- Overdue an Infection Prevention and Control audit
- Recruitment
- Dementia and Mental Capacity Act 2005 training
- A lack of recent whole staff meetings to communicate changes review significant events and share suggestions and ideas.
- Verbal complaints
- Staff awareness of the practice strategy and their role in achieving its ambition and goals.

The practice had an organisational chart in place. Some staff had been appointed lead roles, but they had yet to fully comprehend what their lead roles or responsibilities entailed.

### Managing risks, issues and performance

**There were processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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.	Partial
Explanation of any answers and additional evidence:	
There were gaps seen in assurance systems, such as staff training, recruitment and verbal complaint recording.	
The practice had discussed workforce and succession planning, but this had yet to be fully implemented, the practice manager advised that this had been hindered in some part by staff attrition and the need to recruit.	

### 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

## 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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office (ICO).	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Partial
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:  The practice's ICO certificate was dated until 08/05/2024.  Not all clinical staff were able to demonstrate their understanding of consent, best interest decision making or Gillick competency.	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes

Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had action planned improvements following the results from the National GP Survey and its own in-house survey, however no actions were signed off as taken place.</p> <p>Staff had attended monthly protected learning time events in which they were provided with time to complete online training.</p>	

Feedback from Patient Participation Group (PPG).

Feedback
<p>The PPG provided negative feedback in respect of patient access to GP services at the practice. They reported that this had been fed back to the practice with no resultant action taken by the practice. The PPG had spoken with the new practice manager and provided offers of support such as alerting their communities to the roles of staff within the practice if the practice provided them with this literature. They also offered IT and telephony support and guidance.</p>

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had made improvements following Care Quality Commission Inspections. However, these improvements were not always sustained, for example, recruitment procedures, staff training, infection prevention and control audits, staff meetings and complaints.</p> <p>However, significant event procedures were now embedded, although a meeting to cascade learning from these had yet to take place. Clinical systems had improved such as patient medicine reviews and recalls. The practice results following the clinical searches completed although not flawless were much improved.</p> <p>Staff with extended clinical roles reported positively on the supervision and support received including competency reviews and any derived learning following these.</p>	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>.

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases, at the time of inspection this data may be 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.