

# Care Quality Commission

## Inspection Evidence Table

### Jubilee Park Medical Partnership (1-570676592)

Inspection date: 6 October 2022

Date of data download: 04 October 2022

## Overall rating: Inadequate

### Safe

### Rating: Inadequate

We rated the practice as inadequate for the Safe domain because:

- The practice did not have systems and processes in place to keep people safe.
- There was poor oversight and maintenance of the premises including fire, legionella and infection control.
- Not all staff had completed safeguarding training or were trained to the required level.
- Appropriate standards of cleanliness and hygiene were not met.
- There were gaps in systems to assess, monitor and manage risks to patient safety such as staffing levels and responding to a medical emergency.
- Staff did not have the information they needed to deliver safe care and treatment due to a backlog of correspondence.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.
- There were concerns relating to the monitoring of patients taking high risk medication.
- There was poor management of care information and task management issues.
- The practice could not demonstrate the prescribing competence of non-medical prescribers.
- The practice could not demonstrate an effective system to ensure that learning was implemented when things went wrong.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	No <sup>1</sup>

<b>Safeguarding</b>	<b>Y/N/Partial</b>
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• <sup>1</sup>Staff including GPs, clinical staff and administration staff had either not completed safeguarding training or training was not to the appropriate level as set out in intercollegiate guidance. Following the inspection, the practice provided evidence that the safeguarding lead had received training and staff were working through completing safeguarding training.</li> <li>• The practice held safeguarding meetings on a three-monthly basis which included other health and social care professionals. The practice had records of meetings from January, March and June 2022. Due to staff sickness the August meeting was postponed.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We examined four staff recruitment files and found they did not include adequate checks of staff immunisation in line with current UK Health and Security Agency guidance.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 26 September 2022	No <sup>1</sup>
There was a fire procedure.	Yes
Date of fire risk assessment: Park House Medical Centre: January 2022 Date of fire risk assessment: The Lowdham Medical Centre branch site: September 2020 Actions from fire risk assessment were identified and completed.	No <sup>2</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• <sup>1</sup> The health and safety risk assessments did not demonstrate the level of risks found during the inspection. For example, we found concerns relating to the premises at the Lowdham branch site which included no hot water, inadequate oversight of legionella, electrical safety concerns and the interior of the building such as holes in the ceilings. These issues were not identified in the practice health and safety risk assessment. Following our inspection, we were provided with a risk assessment relating to the management of water.</li> <li>• <sup>2</sup> The practice was unable to demonstrate that there had been actions taken following concerns identified during fire risk assessments at the Lowdham branch site.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial <sup>1</sup>
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: September 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No <sup>2</sup>
The arrangements for managing waste and clinical specimens kept people safe.	No <sup>3</sup>
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• <sup>1</sup>Not all clinical staff had received training on infection prevention and control including cleanliness and hygiene and hand hygiene.</li> <li>• <sup>2</sup>Although an infection control audit had been conducted it did not identify infection control concerns found during our inspection. For example, at the Lowdham branch site there was no hot water for patients or staff to wash their hands. We found clinical rooms to be cluttered and visibly unclean. At both sites we found out of date equipment such as swabs, hand sanitiser and cleaning products. Consideration of what appointments are safe to be conducted during the period of no boiler was not considered and had continued despite their being no hot water available for hand washing and cleaning of the premises.</li> <li>• <sup>3</sup>We found waste was not always managed in line with current legislation and advice. For example, we found a clinical sharps bin which had not been managed in line with waste guidance.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	No <sup>1</sup>
There was an effective induction system for temporary staff tailored to their role.	No <sup>2</sup>
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	No <sup>3</sup>
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	No <sup>4</sup>
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• <sup>1</sup>There was not an effective approach to managing staff absences. For example, we saw evidence of backlogs in correspondence that had occurred due to staff absences. As part of this inspection we sent 30 staff members a questionnaire and received 13 responses. 50% of the responses stated there was not an effective approach for managing staff absence.</li> <li>• <sup>2</sup>The induction systems at the practice did not include areas such as safeguarding.</li> </ul>	

- <sup>3</sup>We found staff were unaware of how to respond in a medical emergency. During our inspection we asked staff members for the location of the medical emergency drugs, resuscitation equipment and oxygen. Some staff we spoke to were not aware of the locations.
- <sup>3</sup>Not all staff were trained in sepsis awareness. During the inspection we were provided with a training matrix for 34 staff members which did not have any information relating to sepsis training. Following the inspection, the practice provided documentation to state that 5 staff members had completed sepsis training prior to the inspection. This also included 15 staff members who had completed sepsis training since the inspection.
- <sup>4</sup>The leadership of the practice articulated difficulties with a lack of space in the buildings to provide appointments. The practice had invested in laptops to allow staff to work from home where possible. There had been a high turnover of staff which had resulted in staff working excessive hours. Of the 13 responses to the staff questionnaire 50% of the responses expressed there was not enough staff to provide safe, high quality care.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. <sup>1</sup>	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	No <sup>1</sup>
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	No <sup>2</sup>
There was a documented approach to the management of test results and this was managed in a timely manner.	No <sup>3</sup>
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• <sup>1</sup> We found there was a lack of process and systems for the management of correspondence putting patients at potential risk of harm. During the clinical remote searches, we identified 811 documents outstanding that required review and actions to be taken. Following our onsite inspection, we found 627 letters outstanding for processing. A further 1200 letters were awaiting attachment to patient records dating back to May 2022. We saw evidence of requests made by secondary care for patients to reduce medication, prescribe and change medication. We found these had not been actioned. There was no process in place to review information by the appropriate staff to deliver safe care and treatment.</li> <li>• <sup>2</sup> The practice did not have a system relating to the monitoring in delays in referrals. The practice significant event tracker had a theme of delays in urgent referrals. There was no evidence of action taken from the practice to monitor or improve this.</li> <li>• <sup>3</sup>At the time of the remote searches on 27 September 2022 the practice had 2182 open tasks on the system which included items marked as urgent, incoming mail and requests for appointments and blood tests. At the time of the onsite inspection this had reduced to 1777. We found 2 tasks dated back to May 2019, 1 from 2020, 18 from 2021 and the remaining from 2022. We were told</li> </ul>	

that staff had worked overtime to review tasks. We saw tasks included test requests such as bloods. We were told by patients on the day of inspection that they had received test results but were unable to speak to a GP to discuss them.

## Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.91	0.82	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	10.4%	7.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.41	4.63	5.31	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	122.8‰	130.1‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.09	0.51	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.7‰	6.2‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	No <sup>1</sup>
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.	No <sup>2</sup>
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	No <sup>3</sup>
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.	No <sup>4</sup>
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	No <sup>5</sup>
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.	Partial <sup>6</sup>
The practice had taken steps to ensure appropriate antimicrobial use to optimize 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.	No <sup>7</sup>
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.	Partial <sup>8</sup>
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li><sup>1</sup>The practice dispensary which was located at the Lowdham branch site was accessible to all staff within the practice and staff from the neighbouring site. We saw no evidence of measures taken or consideration for restricted access.</li> <li><sup>2</sup>The provider could not demonstrate the prescribing competence of non-medical prescribers, and there was not a regular review of their prescribing practice. Some staff told us there was no regular oversight and other staff said there was an informal catch up with supervisors which was not recorded.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• <sup>3</sup>The systems in place for oversight of prescribing and consultations was not always effective. We found evidence of patients being prescribed medicines with no clearly documented rationale for prescribing them and inappropriate amounts of medicines being prescribed and not as recommended by national guidance. This put patients at risk of harm. These omissions had not been identified by a system or process established to ensure compliance with the regulations.</li> <li>• <sup>4</sup>There was insufficient oversight around staff responding to secondary care correspondence. We saw and were told by staff that they did not have regular oversight or competencies checked. We reviewed correspondence sent from secondary care which included changes to medications and requests for appointments. We saw that these requests had not always been made.</li> <li>• <sup>5</sup>There was not an effective process in place for the management of patients on high risk medicines. The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. For example, we reviewed a sample of five clinical records identified by a clinical search for patients taking a high-risk medicine for the prevention of thrombosis. We found none of the records had the required monitoring prior to issuing prescriptions.</li> <li>• <sup>6</sup>The practice held controlled drugs on the premises. We were not provided with any evidence of oversight of the dispensary of controlled drugs including systems to ensure safe ordering and dispensing.</li> <li>• <sup>7</sup>The practice did not have a system in place to monitor stock levels and expiry dates. For example, we found out of date medical emergency equipment.</li> <li>• <sup>8</sup> We saw instances where the fridge temperature had been recorded above the maximum temperature with no assurance that any actions had taken place to ensure the vaccinations remained safe and effective.</li> </ul>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	No <sup>1</sup>
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial <sup>2</sup>
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Partial <sup>1</sup>
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes <sup>3</sup>
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	No <sup>4</sup>
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	No <sup>5</sup>

If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	No <sup>6</sup>
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Partial <sup>7</sup>
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li><sup>1</sup> We were not provided with any evidence of oversight of the dispensary. Dispensary staff had received appropriate training but there was no evidence of checks of their competency at regular intervals.</li> <li><sup>2</sup>The dispensary had a suite of standard operating procedures however, they were not always being followed such as stock checks of CDs.</li> <li><sup>3</sup>We were told by staff that stock of controlled drugs which had expired was destroyed by practice staff rather than an external authorised party. Following the inspection, we were provided with evidence that the correct protocol had been followed during the covid-19 pandemic which gave temporary authorisation for a GP at the practice to dispose of controlled drugs.</li> <li><sup>4</sup>There were instances where the fridge temperature had been recorded above the maximum temperature with no assurance that any actions had taken place to ensure the medicines were fit for purpose.</li> <li><sup>5</sup>The dispensary provided compliance aids for patients who required extra support however, dispensers when asked were not aware of how to ensure medicines were viable within them. We found evidence that some medicines which had been dispensed into the compliance aids were not suitable and therefore the practice did not have assurance that the patient was receiving effective treatment.</li> <li><sup>6</sup>There was no evidence of near misses being recorded or investigated within the dispensary and limited evidence of dispensing investigations at the time of our inspection.</li> <li><sup>7</sup>Due to the layout of the dispensary sharing a room with the reception area of the practice along with a dispensary and reception area of another practice, there was no area for confidential discussions to take place with patients.</li> <li><sup>7</sup>We were told that reception staff often handed out medicines to patients however did not give any advice to patients. We were told that if the patients required support a clinician would be informed. We were told that when handing out medicines to patients, three types of patient identifiable data would be requested to ensure the patients got the correct medicines however this did not happen during our inspection.</li> </ul>	

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

**The practice did not have a system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	No <sup>1</sup>
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial <sup>2</sup>



There was a system for recording and acting on significant events.	No <sup>3</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	No <sup>2</sup>
There was evidence of learning and dissemination of information.	No <sup>4</sup>
Number of events recorded in last 12 months:	18
Number of events that required action:	18
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li><sup>1</sup> The practice did not monitor safety using information from a variety of sources. For example, the practice had not taken actions on risk assessments which highlighted safety concerns. The practice did not have an effective system to recognise patient safety alerts.</li> <li><sup>2</sup> Staff knew how to raise concerns and report incidents. However, staff feedback was that staff were too busy to complete forms to raise concerns. Some staff members told us they felt there was not an open culture to raise concerns.</li> <li><sup>3</sup> The practice used a digital system to raise and record incidents. We found the system to be ineffective. For example, incidents occurred during February and March 2022 but were not raised on the system until May 2022. The practice provided a significant event report which had 8 incidents during the period of May 2022 to September 2022. Of the 8 incidents 5 were awaiting any actions and discussions in a clinical meeting dating back to incidents which arose in February 2022.</li> <li><sup>3</sup> In May 2022 we requested information relating to incidents involving patient care that were raised directly to the CQC. We were told that the practice would raise a significant event analysis. We found no evidence that this had been raised.</li> <li><sup>4</sup> We found that there was not always learning following incidents. Of the 5 significant events awaiting actions 2 included urgent referrals that were missed, medical diagnoses and prescription concerns. We saw no evidence of any learning from these events. We examined other events which stated they were completed however saw no evidence of actions taken despite the practice team being able to articulate changes that had taken place. The dissemination of information from learning was not available. We were told clinical meetings where significant events are discussed had been cancelled due to staff sickness and work loads. Staff told us they were not always told of the learning opportunities from incidents and felt there was a lack of support.</li> </ul>	

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

Event	Specific action taken
Patient prescribed wrong issue of antibiotics.	Incident occurred in February 2022, raised on the system in May. No actions taken, awaiting discussion in clinical meetings.
Loss of keys to vaccination and medication fridges	Acknowledgment that a key box is required and keys to be labelled. No evidence that this action had been taken.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No <sup>1</sup>
Staff understood how to deal with alerts.	No <sup>2</sup>
Explanation of any answers and additional evidence:	

- <sup>1</sup>The system for recording and acting on alerts was ineffective. We were provided with a patient safety alert log. We found the log was not inclusive of all alerts including Medicines and Healthcare Regulatory Agency drug safety alerts.
- <sup>1</sup>The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that there was 49 patients of childbearing age prescribed a medication that could cause birth defects. We reviewed 5 records and found there was no evidence of discussions with patients to inform them of the risks associated with taking the medication or alternative treatments considered.
- We found concerns relating to the management of the patient safety alerts. Due to staffing shortages the responsibility was temporarily placed on a dispensing team member. There was no clinical oversight and we could not be assured staff understood how to deal with alerts.

## Effective

## Rating: Inadequate

We rated the practice as inadequate for the Effective domain because:

- The practice could not demonstrate they had systems and processes to keep clinicians up to date with current evidence based practice.
- Patients with long-term conditions or potential long-term conditions had not received up to date monitoring and review.
- Not all staff had completed training required for their role.
- Staff did not always work together and with other organisations to deliver effective care and treatment.
- Patients did not have access to appropriate health assessments and checks.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	No <sup>1</sup>
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No <sup>2</sup>
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No <sup>3</sup>
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No <sup>4</sup>
There were appropriate referral pathways to make sure that patients' needs were addressed.	No <sup>5</sup>
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	No <sup>6</sup>
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	

- <sup>1</sup>Our remote clinical searches revealed that clinicians were not always following currently evidenced based practice. For example, we conducted a search of patients with asthma who have had 2 or more courses of oral steroids to manage acute asthma in the last 12 months. There were 64 patients identified, we examined 5 patient records. We found 4 of the 5 patients did not have a steroid card when one was deemed appropriate. During discussions with clinicians at the practice there was a lack of knowledge regarding awareness of this.
- <sup>2</sup>There were insufficient processes that patients immediate and ongoing needs were fully assessed. We saw requests made by secondary care for patients to reduce medication for mental health needs and to start treatment to improve physical wellbeing. We found these had not been actioned.
- <sup>3</sup>We found assessments to have taken place over the phone during exacerbations of asthma. This would not allow the clinician to effectively examine the patient and judge the severity of their condition fully. We found there was no process in place to review patients following an exacerbation of asthma. National guidance requires people to be reviewed within 48 hours. This put patients at risk of worsening of their condition.
- <sup>4</sup>Our remote clinical searches identified a high-risk patient who was receiving treatment and medication who had attended the practice for blood pressure monitoring. Blood pressure was found to be raised in September 2021. However, there was no clinical advice given or follow up documented.
- <sup>5</sup>The practice did not have a system relating to the monitoring -of delays in referrals. The practice significant event tracker had a theme of delays in urgent referrals. There was no evidence of action taken from the practice to monitor this.
- <sup>6</sup> Once the practice telephone system had reached capacity of calls there was no option for patients to be able to wait to speak to a staff member to seek further advice.

## Effective care for the practice population

### Findings

- The practice had registered with it 51 patients with a learning disability. The practice opportunistically completed annual health checks for 2 patients. But had not offered any annual health checks to other patients with a learning disability.
- 3,347 patients were eligible for an NHS Health check. Due to the Covid19 pandemic the practice had paused offering eligible patients during this period. The practice had offered 335 eligible patients and had completed 81 during 2022.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- The remote clinical searches identified concerns relating to the management of patients with asthma. The practice had conducted 323 out of 947 asthma review within 12 months.
- We conducted a remote clinical search of patients prescribed a short-acting bronchodilator (SABA or reliever) inhaler who had been prescribed 12 or more inhalers to review potential over usage or unstable asthma. The search identified a possible 33 patients. From these we reviewed 4 patient records, none of which were always reviewed in line with national guidance, including consideration

of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.

- We conducted a remote clinical search of patients with a potential missed diagnosis of diabetes. The search identified a potential 12 patients out of 728. We reviewed 5 records and found concerns relating to the coding of diabetes on patients' records. We saw 2 instances out of 5 where the patient had been made aware of the diagnosis, but this was not coded on the record. Coding of diabetes is important in ensuring long term condition reviews are conducted and patients are not missed through recalls.

## Management of people with long term conditions

### Findings

Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance. As part of our inspection we carried out a remote search of patients' clinical records. We found examples of unsafe care where patient treatment and care was not regularly reviewed or updated. For example:

- We conducted a remote clinical search of patients with thyroid disease. The search revealed 25 patients out of 402 with thyroid disease that were not reviewed to ensure they could be offered treatments or monitoring to improve control. We found there was no clear process in place to recall these patients.
- We conducted a remote clinical search of patients with poorly controlled diabetes. The search revealed 72 out of 728 patients. We reviewed 5 records and found there was no clear pathway to ensure patients were not missed for reviews.
- We conducted a search of patients diagnosed with Chronic Kidney Disease (CKD) stage 4 or 5 who had potentially not received monitoring in line with national guidelines. The search revealed a potential 18 of 25. We reviewed 5 records and found 4 were monitored by secondary care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Due to a backlog of correspondence and tasks on the clinical system the practice did not always share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus,	128	133	96.2%	Met 95% WHO based target

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	132	139	95.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	132	139	95.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	130	139	93.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	156	162	96.3%	Met 95% WHO based target

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

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	81.5%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	81.0%	64.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.8%	67.7%	66.8%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	69.5%	55.7%	55.4%	No statistical variation
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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.

## Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial <sup>1</sup>
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice had conducted an audit on patients prescribed a medication which is associated with an increased risk of children born with congenital abnormalities and developmental delay. The aim of the audit was to ensure all patients prescribed this medication had a pregnancy prevention programme in place. The audit showed in 2020-2021 there were 7 patients prescribed the medicine with 3 patients who had not had a prevention plan assessment completed. The practice aim was to continue to ensure a robust recall system. The audit was repeated in 2021/2022 which found 6 patients to be taking the medication with 1 patient who had not had a prevention plan assessment completed. There was no evidence of discussions, learning or improvements. The practice aim was for the operations manager to continue to monitor the recall system.

The practice told us that audits had not been able to be completed in relation to patient satisfaction and some clinical audits due to staff shortages.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	No <sup>1</sup>
The practice had a programme of learning and development.	No <sup>2</sup>
Staff had protected time for learning and development.	No <sup>3</sup>

There was an induction programme for new staff.	Partial <sup>4</sup>
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial <sup>5</sup>
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No <sup>6</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	No <sup>7</sup>
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li><sup>1</sup>On the day of inspection we found not all staff had received training in basic life support or cardiopulmonary resuscitation training. Following the inspection, we were provided with evidence that 18 staff had completed training in November 2022.</li> <li><sup>2</sup>The practice induction did not include learning and development for areas relating to safe and effective care. For example, sepsis training and safeguarding. Following the inspection, we were provided with an updated induction schedule to include this. The practice team were not up to date with their learning and development including data protection, confidentiality, equality and diversity, infection control and medical emergencies. We were told by staff this was due to staffing shortages.</li> <li><sup>3</sup> Staff did not have protected time for learning and development due to staffing shortages and workloads. We were told staff were able to complete training as overtime at home.</li> <li><sup>4</sup>The practice had an induction programme, however on reviewing staff files we found some to be incomplete. The induction programme did not include areas such as safeguarding and sepsis training.</li> <li><sup>5</sup> We were told by the management that due to staffing shortages not all appraisals had been completed. Clinicians offered informal catch ups to staff who required them.</li> <li><sup>6</sup>We saw no evidence that the competency of staff employed in advanced clinical practice had been reviewed or considered.</li> <li><sup>7</sup>We received 13 responses from a staff questionnaire when asked, "Do you feel the practice manages poor staff performance?" Two responses stated yes with 11 responses stating no or not sure.</li> </ul>	

## Coordinating care and treatment

### Staff worked did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	No <sup>1</sup>
Patients received consistent, coordinated, person-centred care when they moved between services.	No <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li><sup>1</sup>There was insufficient oversight around staff responding to secondary care services and other organisations. There was no process for GPs to have regular oversight or assurance of competence of the activity of the staff carrying out this role. During the clinical remote searches, we identified 811 documents outstanding that required review and actions to be taken. The</li> </ul>	



practice had worked overtime to review the documents and on 6 October 2022 there was 627 letters outstanding dating back to May 2022.

- <sup>2</sup> Patients we spoke with on the day of inspection and feedback received directly by the CQC pre and post inspection described difficulties with gaining appointments, particularly when moving between services. Patients also described difficulties of information being shared between services.

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Partial <sup>1</sup>
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.	No <sup>2</sup>
Staff discussed changes to care or treatment with patients and their carers as necessary.	No <sup>3</sup>
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• <sup>1</sup>Staff were aware of services to refer patients to. However, the provider could not demonstrate effective systems to be able to identify patients at risk.</li> <li>• <sup>2</sup>Patients did not have access to appropriate health assessments and checks. For example, the practice although had opportunistically conducted annual health checks for 2 patients with a learning disability they had not offered any annual health check to other patients with a learning disability or asthma health checks to those eligible.</li> <li>• <sup>3</sup>We reviewed patients clinical notes and found on occasions staff had changed medication without consulting patients and their carers as necessary.</li> </ul>	

## Consent to care and treatment

### The practice did not always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	No <sup>1</sup>
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. <sup>1</sup>	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• <sup>1</sup>We reviewed patients' clinical notes and found on occasions staff had changed prescribed medicines without consulting patients and their carers as necessary.</li><li>• Our clinical review of notes where a DNACPR decision had been recorded found where possible that patients views had been sought and respected. We saw information have been shared with relevant agencies.</li></ul>	

## Caring

## Rating: Requires Improvement

We rated the practice as requires improvement for the responsive domain because:

- There was not always a private area for patients to go to speak to staff if patients were distressed or wanted to discuss sensitive issues. We witnessed patients discussing sensitive issues in the corridors and reception areas with other patients present.
- Many of the national survey indicators published in July 2022 was significantly lower than local and national averages.
- Patients we spoke to on the day of inspection and feedback directly to the CQC told us they were not able to get appropriate and timely information to cope with their care and treatment.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was not always positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Patients we spoke to on the day of inspection explained they had been told they had abnormal results and likely to be diagnosed with a medical condition. We were told that due to difficulties in accessing appointments there had been no timely follow up or information given. We were also told by 2 patients they had not received their medicines on time.</li> </ul>	

Patient feedback	
Source	Feedback
Feedback directly to the CQC	The CQC was contacted directly by 8 patients to share concerns relating to access and experiences of poor care and treatment.
NHS UK	There were 2 reviews in the last 12 months both with a rating of one star. Both reviews related to access and waiting time difficulties for appointments.
Patient cards to the practice	The practice provided 9 compliment cards received from patients. Patients expressed their thanks to the practice for their hard work and caring nature.

## National GP Patient Survey results

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

Indicator	Practice		SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	74.6%		85.0%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	70.7%		83.9%	83.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	77.2%		92.7%	93.1%	Significant 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)	54.1%		74.8%	72.4%	Tending towards variation (negative)

### Any additional evidence or comments

Due to low staffing levels the practice had not analysed the 2022 GP patient survey results. The practice leadership team articulated that as the survey results represented 1% of the practice population with a completion of 112 surveys, and felt it was not an accurate description of the whole patient population opinions. However, the practice had not sought to carry out their own patient survey or feedback exercises to gain further patient voice.

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

### Any additional evidence

The practice told us they had not able to undertake a patient survey during 2021-22 due to staffing shortages and the impact of the Covid pandemic.

## 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: <ul style="list-style-type: none"> <li>We saw notice boards in the waiting rooms to include further information of community and advocacy services including carers information and pregnancy support. Notice boards were categorised into elderly people, children and young people, pregnancy and practice information.</li> <li>The practice team had access to a social prescriber and Citizens Advice Bureau staff who worked with the practice and patients to provide advice on community and advocacy services.</li> </ul>	

Source	Feedback
Interviews with patients.	On the day of inspection, we spoke with 6 patients. We were told by 4 patients that when they were successful in accessing care at the practice the team were helpful and kind. Two patients we spoke to told us of negative concerns feeling the practice team did not care and medicines had not been issued.

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	81.2%	90.5%	89.9%	Tending towards variation (negative)

### Any additional evidence or comments

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	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	378 carers were identified which represents approximately 3% of the practice patient list.
How the practice supported carers (including young carers).	The practice had a newly appointed carers champion. The practice were aware the number of identified carers needed reviewing and planned to complete this within the next 6 months. The carers champion acts as a key point of contact for carers. The practice also codes patients who are carers onto the system to enable letters to be sent for flu reminders and campaigns.
How the practice supported recently bereaved patients.	The practice sent a letter of condolence to family members from the registered GP. The letter includes helplines and advice from the good grief trust organisation.

## Privacy and dignity

### The practice did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	No
There were arrangements to ensure confidentiality at the reception desk.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice articulated difficulties with a lack of space available at both sites. On the day of inspection, we saw confidential discussions with patients were being held in the corridors. We were told this was due to a lack of space available.</li> <li>• We saw at the Lowdham site there was no confidential area within reception for patients to speak to staff. The reception area was also shared with another practice. Confidential discussions were taking place within the reception area.</li> <li>• There was not an area for patients to speak confidentially with dispensers to discuss any concerns they had regarding their medicines.</li> </ul>	

## Responsive

## Rating: Inadequate

We rated the practice as inadequate for the responsive domain because:

- Patients were unable to access care and treatment in a timely way.
- Patient feedback directly to CQC was negative regarding the telephone systems.
- Patient feedback directly to CQC was negative regarding being able to access care.
- Many of the national survey indicators published in July 2022 was significantly lower than local and national averages.
- The facilities and premises were not appropriate for the services being delivered.
- Complaints were not used to improve the quality of care.

### Responding to and meeting people's needs

#### Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial <sup>1</sup>
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	No <sup>2</sup>
The facilities and premises were appropriate for the services being delivered.	No <sup>3</sup>
The practice made reasonable adjustments when patients found it hard to access services.	Partial <sup>4</sup>
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• <sup>1</sup> The practice provided a summary of the quality of care provided for the local population. We found the summary did not reflect our findings on the day. For example, the practice summary stated it had developed services in response to patients with learning disabilities to include an annual health check. However, of the 51 patients eligible, none had been offered an annual health check (although 2 had been completed opportunistically).</li> <li>• <sup>2</sup> Patient feedback through the GP survey, directly to the practice and through speaking to the CQC did not reflect that patients had a choice of flexibility and continuity of care.</li> <li>• <sup>3</sup> We found the premises at the branch site Lowdham to be unsuitable for the services being delivered. For example, due to ongoing boiler issues there was no hot water or heating at the practice branch site. Following our inspection, the practice branch site stopped some procedures to minimise the risk of infection which in turn impacted on the appointments and treatments the practice could offer.</li> <li>• <sup>4</sup> We were told by a patient on the day of inspection that they were being signposted to the branch site but were unaware of how to get there and expressed difficulties with buses.</li> </ul>	

#### Practice Opening Times

Day	Time
<b>Opening times: The Jubilee Park Practice</b>	
Monday	8am to 6:30pm

Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Extended hours	Monday 6:30pm to 8pm Tuesday 6:30pm to 8pm Thursday 6:30pm to 8pm
<b>Opening times: The Lowdham medical Centre</b>	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 12:30pm
Friday	8am to 6:30pm
Extended hours	Friday 7am to 8am
<b>Appointments available for both sites :</b>	
Monday	8am – 9am with nurses 9am – 6pm with nurses and GPs
Tuesday	8am – 9am with nurses 9am – 6pm with nurses and GPs
Wednesday	8am – 9am with nurses 9am – 6pm with nurses and GPs
Thursday	8am – 9am with nurses 9am – 6pm with nurses and GPs
Friday	8am – 9am with nurses 9am – 6pm with nurses and GPs

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was not responsive to the needs of older patients due to a lack of appointments available. We were told where possible the practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available at 8am to 9am Monday to Friday for school age children so that they did not need to miss school.
- Additional nurse and GP appointments were available 6:30pm to 8pm at the Jubilee practice on Mondays, Tuesdays and Thursdays for working age people to avoid taking time off work.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

### Access to the service

People were not 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 minimize the length of time people waited for care, treatment or advice	No
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	No
Patients were able to make appointments in a way which met their needs	No
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	No
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

Explanation of any answers and additional evidence:

- Patient feedback was negative regarding accessing appointments at the practice. Once the practice had reached capacity of calls the telephone system would cut off new callers and stated that callers were to call back later. There were no options for call backs or messages to be left. On the day of inspection, we saw a constant stream of patients attending reception. Patients told us this was because they were frustrated with the telephone system and attended in person in an attempt to get an appointment.
- The statistics showed that the team had been answering on average around 200 calls daily. The practice provided call statistics for the week of the inspection in October 2022. On the Monday the practice had received approximately 1200 calls. The practice had answered approximately 190 calls with over 1000 calls unanswered. On Tuesday the practice received approximately 800 calls with the practice answering around 190 calls. We were told that this was due to staffing issues such as sickness, annual leave and high turnover of care coordinators resulting in new staff unable to answer calls as they were requiring inductions and training. At the time of our inspection the practice were not recruiting more administrative staff/call handlers.
- The practice was operating a 50/50 ratio of telephone appointments vs face to face appointments. We were told some GPs at the practice had a preference for telephone appointments. The practice had no immediate plans to try to incorporate online services.
- The practice held urgent appointments at the end of each day for GPs and nurses to see patients with possible infections, elderly and children under 2.
- The practice had trialled a new system for appointments since August 2022 following significant negative feedback from patients. The appointment system provided prebookable slots for telephone appointments 1, 3, 5, 7 or 14 days ahead. In addition to prebookable appointments urgent same day appointments were available by telephone. On the day of inspection, we reviewed the clinical diaries and found all appointments apart from on the day urgent appointments were booked. We were told that the demand for appointments meant they were full quickly.

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	24.8%	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)	35.0%	59.5%	56.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	35.7%	58.5%	55.2%	Tending towards 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)	57.0%	74.5%	71.9%	Tending towards variation (negative)

### Any additional evidence or comments

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Source	Feedback
Feedback direct to the CQC	Patients we spoke to on the day of inspection and information received directly by CQC prior and post inspection was negative regarding access to the practice. Patients told us of difficulties in getting through on the telephone and once through the struggles to gain an appointment.

## Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	25
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	2

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Although information on how to complain was available on the practice notice boards and website, we saw responses to complainants did not always include information on what action a complainant could take if they were not satisfied with the response from the practice. For example, the parliamentary and health service ombudsman.</li> <li>• We were told that appropriate action to complaints had not been taken in some scenarios due to low staffing and complaints becoming lost or misplaced.</li> <li>• Staff who were responsible for responding to complaints had not received training.</li> <li>• We found that the evidence of actions taken to respond to some complaints was not present on the day of our inspection.</li> <li>• The practice leadership explained they received on average around one verbal complaint daily. These complaints were not part of the 25 complaints received formally.</li> <li>• We were told complaints were discussed during clinical meetings. We were not provided with any evidence of where complaints had been discussed or used to drive continuous improvement.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding diagnosis	<ul style="list-style-type: none"> <li>• Apology given to patient that the original complaint was not responded to due to staff absence.</li> <li>• Investigation conducted and apology given to patient.</li> <li>• There was no evidence that the complaint was discussed in clinical meetings or formed any learning.</li> </ul>

## Well-led

## Rating: Inadequate

We rated the practice as inadequate for the well led domain because:

- Leaders could not demonstrate they had the skills and/or capacity to deliver high quality sustainable care.
- Governance processes were ineffective.
- Processes for managing risks were poor.
- There was not always a supportive and open culture.
- The practice did not always act on appropriate and accurate information.
- The practice did not have clear and effective processes for managing risks, issues and performance.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No <sup>1</sup>
They had identified the actions necessary to address these challenges.	No <sup>2</sup>
Staff reported that leaders were visible and approachable.	Partial <sup>3</sup>
There was a leadership development programme, including a succession plan.	Partial <sup>4</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• <sup>1</sup>Due to absences in leadership including management and clinical leadership there had been at periods ineffective leadership. The practice leaders explained they had struggled to address all the challenges such as staffing shortages, training of staff and clinical governance. During the inspection the practice leaders were not aware of the extent of the concerns found on the day of inspection.</li><li>• <sup>2</sup>The practice were aware of some areas that needed to be addressed such as improvements to the appointment system and had started to make changes. However, due to a staffing shortages leaders explained they were not always able to take the actions necessary to address challenges. Other areas identified during the inspection had not been addressed through audits due to a lack of awareness.</li><li>• <sup>3</sup>Leaders were not always visible due to staffing shortages. Staff feedback was mixed regarding the visibility of leaders.</li><li>• <sup>4</sup>The practice had appointed new leaders however, due to staffing shortages thorough induction and training had not taken place.</li><li>• <sup>4</sup>We found a lack of oversight to ensure the practice performance and governance systems were in place and monitored effectively to ensure staff were fully supported and patients received safe care and treatment. We found shortfalls in some areas for example, we identified poor performance in the management of medicines which had not been identified by the practice, therefore no actions had been taken to mitigate the risks to keep patients safe from harm.</li></ul>	

### Vision and strategy

**The practice did not have a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial <sup>2</sup>
Progress against delivery of the strategy was monitored.	No <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• <sup>1</sup>The provider had a statement of purpose which did not accurately reflect the staffing arrangements and regulated activities provided. For example, the registered manager and partner was no longer working at the premises and hadn't for a period of 9 months.</li> <li>• <sup>1</sup>The practice aims and objectives on the statement of purpose did not reflect findings during the inspection. For example, "To ensure high quality, safe and effective medical services and environment". We found the environment at the Lowdham medical centre branch site required substantive refurbishment including the requirement of hot water, repairs to ceilings and actions taken following fire, legionella and electrical assessments which had identified improvements required.</li> <li>• <sup>2</sup>The practice told us they held a meeting in June 2022 to discuss the visions and values. All staff were invited to this event. However, we received 13 responses to a staff feedback questionnaire and staff told us they were aware of the practice vision and values but had not been involved in developing them.</li> <li>• <sup>3</sup>We saw no evidence that progress of the strategy was monitored. We found the overall governance arrangements to be ineffective.</li> </ul>	

**Culture**

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	No <sup>1</sup>
Staff reported that they felt able to raise concerns without fear of retribution.	No <sup>2</sup>
There was a strong emphasis on the safety and well-being of staff.	No <sup>3</sup>
There were systems to ensure compliance with the requirements of the duty of candour.	No <sup>4</sup>
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	No <sup>5</sup>
The practice encouraged candour, openness and honesty.	Partial <sup>6</sup>
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No <sup>7</sup>
Explanation of any answers and additional evidence:	

- <sup>1</sup>We received 13 responses from a staff questionnaire. 11 responses stated no or not sure that the management dealt with behaviours inconsistent with the visions and values.
- <sup>2</sup> We received 13 responses from a staff questionnaire and asked, “Is there an opportunity to raise concerns?” We received 9 responses agreeing and four responses disagreeing. We also asked “ Do you think managers take concerns raised by patients and staff seriously” we received 9 responses saying yes, 2 chose not to answer and 2 responses saying no. Staff also told us that on occasions they have felt like a nuisance raising concerns to management with a lack of support given.
- <sup>3</sup>At the time of our inspection several members of staff were off work. We were told staff from all roles within the practice were affected by workplace stress and that this was due to high workloads because of staffing shortages. The practice also told us staff struggled with the nature of some interactions with patients. A high turnover of staff resulted in at times increased work due to the recruitment and training of new staff members. Leaders told us there was a helpline number to call that staff had access to. At the time of inspection, the practice were not recruiting for any further staff but had sought external support from the local medical committee for training support for leaders.
- <sup>3</sup>We saw evidence that a staff satisfaction and wellbeing survey was completed in 2020. Responses included high stress levels, one third of staff not feeling safe at work and a lack of commitment to staff wellbeing. The practice actions were to develop an action plan for improvement and to repeat the survey biannually. We saw no evidence that the wellbeing survey had been repeated despite the concerns raised.
- <sup>4</sup> We reviewed significant events and complaints at the practice and saw there was not always compliance with the duty of candour.
- <sup>5</sup>We were told that appropriate action to complaints had not been taken in some scenarios due to low staffing and complaints becoming lost or misplaced this meant people were not always given an apology.
- <sup>6</sup> Staff feedback was mixed regarding openness and honesty.
- <sup>7</sup>Six of the 35 staff members had not undertaken equality and diversity training required by the provider.

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

Source	Feedback
Staff questionnaires sent directly to CQC	All staff agreed that the practice team care about the patients and do their best. However, Staff feedback overall was mixed regarding the practice. Some staff described the practice team as supportive and hardworking. Others described the team as requiring improvements in teamwork and communication.

#### Governance arrangements

#### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No <sup>1</sup>
Staff were clear about their roles and responsibilities.	Partial <sup>2</sup>
There were appropriate governance arrangements with third parties.	Partial <sup>3</sup>
There are recovery plans in place to manage backlogs of activity and delays to treatment.	No <sup>4</sup>
Explanation of any answers and additional evidence:	

- <sup>1</sup>The practice was unaware that some of their systems and processes were ineffective as identified from the remote clinical searches such as:
  - Ineffective medicine reviews
  - Poor management of safety alerts
  - Lack of consistent and accurate coding
  - Poor management of induction processes and oversight of the competencies of staff
  - Lack of some processes to ensure safe prescribing
  - Lack of oversight of risk assessments and audits
  - Poor management of completed tasks and correspondence
- <sup>2</sup> 11 staff responded to say they were clear of their roles and responsibilities however, 2 staff said they were unclear. Staff told us that due to staffing shortages their roles and responsibilities changed at times without training or understanding.
- <sup>3</sup> Due to the backlog of correspondence at the practice there was not always appropriate governance arrangements with third parties. We were told that often backlogs also occurred when patients requested information such as private referrals.
- <sup>4</sup> At the time of the inspection the practice had a backlog of activity in relation to correspondence and tasks on the clinical system. We were told that this was due to staffing shortages and training of staff.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No <sup>1</sup>
There were processes to manage performance.	No <sup>2</sup>
There was a quality improvement programme in place.	No <sup>3</sup>
There were effective arrangements for identifying, managing and mitigating risks.	No <sup>4</sup>
A major incident plan was in place.	Partial <sup>5</sup>
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No <sup>6</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• <sup>1</sup> There was no comprehensive assurance systems in place. For example, we found several health and safety concerns relating to the premises at the Lowdham branch site where assurance systems had not identified these concerns.</li> <li>• <sup>2</sup> Performance was not always managed. We were not provided with evidence that the competency of staff had been reviewed. We saw that some staff had not received an appraisal due to staffing shortages.</li> </ul>	

- <sup>3</sup> We were not provided with a quality improvement plan. The practice articulated the strain of the merge between the two practices previously known as Park House Medical Centre in Carlton and Jubilee practice in Lowdham who merged in March 2020 and following this the impact of the covid-19 pandemic. Quality improvement programmes such as audits to drive improvement and quality had been paused due to staffing shortages.
- <sup>4</sup> The arrangements for identifying and managing risks were ineffective. For example, we found the boiler at the Lowdham branch site had been broken since around January 2022. Risks relating to legionella, and infection control had not been identified until our inspection in October 2022.
- <sup>5</sup> Following the inspection the practice provided an incident plan in relation to the boiler. However, we did not see that this was in place prior to the inspection.
- <sup>6</sup> We found the premises at the Lowdham branch site required substantial refurbishment in order to improve the quality of care for patients. For example, the practice did not have a working boiler resulting in potential cold waiting areas and clinical rooms, and infection control concerns. Further, some parts of the practice were in a state of disrepair such as holes in the ceiling.

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	No <sup>1</sup>
Performance information was used to hold staff and management to account.	No <sup>2</sup>
Staff whose responsibilities included making statutory notifications understood what this entailed.	No <sup>3</sup>
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• <sup>1</sup>Data was used to monitor and improve performance in a small number of areas. However, not all areas were considered.</li> <li>• <sup>2</sup>There was no formal process for the oversight and monitoring of all non-medical prescribers. We were told by staff that an informal catch up was conducted. Staff performance was not always discussed in the informal catch ups and these were not documented.</li> <li>• <sup>3</sup>Staff who dealt with correspondence were not always acting on patient information appropriately. There was a lack of monitoring in regard to the management of data on patients' clinical notes and letters received from secondary services. We could not be assured staff whose responsibilities including making statutory notifications understood what was entailed.</li> </ul>	



## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
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

## 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 <sup>1</sup>
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Partial <sup>2</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li><sup>1</sup>The practice had not acted upon patient views in the most recent GP survey or conducted patient feedback exercises because of staffing shortages. However, the leadership were aware of access concerns and had implemented a new appointment system following increasing verbal negative feedback.</li> <li><sup>2</sup>Of the 13 responses to the staff questionnaire 8 staff members stated they were not involved in the planning and delivery of services. A staff member had raised concerns relating to the appointment system and stated this was positively addressed.</li> <li><sup>3</sup>The practice had sought help from other stakeholders in relation to staffing concerns. However, other stakeholders were unaware of the extent of the challenges the practice had faced.</li> </ul>	

## Feedback from Patient Participation Group.

### Feedback

The Patient Participation Group (PPG) told us they hold quarterly meetings at the practice. The PPG suggest improvements and raise concerns. The PPG described examples where they raised suggestions and the practice acted upon them. One of these was in relation to the practice notice boards to become more organised with headings on each board.

The PPG described the challenges the practice faced in relation to staffing and increased demand and were aware of the practices effort to recruit. The PPG felt that the practice had a difficult time in relation to abuse from patients verbally.

The PPG members had increased by 200% and they hope this will encourage more ideas help and support to the practice.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No <sup>1</sup>
Learning was shared effectively and used to make improvements.	No <sup>2</sup>
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li><sup>1</sup>We were not assured of a strong focus on continuous learning and improvement. For example, there were significant gaps and weaknesses in processes and arrangements intended to identify and deliver learning and continuous improvement in areas such as safeguarding, significant events, medicines managements, patient care, complaints and overall governance of the practice. Staff were not up to date with their training and we were told by staff they did not have time to complete this during work time.</li><li><sup>2</sup>There was limited evidence of effective learning and improvement systems were not comprehensively evaluated. There was limited evidence of learning in relation to significant events and patient safety alerts. In the staff questionnaire we asked "is learning shared effectively" nine staff members agreed with four staff members stating no or not sure.</li></ul>	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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