

## Inspection Evidence Table

The Groves Medical Centre

(1-552497644)

### Inspection Date:

- Site visit: 27/10/23.
- Clinical review day 1: 01/11/23
- Interview with staff: 07/11/2023
- Clinical review day 2: 17/11/23

Date of data download: 03/10/2023

## Overall rating: Inadequate

After we inspected the practice in May 2015, we rated it as good overall, but as requires improvement for safety as we found gaps in the systems and processes to manage risk and learn from things that had gone wrong. The practice had addressed the issues by the time we inspected again in June 2016.

Following this inspection in 2023, we have rated the practice as inadequate because of issues in safety and being well led:

- There were widespread gaps in safety systems and processes, including those to keep people safe and safeguarded from abuse, identify and manage risks, assess, prevent and control the spread of infections and safely use medicines and to learn and improve when things went wrong.
- The practice leaders had not established information systems that allowed them to oversee systems and processes intended to keep people safe and to ensure compliance with guidelines, and we found multiple instances in which they were not working as intended.
- Practice leaders were innovative and attempting to address challenges to the service. However, leaders had not, when making changes, identified the risks that needed to be considered, or had identified the risks, but had failed to establish effective means to manage them. This included the expanded use of advanced clinical roles, which we found were poorly defined and overseen, and the risks associated with the introduction of an online triage service.
- Some of the issues we identified at this inspection had been identified previously and had not been effectively addressed by the practice leaders.

We also found that:

- The practice had not adequately considered the needs of patients who found it hard to access services.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles

- Patients' needs were not always assessed, and care and treatment was not always delivered, in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice did not consistently handle complaints in line with national guidance

Although the practice leaders told us of plans to improve governance arrangements and showed us evidence of some individual systems being improved, ratings are based on evidence at the time of inspection.

## Context

The practice had a list size of approximately 17,600 patients.

Information published by Office for Health Improvement and Disparities showed that deprivation within the practice population group was in the second highest decile (9 of 10). The higher the decile, the less deprived the practice population relative to others.

According to the latest available data, the ethnic make-up of the practice area was 67% White, 24% Asian, 4% Mixed, 3% Other and 2% Black.

The age distribution of the practice population largely mirrored the local and national averages, although the practice had slightly fewer older people and slightly more working age people than the average practice in England.

Like many others, the practice had struggled to recruit GPs and was looking at different ways to provide care, through the use of different staff roles and innovative technology.

## Safe

## Rating: Inadequate

After we inspected the practice in May 2015, we rated the practice as requires improvement for safety because there were some safety systems and processes that were not working well, including the processes for documenting actions identified from significant events, for documenting health and safety risk assessments and the actions from them, and for ensuring that equipment stored was in-date.

We carried out a desk-based review in June 2016 and found that these issues had been rectified and rated the practice as good for safety.

Following this inspection we have rated the practice as inadequate because of widespread gaps in safety systems and processes.

- Systems and processes to keep people safe and safeguarded from abuse were not clear and consistently implemented.
- Systems for identifying and managing risks were ineffective and consequently we saw examples of risks associated with recruitment, training, medicines management, preventing and controlling infections, health and safety, and record keeping that had not been identified or acted upon effectively.
- The practice did not have a consistent and effective system to learn and make improvements when things went wrong.

Some of the issues were identified were the same as those we told the practice to address in 2015.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y <sup>1</sup>
Partners and staff were trained to appropriate levels for their role.	Partial <sup>2</sup>
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>The practice had a policy that covered safeguarding of children and adults. The policy advised staff of the circumstances when they should contact the local safeguarding team. The policy did not have contact details or information about where these could be found, but this information had been shared with staff through the information system and messages.</li> <li>The practice did not have evidence that all staff had completed training in safeguarding. We asked the practice to give us a summary of training records. This showed that there was no record of training in safeguarding children for 3 clinical staff members and of training in safeguarding adults for 2 clinical members of staff (one staff member was on long-term leave). Staff told us that these staff also worked for other organisations where it was believed that training had been completed, although no evidence had been obtained.</li> </ol>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial <sup>1</sup>
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>We looked at the recruitment records of 3 staff members. One had no proof of identity on file.</li> <li>The practice had not ensured that staff had immunity to diseases in line with national guidance, or that immunity was checked in line with the practice's own infection prevention and control audit.</li> </ol>	

- The audit stated that all staff were risk assessed on starting employment with the practice and any deemed at high risk of exposure to Hepatitis or Measles, Rubella and Varicella (primarily clinical staff for Hepatitis) were offered vaccination.
- We looked at 3 staff files. There was no risk assessment of immunity in the file of a non-clinical staff member. The file of a clinical staff member had no risk assessment of the risk of Measles, Rubella and Varicella. The third file confirmed evidence of immunity to Hepatitis and to Measles, Rubella and Varicella, but did not meet the guidance of the current UK Health and Security Agency guidance as there was no evidence/review of the risk of Tetanus, Diphtheria or Polio.
- After we raised concerns, the provider sent us a vaccination declaration form and told us that this had been sent to existing staff and would be used for new staff. We noted the information requested on the form would not (on its own) meet national guidance, which advises “Satisfactory evidence of protection would include documentation of having received two doses of MMR or having had positive antibody tests for measles and rubella.”

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment:	19/09/2023
There was a fire procedure.	Y
Date of fire risk assessment:	19/09/2023
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>Assessments of the risk of health and safety of fire risks were carried out by external assessors on 19/09/2023. The practice had undertaken a number of actions, in advance of the completion dates recommended by the reports. It was unclear how many actions were still to be complete as the action plan was incomplete and because practice staff believed that a number of the issues identified by the assessor were incorrect.</p> <p>Both assessments identified the need for DSEAR (Dangerous Substances and Explosive Atmospheres Regulations) risk assessments to be carried out on potential hazardous substances. The practice had liquid nitrogen, stored in the boiler room. The safety data sheet for the nitrogen (shown to us by a member of practice staff) stated that it may explode if heated and must be stored in purpose-build compound, ideally in the open air, as the storage temperature must not exceed 50°C.</p> <p>The DSEAR risk assessment carried out by the practice identified no hazards associated with the liquid nitrogen and therefore considered no mitigating actions.</p> <p>The fire risk assessment identified the need for clear and effective signage of any potentially hazardous substances. There was no effective signage in place for the storage of liquid nitrogen or oxygen.</p>	

**Infection prevention and control**

**Arrangements to assess, prevent and control the spread of infections, including those that are health care associated, were not effective**

	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.	Partial <sup>2</sup>
Date of last infection prevention and control audit:	24/06/2023
The practice had acted on any issues identified in infection prevention and control audits.	N/A <sup>2</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. We asked the practice to give us a summary of training records. This showed that there was no record of training in infection prevention and control for 6 clinical staff.</li> <li>2. Infection prevention and control audits were carried out but were not effective.</li> </ol> <p>A Legionella risk assessment had been completed by an external organisation on 19/09/2023. There were 9 recommended actions. Four of the actions were described as High Risk to be completed immediately. However, of these, 3 had not been effectively acted upon, including 2 that related to ensuring water temperatures from tap outlets were sufficient to prevent the growth of a bacterium called Legionella that can proliferate in building water systems.</p> <p>The practice had a log for recording water temperatures every month. We noted that for 2023 there were only temperatures recorded in March, June, September, and October. The thermometer used to take the water temperatures was not calibrated.</p> <p>The practice policy stated that disposable privacy curtains were replaced at least every 2 years. We saw a privacy curtain (in the healthcare assistant’s room) with a note that it was installed in 2019.</p> <p>An audit of infection prevention and control had been carried out on 24/06/2023. This did not identify any areas for improvement. For example, it did not identify the issues with the management of staff immunity, legionella controls, or privacy curtains.</p> <p>The audit stated that the provider's cleaning schedule specified the cleaning regime for blinds and high levels but we did not find this in either of the 2 versions of the cleaning schedule we looked at.</p>	

**Risks to patients**

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

	Y/N/Partial

There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were 2 out of date oxygen masks and 3 out of date airways tubes in a bag behind the defibrillator and oxygen cylinder. There was also equipment in date, stored with the oxygen.</p> <p>We asked the practice to give us a summary of training records. This showed that there was no record of training in Basic Life Support for one clinical staff member.</p> <p>The records for 7 of 65 staff (both clinical and non-clinical) indicated that they had not received training in Basic Life Support in the last 12 months. We looked at 2 examples and the practice could not locate more recent records. Staff told us that these staff also worked for other organisations where it was believed that more recent training had been completed, although no evidence had been obtained.</p> <p>In response to the draft report the provider told us that 2 of the 7 staff we identified had stopped working for the practice, 2 had now completed Basic Life Support training, 1 had provided evidence of recent training completed before the inspection and 2 were booked to complete the training.</p>	

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	

Review of patient records identified that care records were not consistently managed in a way to protect patients. For example, examination, rationale for prescribing and management plans were not adequately documented within all the patient records we reviewed.

### Appropriate and safe use of medicines

**The practice did not have systems to ensure 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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.91	0.79	0.91	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). (01/07/2022 to 30/06/2023) (NHSBSA)	9.1%	7.8%	7.8%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	5.84	5.48	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	90.3‰	59.9‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.92	0.50	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	6.4‰	4.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N <sup>1</sup>



The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N <sup>2</sup>
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial <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.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial <sup>4</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial <sup>5</sup>
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> <li>1. We asked to see Patient Specific Directions, used to authorise health care assistants to administer medicines. We were given 3 documents. Two had been marked with a practice stamp, but did not have a signature of a prescriber. The third did not have any practice stamp or evidence of any attempt at authorisation. We looked at the Patient Group Directions. They were completed inconsistently, with some fields left blank. Two had expired.</li> <li>2. There was no consistent or effective system to agree and evidence the prescribing competence of non-medical prescribers. We looked at the scope of practice documents for non-medical prescribers employed directly by the practice and noted examples that had not been signed by the prescriber or the practice, lacked necessary detail, or were out-of-date.</li> </ol> <p>Given these concerns, we looked at examples of consultations carried out by non-medical prescribers and found examples of staff acting outside of their documented scope of competence.</p> <p>There was no consistent and effective system of supervision of non-medical prescribers. The registered manager described a system for the supervision of non-medical prescribers which did not align with documents about the supervision system.</p>	



The systems described/documented would not necessarily be effective as they both relied on non-medical prescribers identifying cases for discussion, rather than random or risk-based sampling.

We looked at an example of a supervision record. This did not align with either the system described by the registered manager or the system described in the documents about supervision.

3. We saw one medicine review recorded as having been conducted without documenting the outcomes from the review and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review.
4. A clinical search identified a total of 443 patients taking medicines that may require another medicine to be prescribed to reduce the risk of damage to the stomach lining. We noted that 171 of these had not been prescribed the second medicine. We sampled 5 of these and found one who should have been prescribed the second medicine. We sent the practice the results of our review of patient records, and the practice showed us evidence that this patient had then been started on the second medicine.
5. There was no documented system to monitor the prescribing of controlled drugs.

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

**The practice did not have a consistent and effective 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.	N <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.	Partial <sup>2</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	Partial <sup>2</sup>
There was evidence of learning and dissemination of information.	N <sup>2</sup>
Number of events recorded in last 12 months:	11
Number of events that required action:	7
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice had processes to collect information about safety from a variety of sources but it was not captured or managed in a way that allowed it to be used effectively to improve safety.</li> <li>2. When we inspected in 2015 we noted that there was a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, records were incomplete and there was no record to indicate that actions identified to reduce the likelihood of the event reoccurring had been</li> </ol>	

taken. We carried out a desk-based review in 2016 and the practice showed us evidence of improved record keeping.

At this inspection we noted that the log used to monitor significant events had no system to record when significant events were discussed with staff, or to indicate when actions agreed had been taken or assessed to check that the action was effective. In some cases, the action described was in the future tense, although staff told us that it had been completed.

Only 11 events were recorded from the last 12 months and for 5 it was recorded that no learning or actions were identified.

Some staff members could not tell us about a significant event and some told us that they did not always hear about the learning from significant events relevant to their role, or that when changes were made that might have been as a result of a significant event, the link was not always made clear.

After we raised concerns about significant events we were sent a new log for recording more details about the significant event process, but with no information about how it would be implemented or how the other issues with significant event management would be addressed.

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

Event	Specific action taken
The alert system did not operate as anticipated to call other staff to support a clinician during an emergency.	<p>The practice had implemented a new alert system. The log did not record one of the key findings, that staff needed additional training/information about how to use the new alert system correctly. There was therefore no record as to how/when this would be communicated.</p> <p>The event had occurred recently so staff told us the learning had not yet been shared. We noted the absence of a system for sharing learning from this incident (for example, clear actions in meeting minutes).</p>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was a system for recording and acting on safety alerts but the provider was unable to demonstrate that this operated consistently. Our remote clinical searches identified 69 patients prescribed a combination of medicines that are sometimes prescribed for high blood pressure or heart failure. A safety alert was issued in 2016 advising that patients on this combination needed regular monitoring. The search suggested 24 patients had not received the required monitoring.</li> <li>We looked at 5 records and found that they were all overdue for monitoring. Evidence shared by the practice showed that monitoring for 4 of these 5 patients was available on a separate system but one was overdue for monitoring with no invitations for monitoring on their record.</li> </ul>	

## Effective

## Rating: Requires improvement

After the inspection in May 2015 we rated the practice as good for providing effective care.

Following this inspection we have rated the practice as requires improvement for providing effective care because:

- the practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles
- patients' needs were not always assessed, and care and treatment was not always delivered, in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

*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 always delivered in line with current legislation, standards and evidence-based guidance.**

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

1. There was no documented system by which changes and updates to clinical guidance were shared with clinical staff.
2. and 3. Please see the information given in the Management of people with long term conditions sections (below).

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients with a learning disability were offered an annual health check, however we saw an example of a review carried out by a non-medical staff member who had not received specialist training. National guidance stated that although other staff could carry out parts of a learning disability annual reviews, there should be direct involvement in every review from a GP or learning disability specialist nurse because of particular vulnerabilities of this group of patients and the risk of medical conditions being missed.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

2. A search identified 127 patients with blood tests indicating they may have an undiagnosed long-term condition. We looked at 5 patient records and found 2 with blood test results suggesting a missed diagnosis. Information shared by the practice indicated that in one of the 2 instances the diagnosis had been made but not coded. This would mean that the patient would likely not be identified for consideration of treatment options and regular monitoring of their condition to prevent long term harm.

The practice shared evidence that showed that patients with this potential undiagnosed long-term condition had been contacted and their records coded with a diagnosis. The same search showed 42 patients with the undiagnosed long-term condition.

We looked at 5 records of patients whose blood test results indicated a potential diagnosis of Chronic Kidney Disease (CKD) 4 or 5. We identified one patient coded as having CKD 3, whose blood test results indicated a diagnosis of CKD 4.

3. Some patients with asthma, CKD, hypothyroidism and diabetes were not monitored and reviewed in line with national guidance.

- A search identified 73 patients prescribed 2 or more courses of rescue steroids for asthma in the last 12 months. We looked at 5 records and found that 3 patients had not received follow up within 1 week of prescribing rescue steroids for asthma, and not all patients had an adequate assessment documented before prescribing.

The practice confirmed that there was no consistent follow up of patients prescribed rescue steroids for asthma but that there were discussions underway as to how to introduce this. The practice told us that a significant event had been raised regarding the lack of documented assessment.

- A search identified 9 patients (of 66) with CKD Stage 4 or 5 who appeared not to have had necessary monitoring in the last 9 months. We looked at 5 records and found that 2 patients were overdue for monitoring (after taking into account information held on a separate results system) and identified one patient whose diagnosis had not been updated from Stage 3 to Stage 4.
- A search identified 23 patients (of 613) with patients with an underactive thyroid who had not had thyroid function test monitoring for 18 months. We looked at 5 records and found that 5 patients were overdue for a medication review and 4 were overdue for blood test monitoring. No invitations for monitoring were seen on 4 of 5 of the records.
- A search identified 36 patients with a complication of diabetes with poorly controlled blood sugar. The practice had 1044 patients with diabetes. We looked at 5 records and (after taking into account information held on a separate results system) found that 1 patient was overdue for monitoring of their blood sugar, blood pressure and overdue a review of their diabetes.

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)	121	129	93.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	126	138	91.3%	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.	125	138	90.6%	Met 90% minimum

received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	129	138	93.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	143	157	91.1%	Met 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>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	57.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	70.8%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	72.4%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	58.4%	53.7%	54.9%	No statistical variation

#### Any additional evidence or comments

- The practice told us that there was a dedicated staff member responsible for contacting patients due to receive cervical screening, and that patients received a text message and then a telephone call.
- The practice told us that many patients were from Black and minority ethnic groups and for cultural reasons did not want to have a cervical smear; and that some patients had their screening in other countries or privately.
- The practice showed us data that indicated improvement in the uptake of cervical screening and the practice believed that they now met the national target of 80% uptake. Practice data cannot be directly compared to the nationally validated data as it is calculated in a different way. CQC uses programme



coverage data from the national cervical screening call/ recall system which is refreshed and published each quarter by NHS England. The latest figure (30 June 2023) for the practice is 72.7%.

### Monitoring care and treatment

**There was quality improvement activity but it was unclear how this was overseen and shared with staff to improve outcomes of care and treatment.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>• There was a system of consultation notes audit, but we were told that it was not consistently used.</li> <li>• We asked the practice for clinical or consultation audits from the last 3 years. The practice sent us 9 examples. Of these, 5 were complete audits, where an initial data collection had been followed by an improvement action and a second data collection to check for improvement.</li> <li>• We noted that the scope of most of the audits was limited, either by small numbers of patients identified and/or by a second data collection within less than 3 months of the first. One audit was from 2018 (both cycles).</li> <li>• We looked at minutes of meetings with GPs and other clinical staff and saw no examples of audit being discussed.</li> </ul> <p>Examples of audits:</p> <ul style="list-style-type: none"> <li>• Amiodarone audit: <ul style="list-style-type: none"> <li>○ July 2023 – 7 patients on Amiodarone, 0 had all required monitoring.</li> <li>○ October 2023 – 7 patients all had required monitoring.</li> <li>○ Note of how processes should be improved to ensure patients continued to be identified and followed up.</li> </ul> </li> <li>• Gabapentinoid plus opioid audit: <ul style="list-style-type: none"> <li>○ Undated: <ul style="list-style-type: none"> <li>▪ 43 patients identified prescribed a high dose Gabapentinoid plus opioid.</li> <li>▪ 26 of these patients were prescribed Gabapentinoid for a licensed indication.</li> <li>▪ 41 of these patients were being prescribed opioids for 28 days supply only.</li> <li>▪ 22 of these patients had a risk assessment.</li> </ul> </li> <li>○ October 2023: <ul style="list-style-type: none"> <li>▪ 41 patients identified prescribed a high dose Gabapentinoid plus opioid.</li> <li>▪ 39 of these patients were being prescribed Gabapentinoids for a licensed indication.</li> <li>▪ 41 of these patients were being prescribed opioids for 28 days supply.</li> <li>▪ 40 of these patients had a risk assessment or medication review.</li> </ul> </li> </ul> </li> </ul>	

- Direct oral anticoagulants (DOAC) audit:
  - August 2023:
    - 467 patients on DOAC for atrial fibrillation (of 467 patients), 67% had the necessary blood tests in the last 12 months.
    - Only 31% of those who had blood tests had a creatinine clearance calculated
  - September 2023:
    - 2.5% increase in the patients who had blood test in the last year but no increase in the creatinine clearances calculated.

**Effective staffing**

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial <sup>1</sup>
The practice had a programme of learning and development.	Partial <sup>1</sup>
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y <sup>2</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>3</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.	N <sup>4</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N <sup>5</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. We asked the practice for the dates staff members had last completed training. No information was available for:               <ul style="list-style-type: none"> <li>○ Basic Life Support for 1 clinical staff member. The records for 7 of 65 staff indicated that they had not received training in Basic Life Support in the last 12 months. We looked at 2 examples and more recent records could not be located, although it was believed that more recent training had been completed, for example through another employer.</li> <li>○ Safeguarding children for 3 clinical staff members (one on long-term leave)</li> <li>○ Safeguarding adults for 2 clinical staff members (one on long-term leave)</li> <li>○ Consent/Mental capacity for 4 clinical staff members</li> <li>○ Infection prevention and control for 6 clinical staff.</li> </ul> </li> <li>2. The practice had recently improved its induction process. Until recently the practice did not have a comprehensive documented induction process to ensure that staff had the knowledge needed to begin in post. The practice carried out an annual staff survey, and based on the 2023 staff survey data, had not ensured that staff had roles clearly defined by smart objectives and a job description.</li> </ol>	

3. The practice had no record of appraisal dates for 7 staff who had been in post for more than 12 months. There was no evidence of appraisal on file for one clinical staff member who had been in post since 2019.

The practice had introduced a system of one to one supervision meetings. In the 2023 practice staff survey, 82% of staff agreed that they had meaningful one to one /checks-in that allowed them to evaluate and understand their performance and 85% of staff agreed that their one to one /check-in allowed them to identify their development needs and resulted in the right training being provided. This was an improvement from the 2022 survey. The practice had planned external training for staff who carried out supervision.

4. We noted the absence of a consistent and effective system to agree the scope of practice for staff in advanced roles upon recruitment or to assure their ongoing competence. We looked at the scope of practice documents for non-medical prescribers employed directly by the practice. There was no consistent clinical supervision arrangement recorded. One scope of practice stated that non-medical prescriber received no supervision.

After we raised concerns about non-medical prescribers the practice carried out a review. We asked for a copy of this. The scope of the non-medical prescribers' practice assessed in the review was significantly narrower than that in the individual scope of practice documents. The registered manager told us that the changes reflected the up-to-date evidence of competence available.

The partners described a system for the supervision of non-medical prescribers which did not align with documents sent about the supervision system.

We reviewed 10 consultations of each of the 6 non-medical prescribers and found 7 instances of prescribers acting outside of their documented scope of practice. This issue had not been identified by the practice's own processes.

5. We looked at an example of a supervision meeting. This did not align with either the system described by the registered manager or the system described in the documents about supervision.

### 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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

**Helping patients to live healthier lives**  
**Staff helped patients to live healthier lives.**

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had systems to discuss changes to care or treatment with patients and their carers where necessary, but searches and review of records showed that these did not always operate consistently.</li> </ul>	

**Consent to care and treatment**

**The practice obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial <sup>1</sup>
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y <sup>2</sup>
Explanation of any answers and additional evidence, including from clinical searches: <ol style="list-style-type: none"> <li>We asked the practice to give us a summary of training records. This showed that there was no record of training in consent or mental capacity for 3 clinical staff members.</li> <li>Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible the patients' views had been sought and respected.</li> </ol>	

## Responsive

## Rating: Requires improvement

After the inspection in May 2015 we rated the practice as good for providing responsive care.

Following this inspection we have rated the practice as requires improvement for providing responsive care.

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

We also found that the practice:

- had not complied with the Accessible Information Standard.
- had made reasonable adjustments when patients found it hard to access services, but had not considered the impact on these of a new appointment booking system, before the system was introduced.
- did not consistently handle complaints in line with national guidance.

### Responding to and meeting people's needs

**The practice had made efforts to meet patients' needs, but had not adequately considered the needs of patients who found it hard to access services.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y <sup>1</sup>
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Partial <sup>2</sup>
There were arrangements in place for people who need translation services.	Partial <sup>2</sup>
The practice complied with the Accessible Information Standard.	Partial <sup>3</sup>
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice implemented a new appointment booking system during the inspection. Under this system, patients were required to complete an online triage questionnaire (or answer questions to allow practice staff to complete the questionnaire) to book most appointments. Based on the answers, the online system determined the most appropriate clinical staff member for the patient to see and the clinical urgency. The patient was then offered a choice of appointments and booked directly within the system.</li> </ol>	

Staff told us that if a clinical staff member saw a patient and thought they would benefit from being seen again by the same person, the staff member could book another appointment or add a note to the patient's record saying that they would see them again.

Members of the patient participation group expressed concerns about the ability of patients to see the same GP to provide continuity of care.

The online triage system did not take account of details on the patient record system, so a note on a patient's record would not necessarily result in the system suggesting an appointment with the same GP.

In response to the draft report the provider confirmed that GPs could book follow up appointments and that patients who wished to see the same GP but who were not booked a follow up could use the online system to see if an appointment with the GP was offered. If this was not available, a patient could decline the online appointment offered to receive a call back from reception to book an appointment, or call the surgery direct and ask for the next appointment with the preferred clinician.

2. The practice had made reasonable adjustments for patients who found it hard to access services and there were messages on patient records to alert staff who booked appointments to these. The online triage system did not link to these in considering what appointment would be suitable for a patient, so patients would need to call the practice to ask a staff member to consider the alert. Before the system was implemented the provider had considered the risk that patients would be disadvantaged if they were unable to access the system digitally. To mitigate this risk, patients were advised, through the website, a phone message and leaflets, that they could continue to contact the practice by phone and in person if they were unable or uncomfortable using the online system.

Before implementing the new system the practice had not assessed the impact on patients who although comfortable with using the online system, had adjustments in place that would not be considered by the online system. There was not information for patients who might be affected by this on the triage tool, or the appointments page of the practice website, the recorded phone message or the leaflet.

Staff told us about how issues that arose after the triage system was implemented were being managed and learning shared, and about measures that had been put in place for some of these patients. For example, information was added to the booking confirmation to ask patients who needed interpreting support to call the practice with their appointment details so that an interpreter could be booked.

We saw and heard evidence that patients calling the practice could experience long delays, especially at peak times. In response to the draft report, the practice leaders told us that they believed the telephone delays observed during the inspection were experienced before the impact of the online system had taken effect. The practice leaders told us that a review undertaken on 17th November showed a 20% reduction in incoming calls dialled between the first three weeks in October 2023 and the first three weeks of November 2023 and a reduction in the percentage of calls answered seeking appointments from 59% in October to 53% in November. Practice leaders said that during November 23% of appointments were booked online, allowing the significant reduction in the number of telephone calls anticipated before implementation and actually experienced.

3. The patient registration of the form available to patients to complete on paper did not meet the Accessible Information Standard because it asked patients for information about their information and communication needs, but restricted the adjustments patients could request (to email, large print letter, braille and British Sign Language (BSL) interpreter). The online registration form allowed patients to request any adjustment be considered. Staff told us that the online form had been very recently revised

as part of the implementation of the online triage system. There was a poster in reception encouraging patients to tell the practice about their accessibility needs.

### Practice Opening Times

Day	Time
Opening times:	
Monday	8am - 1pm, 2pm – 6.30pm
Tuesday	8am - 1pm, 2pm – 6.30pm
Wednesday	8am - 1pm, 2pm – 8pm (6.30pm – 8pm for pre-booked appointments only)
Thursday	7am - 1pm, 2pm – 6.30pm (7am – 8am for pre-booked appointments only)
Friday	8am - 1pm, 2pm – 6.30pm
Saturday	9am – 1pm (for same-day appointments only)
Appointments were available within these times	

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

- The practice offered home visits.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments with nursing staff were available outside of school-hours.
- The practice had introduced an online triage tool. Staff told us that this took account of the clinical urgency of the presenting symptoms and other clinically relevant factors, such as the age of the patient, and ensured that the practice would be able to track all appointment requests.
- The practice was open until 8pm on Wednesday and 9am – 1pm on Saturday.
- Pre-bookable appointments were also available to all patients at additional locations within the area, through a local 'hub' service. Appointments were available 6.30pm – 8.30pm Monday – Friday and Saturday and Sunday 9am - 3pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice had adjusted the delivery of its services to meet the needs of patients with a learning disability, but it was unclear how these patients would be impacted by the introduction of the online triage tool, especially given the reported difficulties with phone access.
- We noted one example of a learning disability annual review that had been carried out by a non-medical staff member who had not received specialist training. National guidance stated that although other staff could carry out parts of a learning disability annual reviews, there should be direct involvement in every review from a GP or learning disability specialist nurse because of particular vulnerabilities of this group of patients and the risk of medical conditions being missed.



**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).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Partial
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• In the 2023 National GP Patient survey, only 29% of patients responded positively to how easy it was to get through to someone at this GP practice on the phone.</li> <li>• Satisfaction with phone access at the practice had been below average for a number of years. The practice was aware of this and had introduced a new phone system in 2022 with new functions, such as a callback option. Despite this, satisfaction with phone access (as measured by the National GP Patient Survey) fell further in 2023. The practice increased the number of staff answering phones at peak times and introduced an online triage system, with the aim of reducing the number of patients calling to book appointments. There was also a direct telephone number that had been given to hospitals (for communication of urgent test results) and care homes.</li> <li>• Staff told us that the callback system worked well but members of the patient participation group told us that it often did not work. In response to the draft report, practice leaders sent us data on the number of callback requests made and carried out as evidence as to the functioning of the callback system.</li> <li>• The practice had access to data on phone access and was monitoring the average wait time per week, but was not routinely reviewing the time taken for patients to get through to the practice at different times or the number of patients who did not get their calls answered. In response to the draft report the provider said that monitoring average wait time can provide useful trend data, but it was not the only means of monitoring patient experience. The provider confirmed that 2 additional staff now handled patient demand at the busiest time, and that the practice manager and assistant manager also provided assistance on reception at busy times. The provider told us that monitoring the queue, the operation of the appointments system, and ensuring adequate staffing was in the job description of the Patient Services Manager and that the practice could not terminate calls and patients could request a call back.</li> <li>• The practice had made reasonable adjustments for patients who found it hard to access services and there were messages on patient records to alert staff who booked appointments to these. The new online triage system did not link to these in considering what appointment would be suitable for a patient, so patients would need to call the practice to ask a staff member to consider the alert. Before the system was implemented the provider had considered the risk that patients would be disadvantaged if they were unable to access the system digitally and as a result patients were advised, through the website, a phone message and leaflets, that they could continue to contact the practice by phone and in person if they were unable or uncomfortable using the online system. The practice did not, before implementing the new system, assess the impact on patients with adjustments in place who were able to and comfortable with using the online system. There was not information for patients who might be</li> </ul>	

affected by this on the triage tool, or the appointments page of the practice website, the recorded phone message or the leaflet..

- The practice did not take steps, before the new system was implemented, to inform all patients about the change to appointment booking, only communicating through means that relied on patients being in recent contact with the practice. In response to the draft report, the provider told us that the decision not to send a message to all patients before the system was implemented was taken to reduce unnecessary telephone traffic that it was believed would have occurred. The provider confirmed the ways that patients were informed before the change, including information on the website and an information leaflet. The provider also confirmed that after the system was established in use, a text was sent to all patients who had a mobile number on file.
- Not all interactions with the practice could be booked through the online triage system. Information about which still needed to be booked by phone was included in a leaflet and on a Frequently Asked Questions (FAQ) page on the website. The information was not on the phone message advising patients to use the online system or on the triage tool, or on the main appointments page of the practice website.
- Following the introduction of the online triage tool, patients who called the practice were asked the questions on the tool by staff, who completed the questionnaire and booked patients one of the appointments that the system selected as suitable. Staff told us that as a result, calls were taking longer to answer, despite additional staff answering calls. However, it was hoped this would change as patients became more aware of the new system and usage increased.

### 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 (01/01/2023 to 30/04/2023)	28.7%	N/A	49.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	45.0%	61.9%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	45.1%	59.6%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	70.6%	73.4%	72.0%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There were 15 comments in the last 12 months: 7 positive, 1 mixed and 7 negative.</p> <p>Positive comments included feedback that staff were efficient, professional and kind. There were 2 positive comments about the online triage system.</p> <p>Negative comments included feedback about issues with a referral, a delay to being seen after the appointment time and difficulties with getting through to the surgery by phone and with appointment availability. There were 4 negative comments about the online triage tool, including about difficulties completing the questionnaire and the time it took.</p>
Friends and Family Test	<p>The practice sent patients a text asking for feedback after their appointment.</p> <ul style="list-style-type: none"> <li>In September 2023, there were 527 responses. 92% of patients said that their experience was good or very good, and 4% said it was poor or very poor.</li> <li>In October 2023, there were 486 responses. 93% of patients said that their experience was good or very good, and 4% said it was poor or very poor.</li> <li>In November 2023, there were 669 responses. 91% of patients said that their experience was good or very good, and 5% said it was poor or very poor.</li> </ul> <p>64% said that they found booking easy or extremely easy, 13% gave a neutral response and 18% said that it was not easy or extremely not easy.</p> <p>62% of the 208 patients who booked their appointment online in November said that they found it easy or somewhat easy to book, 18% didn't respond or gave a neutral response, 20% said that they found it not easy or somewhat not easy. Of the 42 patients who said that they found it not easy to book online, 30 said that their overall experience of the practice was good or very good.</p>

### Listening and learning from concerns and complaints

**Complaints were not consistently handled in line with national guidance.**

Complaints	
Number of complaints received in the last year.	29
Number of complaints we examined.	3
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.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There were 2 complaints log documents that recorded complaints that had been received. One had no dates of responses. The other complaints log had details of when final responses were sent, but most complaints had no acknowledgement date recorded.</li> <li>• The log that stored the learning and changes from complaints had no dates of how or when the learning was shared, when actions were completed or were checked to make sure they were effective.</li> <li>• We reviewed 3 complaints which should have received an acknowledgement under national guidance, and found that 2 were not acknowledged.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
The practice had complaints about reception staff	Staff told us that the reception team attended training courses on developing resilience & empathy and dealing with challenging patients.

## Well-led

## Rating: Inadequate

After the inspection in May 2015 we rated the practice as good for being well-led as there was a clear vision and strategy, a documented leadership structure, and documented policies and procedures and as staff felt supported by management. However, we did note that weaknesses in the records made of meetings limited their use as a governance tool.

Following this 2023 inspection, we have rated the practice as inadequate for being well-led because:

- Governance failures hindered the delivery of high-quality care, for example, failures regarding adherence to emergency medicines protocols, recruitment checks and Infection Prevention and Control.
- We noted limited systems for identifying and managing risks and consequently saw examples of risks that had not been identified or acted upon, for example lapsed or absent staff training evidence, management of potentially hazardous substances, missing pre-employment checks and risks associated with the recent introduction of an online triage system.
- The practice leaders had not established information systems that allowed them to oversee systems and processes intended to keep people safe and to ensure compliance with guidelines, and we found multiple instances in which they were not working as intended. The 9 practice leaders also managed 3 other GP practices, serving a population of more than 37,000 patients across 4 locations, posing challenges for the leaders in ensuring that systems and processes were working effectively through more informal mechanisms.

Some of the issues we identified at this inspection had been identified previously and had not been effectively addressed by the practice leaders.

Although the practice leaders told us of plans to improve governance arrangements and showed us evidence of some individual systems being improved, ratings are based on evidence at the time of inspection.

### Leadership capacity and capability

**Leaders had not, when making changes to the service, identified the risks that needed to be considered, or had identified the risks, but had failed to establish effective means to manage them.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• The practice leaders understood the challenges to quality and sustainability, particularly the scarcity of GPs in the national workforce, the increased complexity of care that GP practices are required to deliver and difficulties with providing timely access for patients.</li></ul>	

- The practice leaders had put in place a plan to address these by:
  - increasing the standard GP appointment length to 15 minutes
  - increasing the clinical care delivered by advanced clinical practitioners, such as physician associates, prescribing nurses and pharmacists, rather than GPs
  - rolling out an online triage system to direct patients to appointments with clinically appropriate clinicians within a clinically appropriate time, without the need for any staff involvement.
- The practice leaders had not identified all of the actions necessary to ensure that, following these changes, care would continue to be delivered safely and without potential for adverse impact on patients who found it difficult to access care.
- The leaders also manage 3 other GP practices. When we inspected one of these practices in 2016 we raised concerns about the scope of practice for non-medical prescribers. The leaders introduced a comprehensive risk assessment and competency framework for these staff. This had not been implemented for staff in the same roles at this practice.
- After we raised concerns about non-medical prescribing during this inspection, the practice leaders carried out a review using some, but not all of the practice's own risk assessment and competency criteria. The aspect not assessed was agreement of scopes of practice.
- We looked at the review that the practice leaders completed. In some cases the scope in the review document was significantly smaller than in individual scope of practice documents. The registered manager told us that the changes reflected the up-to-date evidence of competence available. We were told that the review was carried out on 28/29 October 2023. Some of the information in the review did not align with evidence we gathered during the site visit on 27 October 2023. For example, in the review all non-medical prescribers are recorded as having up-to-date mandatory training on an online system. During the site visit on 27 October staff told us that they did not have a number of training records for one non-medical prescriber as they worked for another employer, with whom leaders assumed they had carried out their training.
- We looked at the information available for staff who booked appointments about the types of symptoms/conditions suitable for consultation by the non-medical prescribers. The information about one non-medical prescriber stated that they had proficiency in multiple areas of medicine, including menopause and mental health) which were not listed as in their scope of competence (either the individual document or the review document that the registered manager told us reflected the up-to-date evidence of competence available). We looked at the information programmed into the online triage system and noted that this would also be likely to take the non-medical prescribers beyond their documented scope of practice. In our small sample of patient records we found examples of staff acting outside of their documented scope of practice.

## Vision and strategy

**The practice had a clear vision, but the strategy for achieving it had not been designed to ensure safe, high quality care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice leaders had a clear vision for how to improve the service, but the strategy to achieve this had not been adequately risk assessed and implementation was not being comprehensively monitored.</li></ul>	

## Culture

**Staff were positive about the practice culture, but this was not underpinned by effective systems to ensure it drove high quality care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial <sup>1</sup>
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial <sup>2</sup>
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ol style="list-style-type: none"><li>There was a system of regular one to one meetings but these were not operating effectively.</li><li>The provider had a Duty of Candour Policy and also encouraged candour through a Freedom to Speak Up Regime that had been launched in 2019 and refreshed in 2021.</li></ol> <p>We noted the absence of any reference to Duty of Candour in the provider's complaints and significant events policies and process documents.</p> <p>In response to the draft report the provider pointed us to the policies in place and told us that staff understood the importance of openness and honesty, particularly with reference to Patient Safety. The</p>	



provider told us that a specific reference to Duty of Candour would be added to the complaints and significant events policies.

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

Source	Feedback
Staff interviews and responses to our questionnaire	Staff told us that they felt well-supported and enjoyed good opportunities for development. The culture was described as positive, and colleagues as friendly and helpful.

### Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N <sup>1</sup>
Staff were clear about their roles and responsibilities.	Partial <sup>2</sup>
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. Policies had not been updated to take account of changes to national guidance, for example to staff immunity.</p> <p>The practice was not consistently following their policies, for example related to complaints handling, infection prevention and control or training. There were also governance failings in the systems and processes for defining roles, staff training, supervision and appraisal, management of medicines and patient monitoring.</p> <p>We noted the absence of an effective system to monitor the management of complaints or significant events and to track actions from these to improve the service. After we raised this with the practice, we were sent a new tool to monitor significant events.</p> <p>Meeting minutes did not operate effectively as governance tools as there was no consistent system of recording of actions and no documented system of review action agreed at previous meetings.</p> <p>The practice leaders had failed to put in place effective measures to ensure the clinical care delivered by staff in advanced roles was safe and of high quality. Scopes of practice had not been agreed using up-to-date evidence of staff member's competency and there was no effective system to ensure that staff remained within the areas of clinical care agreed.</p>	

The practice leaders told us that they had identified weaknesses in governance and were restructuring their governance structure to allow smaller numbers of partners to have oversight of distinct areas of service delivery: finance, people and workforce, clinical care and compliance.

- In the provider's 2023 staff survey, 82% of staff agreed that their role and responsibilities were clearly defined by smart objectives and a job description (6 staff disagreed).

However, we noted the absence of protocols to ensure that advanced clinical roles were clearly defined and to ensure that staff worked within the limits of their competence. We found examples of staff acting outside of their documented scope of competence.

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N <sup>1</sup>
There were processes to manage performance.	Partial <sup>2</sup>
There was a quality improvement programme in place.	Partial <sup>3</sup>
There were effective arrangements for identifying, managing and mitigating risks.	N <sup>1</sup>
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial <sup>4</sup>

Explanation of any answers and additional evidence:

- Practice leaders rolled out new governance structures in early 2023. There was a new Executive Board and 4 governance domains to oversee the 4 practices managed by the partners. The domains were Finance, People and Workforce planning, Governance and Compliance and Clinical.

The governance domains were at different stages of development at the time of the inspection, but all had terms of reference, a structure for meeting agendas and minutes, and an action log, and the staff assigned to each domain had had meetings.

We asked how risk was currently overseen. We were sent information about the governance structures and were told that a risk register was being populated but would not be shared as it was incomplete. We asked for any other documented system for overseeing risk and were sent information but none was sent at that time. A risk log was later sent for the project to implement the online triage system.

We identified evidence of weaknesses in oversight of risk that had not been addressed by the practice's assurance systems, for example:

- Action plans to record the status of actions arising from risk assessments were incomplete.
- Actions that had been taken had not addressed the risks identified, for example related to potentially hazardous substances or the risk of legionella.

- Processes to identify and mitigate risks, for example an infection prevention and control audit, were ineffective.

Some of the issues we identified at this inspection were identified during the 2015 inspection, but the improvement we noted in 2016 had not been sustained.

2. The systems and processes to safely and effectively manage the recruitment, training and supervision and appraisal of staff were inconsistently implemented. Practice leaders had identified weaknesses in these areas and were working to improve them. Leaders showed us evidence of this in improved staff survey data.
3. The practice was engaged in improvement work, but leaders had not identified and addressed the issues we identified.

For example, the practice leaders had identified that the use of an online triage system could improve access for patients, by reducing the number of phone calls so that those who could not use online tools could have their calls answered, and by ensuring a consistent assessment of clinical need. The practice did not, before implementing the new system, assess the impact on patients who were able to and comfortable with using the online system, but who had adjustments in place that would not be considered by the online system. There was not information for patients who might be affected by this on the triage tool, or the appointments page of the practice website, the recorded phone message or the leaflet.

4. The practice had made service developments including:
  - an increase in patients being seen by other trained health professionals rather than GPs
  - the implementation of an online triage system.

The impact of these on the quality of care had not been adequately assessed.

### Appropriate and accurate information

**Data and information was used to drive decision making in some areas of service delivery, but it was not used consistently and was not always used effectively, with large gaps in the information the practice leaders used for monitoring.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Data was used to monitor and improve some areas of the service's performance. For example, delivery of clinical care against targets. The practice leaders had also looked at data about the reasons patients called the practice and about appointment take-up to decide to implement the online triage system.</li> <li>• Data was not always effectively used for monitoring. Practice leaders used an annual staff survey to identify areas and monitor areas for improvement, which we saw had improved staff satisfaction.</li> </ul>	

The practice had access to data on phone access and was monitoring the average wait time per week, but was not routinely reviewing the time taken for patients to get through to the practice at different times or the number of patients who did not get their calls answered.

In response to the draft report the provider said that monitoring average wait time can provide useful trend data, but it was not the only means of monitoring patient experience. The provider confirmed that 2 additional staff now handled patient demand at the busiest time, and that the practice manager and assistant manager also provided assistance on reception at busy times. The provider told us a specific staff member had responsibility for monitoring the queue, the operation of the appointments system, and ensuring adequate staffing, that the practice could not terminate calls, and that patients could request a call back.

## 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.	N
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Insufficient evidence gathered to make judgement
Patients were made aware of the information sharing protocol before online services were delivered.	
The practice advised patients on how to protect their online information.	
Online consultations took place in appropriate environments to ensure confidentiality.	Y
Staff are supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Health care organisations who wish to use digital services such as online triage tools are required to carry out a specific set of activities to assess and manage risk, against a documented standard.</li> <li>We asked the practice for their assessment against the standard and were sent a document completed by the system developer. This would not meet the requirements as the assessment work must be completed by the adopting health organisation, taking into account their own staffing, governance and safety systems. We asked for any assessments that the practice had carried out to check compliance with the standard. We were told that these could not be supplied as a staff member was on annual leave.</li> </ul>	

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

**The practice involved patients, staff and external partners but did not always act upon the feedback given.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We heard of examples when the practice had acted on feedback from patients.</li> <li>• However we noted that the patient participation group told the practice on 28 June 2023 that the callback function on the phone system did not work well. Feedback received indicated that the issues were ongoing. In response to the draft report, the practice sent us data on the number of callback requests made and carried out as evidence that of the functioning of the callback system.</li> </ul>	

#### Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• Representatives from the Patient Participation Group (PPG) told us that the practice had shared information with them about proposed structural changes and had worked with them to develop information for patients about the online triage tool and on wider improvements to the practice website.</li> <li>• For example, leaders had acted on a PPG suggestion to increase the privacy at reception by installing a sound-absorbing panel.</li> <li>• PPG representatives told us that the callback function on the phone system did not always work. In response to the draft report, practice leaders sent us data on the number of callback requests made and carried out as evidence of the system working well.</li> <li>• PPG representatives also fed back that patients, particularly older patients, would be concerned that the online triage system would not allow them to request to see one of their preferred doctors (as the system directed them to appointments with the most appropriate clinician). In response to the draft report the provider confirmed that GPs could book follow up appointments and that patients who wished to see the same GP but who were not booked a follow up could: use the online system to see if an appointment with the GP was offered, and if not, decline the online appointment to receive a call back from reception to book an appointment, or call the surgery direct and ask for the next appointment with the preferred clinician.</li> </ul>

#### Continuous improvement and innovation

**The practice was innovative, but there were weaknesses in systems to make sure that changes worked well and to share learning to make improvements.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Practice leaders had not, through their improvement activities identified and addressed the issues we identified.</li> <li>Practice leaders were innovative in their approach, and were attempting to find answers to the challenges faced by the practice. However the solutions arrived at had not been well-thought through, and there were weaknesses in the implementation and monitoring of changes.</li> <li>There was not an effective system for sharing learning to improve care, for example resulting from significant events.</li> </ul>	

Examples of continuous learning and improvement
<ul style="list-style-type: none"> <li>The practice had worked with an external organisation to improve recruitment and induction processes. We saw new templates and that staff recruited more recently had more complete records, although some gaps still remained.</li> <li>There was an annual staff survey. The practice leaders reviewed this and used it to identify areas for improvement. These were communicated to staff as 3 annual pledges, linked to wider improvements in service delivery. Progress on the previous year's pledges and new pledges were shared with staff at an annual roadshow. We saw evidence that satisfaction had improved in all 3 areas pledged to staff in 2022. For example, staff saying they felt happy at work increased from 68% to 92% and staff saying they felt the culture was equal and inclusive in providing opportunities increased from 33% to 77%.</li> <li>We noted there had been improvement in areas of weakness based on the staff survey results. For example, the percentage of staff saying that they had meaningful one to one /check-in meetings that allowed them to evaluate and understand their performance increased from 56% in 2022 to 85% in 2023. Practice leaders told us that external training was planned for those who supervised other staff.</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 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)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥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 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 those aged 25 to 49, and within 5.5 years for those aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

#### **Glossary of terms used in the data.**

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