

Care Quality Commission

Inspection Evidence Table

The Old Dispensary (1-6621329120)

Inspection date: 27 & 28 July & 3 August 2022

Date of data download: 19 May 2022

Overall rating: Inadequate

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe services because:

- Staff did not always have the information they needed to deliver safe care and treatment. Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice did not provide care in a way that kept patients safe and protected them from avoidable harm
- The practice did not have consistent systems for the appropriate and safe use of medicines, which included medicines optimisation.
- However there were appropriate standards of cleanliness and hygiene.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a safeguarding lead GP who oversaw all concerns. Safeguarding registers were updated regularly and reviewed, and staff were made aware of children in care. The practice held safeguarding meetings annually or more frequently if required. Safeguarding issues were discussed at practice meetings to inform and update staff. The meetings were undertaken to ensure an audit trail of discussion of required actions needed and taken. • All children who were looked after on a Child Protection Plan, Children in Need Plan or on an Adult Safeguarding Plan were reviewed quarterly or earlier if required. • Codes and alerts were added to notes where appropriate for adult and child safeguarding. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<ul style="list-style-type: none"> • We reviewed four staff files; the records were complete. • We reviewed an audit of recruitment files which highlighted if any checks were missing. • Clinicians required to register with a professional body had evidence to demonstrate they were up to date with their registrations. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01 April 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 20 June 2022 Actions from fire risk assessment were identified and completed.	Yes
<ul style="list-style-type: none"> • The property is located in a residential area and has been purposely converted to become a GP practice. The environment was small but well utilised and maintained. • Health and safety risk assessments and identified actions had been completed. There was auditing and oversight of health and safety checks to ensure that they had all been completed. • All consultation and treatment rooms have been equipped with panic buttons for the use of staff members in the instance of an emergency. The alarm would notify the reception desk and enable assistance to be called. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: May 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<ul style="list-style-type: none"> • The practice provided an infection prevention and control policy and guidelines for staff which were reviewed annually. The document included a risk assessment which was reviewed annually or in the event of new recommendations or any relevant significant event. • There were plans for further redecoration and maintenance of the property. • Cleaning staff were employed and worked daily cleaning all clinical and non-clinical areas and appropriate records were maintained. Some equipment was cleaned by nursing staff and patient equipment was cleaned after each use. • We observed staff taking measures to reduce the risk of COVID-19 infection. We saw staff wearing appropriate Personal Protective Equipment including facemasks. Alcohol gel was located at the entrance and throughout the building for patients and staff and there was signage reminding people to use it. The practice had taken action to follow national guidance to reduce the number of patients attending the practice during the COVID-19 pandemic. • Clinical waste storage was available in clinical rooms. Sharps boxes were dated and signed when first in use and again when ready for disposal. This enabled an audit trail of their use. Storage of clinical waste was held securely until collected. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes

- Staffing levels were planned to ensure there was enough cover for periods of leave such as annual leave or to cover sickness. The practice had an induction pack for locum or temporary staff should this be required to ensure safe practices were maintained.
- Staff were provided with training in basic life support and how to deal with medical emergencies.
- Reception staff had access to the GP if they had concerns about the wellbeing of patients waiting in reception. They also had access to posters describing risks such as sepsis and COVID-19 and used a symptom check list if they had concerns. Sepsis is a life-threatening medical emergency which would be caused by an infection triggering a chain reaction through the body and requires urgent attention.
- The practice had two small waiting areas, one on the ground floor and one upstairs. During the COVID-19 pandemic, social distancing was introduced at the practice to reduce the risk of contracting COVID-19. As the waiting areas were small, the practice asked patients to wait outside until their appointment time so there were fewer people using the waiting areas. Staff could see patients waiting outside by CCTV however, this could mean staff had less chance of recognising a deterioration in a patient's condition. At the time of our inspection patients were still being asked to wait outside until their appointment time.

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • All new patients registered with the practice completed a registration form and had a medicine and a medical history review. Those patients with long-term conditions or those taking multiple medicines where are able to see a GP or practice nurse if necessary or at their request. • There was a process in place which required staff to update the electronic clinical patient records system with the patient's historical records which were paper based. All summarisation of new patients' records were completed by the lead GP who confirmed patient records were up to date. 	

- The practice had a system to manage test results and enabled clinical oversight of the tests however, the oversight of this system was found to not be well managed at the time of inspection.
- The lead GP took primary responsibility for reviewing, actioning, filing and providing initial advice to patients on all incoming correspondence. This was undertaken as the results arrived on the practice computer system, seven days per week (including weekends).
- The electronic clinical patient records system used by the practice changed in March 2021. During the inspection process, we identified 195 records had been awaiting download, review and action by the practice. The practice did not know those documents existed or how to download them. Those records included hospital Outpatient Department letters and medicine reviews from external pharmacists or secondary care. This meant that there was a lack of timely management and clinical oversight. Some of those documents were from 2021 and as they had not been read or appropriately actioned, the risk to patients was unknown. The lead GP was shown where the documents were and began to download and action the documents during the inspection and has since confirmed that a system will be implemented to prevent reoccurrence.
- When the lead GP was not available, results were reviewed by the GP taking lead-responsibility that day. In the uncommon event of any test results arriving at the practice in other formats (paper or email), the communications were scanned/attached to the electronic record after review by the responsible doctor.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.88	0.74	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA)	9.6%	9.6%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	6.67	5.46	5.28	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	110.3‰	103.1‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>	0.42	0.58	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	5.1‰	7.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	No
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> • The practice did not employ any non-medical prescribers. All prescriptions were completed by medical staff. Nursing staff used a selection of Patient Group Directions (PGDs) to administer some previously agreed, specific medicines. PGDs provide a legal framework to enable some registered health professions to supply/administer specific medicines to a pre-defined group of patients without them having to see a prescriber. We saw that the all the PGDs were incomplete in their management, this included incorrect signing and authorisations. This meant that the use of the documents may be unlawful. We informed the practice manager who after the inspection completed an online training course and updated the PGDs. • Medicine reviews were not all completed in a timely way or recorded correctly. Our searches of the practice's electronic clinical patient records system undertaken during this inspection, showed a lack of consistency of review. The practice explained this may have been caused by the transfer from one electronic system to another however, this transfer took place over 12 months prior to this inspection. Therefore, all patients that required appropriate monitoring, should have had their annual review recorded on the practice's new clinical records system. • Medicine reviews were planned annually or in between times as needed. However, we saw that reviews were recorded as completed by the addition of a review code on the electronic clinical patient records system but there was no evidence of a consultation or discussion with the patient. We saw that between 2nd and 9th March 2022, 677 medicine review codes had been added to indicate they were completed. This would cause confusion to any other clinician reviewing the records as they would be interpret the review had been completed however, there were no notes to evidence the review taking place. The provider advised that this was a one-off bulk upload of codes to update the addition of a new electronic system. However, the new electronic clinical patient records system was implemented in March 2021 and we saw medicine reviews outside of the annual review timescale still not yet appropriately recorded as completed by August 2022. <p>As part of our inspection, we conducted a series of clinical searches to assess the practice's procedures around medicines management and prescribing. The remote electronic review of the searches was undertaken by the CQC GP specialist advisor (SpA). The searches were visible to the practice. Searches were carried out on the following:</p> <ul style="list-style-type: none"> ○ We saw missed opportunities for patients to be reviewed and some patients who had diagnostic tests which should have prompted a medicine review and action, but we could not find evidence this happening. ○ We reviewed a sample of five patients who required medication for kidney disease. The dose of the medicine those patients take would vary depending on their creatinine clearance level (a test to assess kidney function). This test requires a blood test and a weight to calculate a score which indicates the dose of medicine that is required. The five patient records we reviewed did not have up to date blood tests or weight measurements recorded, so we could not be assured that the current dose of medicine prescribed was accurate. ○ We reviewed records for two patients receiving treatment for thyroid problems, one had an overactive thyroid and one had an underactive thyroid (the thyroid is a gland that 	

makes and stored hormones in the body). We saw from the searches of the electronic patient records that they had not had the appropriate monitoring and the latest test results we reviewed for those patients were abnormal. The records showed that a code had been applied to their electronic patient record which indicated a review had been completed, when it had not taken place.

- The systems used to manage patient dosage did not all follow best practice guidance. We saw records for five patients prescribed Direct Oral Anticoagulants (DOAC) medicines used to prevent blood clots from forming. Patients' bloods results and weight are used to determine the required dose. However, in all five records reviewed, up to date blood results and weight had not been used, therefore there was a risk that the calculated dose was incorrect. This was being followed up by the practice after our inspection.
- We reviewed six patients prescribed gabapentinoids (a group of medicines prescribed to treat epilepsy and neuropathic pain) and found four of those patients had been prescribed in excess of the tablets needed. One patient had stopped taking the medicine, but the medicine had remained on their prescription list. This did not assure CQC that the practice was carrying out medicine reviews regularly and indicated the overprescribing of those medicines.
- There were seven patients who were prescribed methotrexate, which is a disease-modifying antirheumatic drug (DMARD). The search showed that one patient had not received appropriate monitoring in line with guidance. The practice told us they would follow this up.
- Some patients requiring ongoing monitoring had not been reviewed for their health condition or the medicines they took. We reviewed the prescribing of SABA (Short acting Beta Antagonists) inhalers for five patients. The inhalers were used by patients who have asthma and were used to improve symptoms, making it easier for those patients to breathe. We saw that in some cases patients were issued more than one inhaler without having had a recent asthma review and without any narrative around why they had been issued more than one. One inhaler technique was recorded as being done by telephone. We saw some patients with asthma review scores which indicated the highest risk, but no action was taken. We also saw that inhalers were prescribed two at a time without any narrative to support the reason for this which would indicate over prescribing. We saw one patient hadn't had a prescription for some time but this had not been questioned or checked with the patient.
- We saw that some diagnostic indicators had not been followed correctly or in line with their instructions and may have placed patients at risk. The scoring of Asthma Control Tests (ACT) recorded in some patient's records indicated they were at the highest risk (scoring five) with very poor asthma control and at significant risk of an acute illness. There was no follow up action indicated in the records. At the site visit it became apparent that the scoring system was not being used correctly and therefore patients were not getting the appropriate follow up indicated by the ACT score.
- The practice data for the prescribing of Nitrofurantoin (an antibiotic medicine used to treat urinary infections) was higher than the local and England average. The provider did not have systems in place to monitor and audit Nitrofurantoin use and had not carried out Antimicrobial monitoring (to review the use of antibiotics) since 2020.
- We reviewed the storage of emergency medicines and saw that one medicine in both the emergency medicines boxes was out of date. This did not assure us that the monitoring of emergency medicines was safely managed. The practice replaced the medicine on the day of inspection.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Three
Number of events that required action:	Three
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> In response to each significant event identified as part of the inspection a root cause analysis had been completed by the lead GP. Systems had been implemented to prevent reoccurrence and ongoing monthly monitoring was being maintained. Significant events were reviewed at clinical meetings. Information was disseminated to staff if the incident was related to them. 	

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

Event	Specific action taken
<ul style="list-style-type: none"> A patient had been referred as part of a two week wait referral. This meant the patient should receive an appointment within two weeks. The patient did not receive the appointment and it was identified that the appropriate documentation had not been attached to the referral. 	<ul style="list-style-type: none"> The initial referral was rectified, and a further process was implemented which involved staff checking each week that all referrals had been actioned and that a response had been received.
<ul style="list-style-type: none"> A patient was contacted to offer an appointment, but the patient had died. 	<ul style="list-style-type: none"> The relative received an immediate apology. A process was implemented to ensure that all records were checked prior to any calls. A further process was implemented to remove the patients contact details when the practice was notified of death. This event was added to the agenda of the next practice meeting to review the changes.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had not consistently acted on safety alerts and it was evident that the practice did not run searches regularly to ensure compliance with older but still relevant Medicines and Healthcare Products Regulation Agency (MHRA) alerts. Our search of the practices' clinical patient records system showed that in some cases alerts had not been actioned. For example, we saw that some prescribing had continued against national guidance; <ul style="list-style-type: none"> ○ The MHRA had issued a safety alert regarding the combined prescribing of Omeprazole (a medicine to treat indigestion and heartburn) and Clopidogrel (a medicine to prevent platelets, a type of blood cell, from sticking together and forming a blood clot). This was due to the potential risk that Omeprazole can prevent or alter the absorption of Clopidogrel, therefore reducing its effectiveness. From the searches that we undertook of the practice's electronic clinical patient records system, we found that of the five patient records we reviewed the practice had not recorded the review and discussion with any of those patients. This meant we could not be assured that the patient was aware of the risks. Following inspection, the practice advised us as part of their action plan that existing alerts would be searched, and appropriate actions taken to address any shortfalls. ○ The MHRA recommended that Pregabalin (an anticonvulsant medicine used to treat several illnesses including epilepsy and fibromyalgia but was also used for anxiety and opioid withdrawal) should not be prescribed to women during pregnancy or planning a pregnancy. Our searches showed that the practice had not consistently recorded the review and discussion with two patients. This meant we could not be assured that the patient was aware of the risks. ○ We reviewed five patients prescribed a combination of Simvastatin (a medicine used to treat patients with high cholesterol levels) and Amlodipine (a medicine used to treat high blood pressure and coronary artery disease). The use of the combined medicines potentially increases the risk of muscle problems. All five patient records had no record of discussion to inform those patients about the potential risks. This meant they did not make an informed decision about their treatment. ○ We reviewed a safety alert for a medicine used to treat depression where a reduced dose was required for use when treating patients over the age of 65 due to the risk of developing a potentially fatal cardiac arrhythmia. We reviewed four patient records and found that none of those patients had a record of the risk of use being discussed with them. For three of those patients, the records had a medicine review code indicating a medicine review had taken place however, there was no evidence that the medicine review had been completed. 	

Effective

Rating: Inadequate

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.

We rated the practice as inadequate for providing effective services because:

- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. There was monitoring of the outcomes of care and treatment, but not all audits provided the assurance needed.
- Staff were not always consistent and proactive in helping patients to live healthier lives.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance. The practice could not show how it shared learning or made improvements when things went wrong.

Effective needs assessment, care and treatment

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

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

- The protocols needed to ensure consistent safe monitoring and practice were not always implemented. For example, the MHRA alerts used to direct practices to review and change some medicine combinations, had not been actioned.
- Patients presenting with symptoms were not always being diagnosed in an appropriate way. We saw that there were two patients the practice had diagnosed with diabetes. Those patients did not have an audit trail to confirm that diagnosis which followed national guidance.
- We saw some reviews were added to patient records when they were attending appointments for other medical issues. For example, one patient had a record of a foot examination completed by telephone when having an unrelated long term health condition review over the phone.
- We saw some coding issues with one patient not correctly coded for a cardiac health problem. This meant monitoring and treatment may not be accurately noted and provided. A further patient was coded as having osteoporosis, but the test results we reviewed did not confirm that diagnosis.
- Some audits had been used to promote patient health and wellbeing. Those included audits of antibiotic use, however those audits had stopped in 2020 and were not scheduled to restart until 2023.

Effective care for the practice population

Findings

- The practice website and notice boards provided information, advice and signposting for a range of health promotion.
- The practice had previously monitored accident and emergency admissions for patients over 75 years, but this had stopped at the start of the pandemic and had not been recommenced.
- The practice assessed and monitored the physical health of people with mental illness. Patients with poor mental health, including dementia, were referred to appropriate services. The practice took part in the Dementia Enhanced Service, screening patients for this condition and offering intervention if required. Screening could be undertaken at home by the Assistant Practitioner when patients were unable to come to the surgery. The practice was accredited by the Wessex Academic Health Science Network (AHSN) as a Dementia Friendly Practice after implementing iSPACE, an innovative model of dementia-friendly primary care. We reviewed five care plans for patients who had a diagnosis of dementia and found one of those patients had a code placed on their record to indicate a review had been completed, however, we saw no evidence of this taking place as there was no written narrative recorded in their patient records.
- All patients with a learning disability were offered an annual health check and support for vulnerable patients was maintained.
- The practice followed up on patients they knew had been discharged from hospital. This ensured those patient's care plans and prescriptions were updated to reflect any extra or changed needs. However, during the inspection, we identified 195 acquired documents had not been reviewed including some hospital Outpatient Department letters and medicine reviews from external pharmacists or secondary care. This meant that we were not assured that all patient documents that were received by the practice were reviewed and patients appropriately followed up.
- End of life care was delivered in a coordinated way which considered the needs and requests of those whose circumstances may make them vulnerable. The practice had audited end of life

care in 2020 and identified that work was needed to ensure recording of the patients preferred place of death.

- The practice had access to a social prescriber to support older patients and their carers to maintain independence and improve quality of life in the community.
- The practice carried out regular cervical screening for women aged 24-65. This was also used as an opportunity to consult and assess in respect of sexual health, contraception and chlamydia testing. They also ran well-woman and well-man clinics and NHS health checks.
- The practice carried out six-week mother and baby checks.

Management of people with long term conditions

Findings

- Patients with long-term conditions were not all offered a structured annual review to check their health and medicines needs were being met. While patient records may have indicated patients had been reviewed, there was no written narrative in their records. Not all those patients had been regularly invited for structured examinations with appropriate intervention and management;
 - We reviewed four patient records for patients who already had complications of diabetes whose blood test results suggested diabetic control should be reviewed and improved. However, we found that the practice had not effectively followed up, reviewed or monitored those patients appropriately.
 - We reviewed five records for service users requiring thyroid monitoring. We saw all five had a review code added to their clinical records in bulk, all dated 8 March 2022. Those records did not include further documentation, other than the code, to indicate a review had been undertaken. One of those patients had not had a blood test since 2016 which meant they were not being monitored and could be at risk of being prescribed the incorrect medicine.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice maintained registers of patients with long-term conditions such as diabetes, COPD, asthma, heart disease, hypertension, thyroid disease, cancer, rheumatoid arthritis, stroke and vascular/heart disease.
- The practice told us that with 33% of the practice population aged 60+, there were a significant number of patients with multiple morbidities. Some patients required longer duration of appointments and the practice was happy to accommodate this, even once a consultation started. They told us they were happy to see patients as often as they felt it necessary.

All relevant patients were offered a vaccine in line with national guidelines. The practice also provided unscheduled appointments in order to ensure that vaccinations were given at the recommended and appropriate intervals. Services could be arranged both at the service and in patients' homes. Phlebotomy could be arranged to be performed at home visits for housebound patients if clinical circumstances dictated. Ear syringing facilities were available for all adult and elderly patients.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	29	93.1%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	16	17	94.1%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	16	17	94.1%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	16	17	94.1%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	21	23	91.3%	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>

Any additional evidence or comments

- Childhood immunisation uptake rates exceeded the minimum World Health Organisation (WHO) targets in all areas but are still below the WHO target of 95%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	78.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	75.2%	61.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	74.8%	72.3%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	71.4%	58.5%	55.4%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> The percentage of women eligible for cervical cancer screening who were screened adequately within a specified period was 78% which is below the 80% national target level. The practice followed up with patients who do not attend for their cancer screening appointments and provided them with alternative appointments.

Monitoring care and treatment

There was monitoring of the outcomes of care and treatment. Not all audits provided the assurance needed.

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

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

- The practice conducted a range of clinical audits to review and monitor activity at the practice. For example, frailty, mortality and referrals for admissions. Audits were used to reflect on the changing health needs of the local population. However, we were told they were also used to provide the practice with assurance that patients received the appropriate monitoring, care and treatment required. We saw that the current audits used did not reflect some of the areas of concern we identified and so did not provide CQC with that level of ongoing assurance of the auditing processes being used.
- Auditing of several areas had been on hold since 2020 with a view to recommencing in the future. Audits included cancer data, mortality data, referral data, consultation data and patient frailty. Audits of emergency admissions had recommenced with a view to using the outcomes to reduce admissions for patients over 75 years.
- The practice were members of the Wimborne and Ferndown Primary Care Network and contributed to the development and activity of this group. The group met monthly to discuss administrative, clinical and planning issues (the lead GP and practice manager attended). In addition, the practice managers met regularly to support practice management issues.
- The practice were also members of Castleman GP Federation which involves a larger group of GPs from North Poole and the Wimborne, Ferndown and Crane Valley areas. This group supports the work of the PCNs administratively and clinically.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<ul style="list-style-type: none"> • During the inspection, we identified the ACT scores for asthma patients were not being calculated correctly which meant we were not assured patients were being provided with the right level of care, support and treatment. • Staff personal development was supported and encouraged with staff allocated time to complete online training during work hours. 	

- Clinicians, for example GPs and nursing staff, were required to maintain their professional registration and demonstrate their competencies when they revalidated with the relevant professional body. The practice monitored their up to date registrations to ensure they were registered to practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes
<ul style="list-style-type: none"> • Multi-disciplinary meetings were held which enabled sharing of information and monitored that referrals were made in a timely way. • We were provided with minutes of a meeting in April 2022 which recorded the discussion about each patient and included patients at the end of their life. This meant that clinicians would have a clear understanding about the plan of care for those patients. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<ul style="list-style-type: none"> • The systems used to monitor, and record health checks did not ensure that all patients were contacted or seen by the doctor for ongoing review. We saw as part of our remote electronic searches that some monitoring of long-term conditions and high-risk medicines was recorded by a code as completed, but the records did not provide any evidence the review had been undertaken. The records did not demonstrate that patients had been involved in their monitoring and supported in managing their own health. 	

- The practice had used a PCN Social Prescriber to work with practice patients, particularly patients who were registered as carers.
- Information was available on the practice website regarding action and support to live healthier lives. Information regarding health and wellbeing was also provided to patients during health checks and appointments with clinicians.

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial

- The GPs used opportunities as they presented, to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders were reviewed and updated. Those agreements of care ensured that the correct legal pathways were created to support patient choice. However, we saw that some patient's records did not include a copy of the decision record or in some cases a blank form was held on the patients record, so other health professionals may not be aware of the patient's choices.
- We did not see that consent was documented in patients' records. Staff told us that consent to provide procedures was established at the time of any procedure but was not consistently recorded as participation in any procedure was the patient's implied consent.
- Remote consultations were not used to assess capacity in adults or children and face to face appointments would be made to ensure any consent needed was correctly obtained.

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We spoke with a very small number of patients. The patients we spoke with reported that staff were kind and supportive, and they were always able to obtain an appointment. The provider used NHS friends and family survey and their own survey to identify any shortfalls in patient experience. They provided CQC with a “You said.... we did” poster to demonstrate some changes to service prompted by patient feedback. The staff ensured that patients were aware of the availability of trained chaperones as required. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	90.5%	92.7%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	88.0%	91.8%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	93.2%	96.9%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	93.6%	88.0%	83.0%	No statistical variation

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

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
<ul style="list-style-type: none"> • Easy read and pictorial materials were accessible when needed to ensure patients to understand their care and treatment. • The practice waiting room had signposts to a range of community services to support patient's needs. 	

Source	Feedback
Interviews with patients.	We spoke with two patients who spoke positively about the care and treatment they received.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	93.1%	95.2%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice website included a translation facility for patients whose first language was not English. Staff confirmed the use of a translation service for appointments if needed. • Leaflets were available in easy read formats if needed. 	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> • At the time of our inspection, the practice had a register of 81 patients who were identified as carers, which represented 2.16% of the total patient group.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • The practice staff told us they had no young carers recorded. • Annual carers reviews were currently being undertaken by the practice carers lead.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • The practice staff supported recently bereaved relatives and carers by contacting them and offering support if needed.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
<ul style="list-style-type: none"> • A room was available for any patients requesting privacy for any discussion or consultation. • There were screens available in all consulting and treatment rooms which would be closed when a patient was being treated. The windows were covered so that patients could not be seen in the consulting or treatment rooms, from outside. 	

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services because:

- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic.
- The GP Patient Survey results for 2022 shows that patients are happy with gaining access to the practice and could access care and treatment in a timely way.
- However, learning from complaints was not well managed.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The provider had considered the needs of the local population and planned where services would be provided to meet these; the building had ramps to access the ground floor and a lift to access the second floor. The availability of clinics provided patients further access to nursing staff for review.• The practice had a portable Hearing Loop in reception and access to translation services.• Increased levels of reception staff could be made available to meet high telephone demand. The service did not monitor calls to identify how long patients waited for their call to be answered or how many calls were abandoned by patients. Calls were also not recorded to enable staff to use in case of complaints or reflective learning. The practice management told us that they had never had a problem with patients accessing services and patient satisfaction with reception staff scored highly on the NHS Patient Survey.• During our searches of the electronic clinical patient records system, we identified MHRA safety alerts around certain medicines or combinations of medicines were not being managed appropriately. Patients were not always fully informed of the risks of the medicines they were prescribed and therefore we were not assured patients were able to make an informed choice.• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.• People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.	

- The practice told us they had a 'Tracker Service' and carer's programme in place for vulnerable patients who were kept under regular review by our Assistant Practitioner. The patients were visited at home or telephoned by the staff on a regular basis. Any concerns were immediately reported to the GP for further action and any cases could be discussed at MDT meetings. This gave an opportunity for input from other healthcare professionals and social care organisations.

Practice Opening Times

Day	Time
Opening times:	
Monday	8:00am – 6:30pm
Tuesday	8:00am – 6:30pm
Wednesday	8:00am – 6:30pm
Thursday	8:00am – 6:30pm
Friday	8:00am – 6:30pm
Appointments available:	
Monday	8:30 – 10:30am and 2.30-8pm*
Tuesday	8:00 – 10:00am and 2pm-7pm*
Wednesday	8:30 – 10:30am and 4-6pm
Thursday	8:30 – 10:30am and 4-6pm
Friday	8:00 – 10:00am and 2pm-6pm
*only patients with pre-booked appointments after 6.30pm can gain access to the practice	

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
<ul style="list-style-type: none"> • Patients could access the practice on a day to day basis. However, not all patient records accurately reflected care and treatment required or delivered by the practice and the practice had not actioned updates from secondary care documents. This meant that while patients could access the service, they may not have been recalled or invited to clinical care appointments in a timely way. • The needs of the population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. • Later appointments had been implemented to enable access for those patients unable to see a doctor during surgery hours. • The practice did not use a duty doctor system, as they were a smaller practice the GPs working each day took calls from their own patients or covered for a GP not available that day. They told us that the system worked responsively for them. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	99.6%	N/A	67.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	96.8%	77.1%	70.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	93.3%	72.5%	67.0%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	97.9%	86.1%	81.7%	Variation (positive)

Source	Feedback
National GP Patient Survey results (10/01/2022 to 11/04/2022) published July 2022	<ul style="list-style-type: none"> The percentage responses to the GP Patient Survey published in July 2022 showed that patients were enabled to access the practice when needed. The percentage of patients that found it easy to get through to the GP practice is 100%. This was compared with the national average of 68%. The percentage of patients that would describe their overall experience of this GP practice as good is 97%. This was compared with the national average of 72%.

Listening and learning from concerns and complaints

Complaints were listened and responded to, however, subsequent learning was not shared or used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	3
Number of complaints we examined.	1
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Prior to the inspection visit the practice sent us information identifying the number of complaints received by the practice since April 2021 was two, with a further complaint pending. Each complaint was investigated, and an outcome recorded. • We saw no evidence that learning from complaints was disseminated to staff. Staff told us they were informed if the complaint involved them. The practice manager kept a record of all concerns raised with the practice and any action taken. We reviewed staff record logs and staff meeting minutes but did not see any record of learning from complaints or concerns. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
We saw a record of a complaint relating to patient care.	The practice GP lead had responded in writing and included a full apology. No learning was identified or shared.

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well-led services because:

- Leaders could not consistently demonstrate that they had the capacity and skills to deliver high quality sustainable care. The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.
- The overall governance arrangements were ineffective and the practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not have systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.
- The practice involved the public, staff and external partners to review their care.
- There was limited evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
<ul style="list-style-type: none">• Partners held managerial and financial responsibility for running the practice. There was a business development plan for the ongoing running and development of the service.• The senior management team had previous experience in the delivery of GP services. The provider had clear management and staffing structures in place, so people understood their roles and responsibilities clearly. Staff were allocated leadership roles which included infection prevention and control, safeguarding and clinical and non-clinical leads.• The management of the service did not demonstrate a clear understanding of what was required to manage challenges to quality. During the inspection, we identified patients that did not always receive the correct and appropriate care. Arrangements for identifying, managing and mitigating risks were not effective. This demonstrated a lack of clinical oversight and the potential risk to the patients and the practice.• Staff spoke positively about the support they had from colleagues and told us they could speak to GP partners or the practice manager for support when necessary.• We saw no evidence of a succession plan.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	No
<ul style="list-style-type: none"> Staff were aware of the provider's vision but did not feel involved directly in its development. However, staff spoke about their input and involvement in the practice and how they supported the management of changes to the practice. The ongoing practice development was reviewed as part of operational meetings with clinical and practice staff. There was no recorded management of the strategy and no consistent agenda or recording of a strategy in any practice minutes. 	

Culture

Aspects of the practice culture supported sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none"> Staff we spoke with both before and during the inspection told us that the practice had systems to support the wellbeing and welfare of staff. The bulk upload of codes to the clinical electronic clinical patient records system in March 2021 did not assure us that the practice has been accurate about the work they have completed and reviews that have taken place which may place patients at risk. The practice could access a Freedom to Speak Up Guardian. Staff described how they could safely raise concerns and what action was taken. 	

- Staff spoke clearly about their responsibility under their Duty of Candour. However, we saw that transparency with patients about the risks to their care was not always recorded.

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

Source	Feedback
Care Quality Commission (CQC) staff survey forms	<ul style="list-style-type: none"> • We sent staff surveys to the practice prior to the inspection. Six staff completed the surveys before the inspection. Staff told us they felt supported and enjoyed working at the practice.
Staff interviews	<ul style="list-style-type: none"> • Staff spoke positively about working at the practice, felt well supported by their colleagues and felt they know their patients well.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	No
<ul style="list-style-type: none"> • During the inspection, we identified shortfalls within the governance arrangements. There was no evidence of a system which ensured all patients who required regular monitoring and review would be identified and actioned. • Staff meetings were held every three months and a practice log was maintained to record all ongoing issues. Staff we spoke with told us they had protected time to carry out non-patient duties such as attending staff meetings, training and stock checks. • The practice had a program of internal auditing to monitor the quality of the service, to identify shortfalls and to make improvements. However, those audits did not reflect the risks identified at this inspection. We saw that an overview was not maintained for the management of safety alerts, health checks and monitoring of long term conditions, medication systems for prescribing, monitoring of high risk medicines, monitoring controlled medicines, antimicrobial monitoring or the management of emergency medicines. There were also no audits or overviews of document downloads, patient group directions or learning from complaints. • Clinical meetings were not held routinely and so audits and governance were not regularly discussed. Staff meetings were held every three months and minutes and a practice log were maintained to record all ongoing issues. The minutes and log did not identify any discussion about audits and outcomes and so the wider practice was not aware of any issues or developments. • Complaint and incident outcomes were not consistently shared with the practice staff to ensure learning and full compliance with any actions. There had been three complaints requiring action but the minutes only noted briefly one of the complaints. 	

- Incidents were recorded but not audited for themes and trends and so not used consistently to develop the practice. Staff confirmed they only received feedback from issues raised as incidents if they were directly involved. This did not support a wider learning.
- Consent was not recorded as agreed and not monitored to ensure all staff were considering patient consent at all times. Not all patients had a fully completed Do Not Attempt Resuscitation agreement recorded to ensure their choices and preferences would be managed.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

- Risk assessments were not used to monitor and mitigate against all identified risks. Some areas of the practice were not risk managed consistently. For example, systems for medicine reviews for patients were unclear and placed patients at risk.
- The practice did not always act on appropriate and accurate information. For example, we identified a backlog of 195 outstanding acquired documents on the clinical records system that the provider was not aware of. Some of those documents were outpatient follow up letters from secondary care dating back to 2021. These documents had not been reviewed by the practice and therefore the potential risk to patients was unknown.

There were ineffective arrangements for identifying and managing risks. The monitoring system used by the practice to provide them with clinical assurance was a series of audits completed throughout the year and using registers to identify when patients needed to be seen and monitored. However, there was no record in patients records of the appropriate monitoring having taken place, for example bloods tests had not been taken for patients who required monitoring for a long-term condition or because they had been prescribed high-risk medicines. The systems used were not clear to other clinicians if monitoring had been completed and this placed patients at risk of harm as care and treatment was not being delivered safely.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<ul style="list-style-type: none"> The practice provided telephone calls from clinicians, video consultations, face to face appointments at the practice and home visits as needed. Visits to patients in a local care home were made as needed. 	Yes

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<ul style="list-style-type: none"> Non-clinical audits were maintained for health and safety, equipment safety and infection control. These audits demonstrated that the appropriate checks were maintained to ensure a safe environment for patients and staff. Patients who did not attend appointments were monitored to ensure follow up contact was made, and appointments rebooked. Performance information was not used to support decision making. We saw that clinical audits were completed but did not demonstrate any change of practice. The audits did not reflect the remote searches made of the providers electronic systems, and so were not an accurate reflection of the service provided. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	NA
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	N/A
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information was provided for patients on the practice website on how their personal details were stored securely and how their privacy was maintained. The website detailed how personal data was gathered and what that data would be used for. All electronic equipment was password protected and the reception area faced away from service users. Patient data were stored securely when it was on-site, and other records were stored off-site. 	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to review their care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice gathered information from a suggestions box, a suggestions platform available on the practice website and face to face feedback. 	

- The practice had a 'You said.... We did' board which enables comments from patients to be actioned. The last comments and actions noted from October 2021 included the comment and the actions taken by the practice. For example, a comment was that the practice website looked slightly outdated. The practice responded saying that they agreed and would look to see how it could be improved.
- The practice told us that 'NHS friends and family' surveys were used as feedback. Feedback was assessed and learning implemented when required to improve service quality. There was no auditable record of how learning and changes were implemented.

Feedback from Patient Participation Group.

Feedback

The practice told us they ran a virtual PPG and have nearly 600 members. The PPG did not have a chair person as the practice preferred to encourage all patients to express their views

- The practice gave us the details of members of their PPG but when spoken to, they were not aware they were members of the PPG and had not attended any PPG meetings.
- The PPG survey was halted during the pandemic but the practice told us they were planning to restart the survey in the future.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
<ul style="list-style-type: none"> • Staff were supported to undertake training and felt able to ask for any courses they felt appropriate. However, we saw that some staff had roles they had not trained for, for example management of Patient Group Directives (PGDs). After the inspection the authorising manager completing the PGDs completed an online course to support their practice. 	

Examples of continuous learning and improvement

- The practice had looked at the use of Vitamin D and had monitored its effects. This audit looked at patients opportunistically. These patients were randomly selected and tested for vitamin D levels as when they had presented for other routine blood tests between the years 2018-2022. The first cycle of audit was undertaken in January 2020. The audit was reviewed in July 2022 as part of ongoing monitoring – the purpose of this second review as to ensure ongoing testing was being implemented.
- Pre-pandemic the practice monitored trends in attendance at Accident and Emergency (A&E) departments by patients registered at the practice; to understand and respond appropriately to

the challenges posed by these attendances. The practice told us this audit was being recommenced in the near future.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -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 women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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