

Care Quality Commission

Inspection Evidence Table

GP Practice at Riverside (1-2866464538)

CQC Remote Assessment Date: 28 / 29 June 2021

Date of data download: 16 June 2021

Overall rating: Not assessed.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Not assessed

We carried out a remote assessment on the 9-12 November 2020. This did not result in the practice being rated or a change to the current rating. We identified concerns and issued the provider with enforcement actions to: -

- Ensure care and treatment is provided in a safe way to patients.

We carried out a further review on 28 and 29 June 2021 to assess the actions the provider had taken. At this review we found the following:

- The provider had undertaken a recruitment drive since the last remote assessment and new systems and induction programmes had been developed to support new and temporary staff.
- New locum staff packs were in place at the practice to support their induction.
- Since the last remote assessment, the processes for monitoring patients' health in relation to the use of medicines including high risk medicines, had significantly improved.
- The practice had a system in place to ensure that they received, disseminated and acted upon all medicines safety alerts and information relevant to general practice.
- The arrangements for identifying, recording and managing risks, issues and mitigating actions had improved since the last remote assessment.
- A systematic approach to determine the number of staff and range of skills required in order to meet the needs of patients and keep them safe was not in place.
- The practice does not have permanent General Practitioners (GPs). There was a heavy reliance of medical cover from GP locums. We identified that on a day to day basis there was a lack of close support for clinical and non-clinical staff to ensure supervisions took place and effective leadership was in place.
- We identified that some staff did not have an employment contract.

Risks to patients

There were some improvements in systems to assess, monitor and manage risks to patient safety. However, further improvements were needed.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Since the last remote assessment, the provider had developed a new staff recruitment and planning policy which stated that recruitment checks were carried out in accordance with regulations. This included the recruitment of clinical and non-clinical staff and the approach taken for managing staff absences. • The provider had undertaken a recruitment drive since the last remote assessment and new systems and induction programmes were developed to support new and temporary staff. A list of all new starters was provided for the entire organisation and showed new recruits to the roles of reception, administration staff and a mix of clinical staff such as locum GP and nursing roles. Since the last remote assessment, the provider had recruited clinicians in lead roles such as nurse and GP leads. Job descriptions set out their key responsibilities however, formal contracts were not in place. • New locum staff packs were at the practice to support the induction process. This included information about policies and procedures, contact information for key staff and a description of the triage systems in place at the practice. The practice has a number of long-term locum GPs that worked across the providers organisations. New feedback forms were in use for GP locums. This included feedback about their experience working at the practice, comments on how effective the induction support had been and how improvements could be made if needed. • At the last remote assessment, we identified there was no system to determine how many staff and the skill mix needed to meet patient demand. For this assessment we asked the provider for information to show a systematic approach was taken to determine the number of staff and range of skills required, in order to meet the needs of patients and keep them safe. We asked how decisions were made about the number of clinical staff needed for the practice, in particular medical clinicians to ensure that practice staff were supported with supervisory and leadership needs. The information provided did not demonstrate a systematic approach was undertaken in determining clinical staffing levels and it was unclear how the numbers of staff required for the practice was reached. • The practice does not have permanent General Practitioners (GPs) and had locum GPs. The provider did not have effective oversight of their recruitment, training and appraisal. Gaps in the oversight for how GP locums were managed increases the risk for patient safety. We also identified that on a day to day basis when locum GPs were working there was a lack of close support for other clinical staff resulting in no designated time for supervision and on-going support. Feedback from staff aligned with our concerns. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A new policy relating to the management of test results was in place. A review of the practice IT system (EMIS) showed there was appropriate clinical oversight of all results and they had been reviewed and acted upon in a timely way. Clinical staff we spoke with confirmed the new process. • A review of patient records during the assessment showed that referrals to specialist services were documented and monitored by practice staff. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization. However, further improvements were needed.

Medicines management	Y/N/Partial
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had access to a Pharmacist as part of the multi-disciplinary team approach. At our last remote assessment, we found that pharmacy support across the organisation had reduced over the previous three years and workloads were excessive. This was reviewed by the provider following our remote assessment and an increase in pharmacy numbers and support was in place. Staff we spoke with were positive about the increased support and reported a reduction in staff stress. The provider had taken some steps to support clinical staff with informal clinical supervision at clinical meetings and on an ad hoc occasion when requested. However, there was no formal process in place to demonstrate the prescribing competence of non-medical prescribers, and there were no documented reviews of their prescribing practice. Staff we spoke with felt confident that if they needed prescribing support, they could access this daily. However, there was no designated time to encourage this and formal clinical supervision was not in place for all non-medical prescribers. Since the last remote assessment, the processes for monitoring patients' health in relation to the use of medicines including high risk medicines, had significantly improved. Some medicines are considered high risk because the potential side effects mean appropriate blood monitoring and careful dose adjustment is required. The provider had implemented monthly monitoring of high-risk medicines. This was undertaken by a central team and shared with individual practices at a monthly clinical meeting. There was medical oversight of the results of the searches undertaken for the high-risk medicines and if results showed that action was needed this was carried out promptly. During the assessment we undertook a number of EMIS web searches (the practice computer system) to ensure that patients on high risk medicines received appropriate monitoring and clinical review, prior to prescribing. We looked at a sample of patients prescribed high risk medicines on the practice recall system and registers. We found that annual reviews of these patients and the monitoring of the medicines before they were prescribed had greatly improved. 	

Medicines management	Y/N/Partial
<p>There were issues identified during our searches with the coding of particular test results and how these were recorded in patient records. As a result of this we identified a small number of patients where the monitoring arrangements required improvement. After the remote assessment, the practice provided information to show the coding errors and that all patients highlighted had been followed up by the practice.</p> <ul style="list-style-type: none"> A number of patient's medicines reviews and audits had been completed by the practice and the medicines management team at the Clinical Commissioning Group (CCG). Appropriate actions were taken for the results of these reviews. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	2
Number of events that required action:	2
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The arrangements for identifying, recording and managing risks, issues and mitigating actions had improved since the last remote assessment. The provider presented evidence to show that when risks were identified, appropriate measures were taken within a timescale that reflected the level of risk and impact on people using the service. We noted that the details of learning and actions taken were documented in the minutes of meetings but less fully on the significant event recording forms. A new policy and procedure was in place for the management of significant events. All staff had been notified of the changed process via the staff newsletter. Staff training had taken place and those staff we spoke with all confirmed they knew how to report concerns, safety incidents and near misses. All significant events were reviewed by the lead GP, investigations took place and actions were taken when required. All such events were discussed at monthly practice and clinical meetings so that learning could take place. 	

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

Event	Specific action taken
Medicines management	Prescription error. Incident reviewed by clinical staff. Incident discussed at staff meeting to share learning and prevent such incidents occurring again.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • New systems were in place for sharing information with all clinical staff including locum staff. The practice had a number of long-term locums that worked across the providers organisation. Those we spoke with confirmed that communications and informal support had improved since the last remote assessment. This included information for recording and acting on patient safety alerts such as MHRA alerts. This was an improvement since the last remote assessment. • We saw examples of actions taken on recent alerts for example, regarding sodium valproate. 	

Effective

Rating: Not assessed

We carried out a GP Focused Remote Assessment on the 9-12 November 2020. We did not review whether an Effective service was provided during this assessment.

At this review we found the following:

- Regular meetings were taking place to keep staff up to date with current clinical practice and organisational changes.
- The system for staff induction had been reviewed to provide a clearer process.
- An induction for locum clinicians had been introduced and communication with locums had been improved.
- There was evidence of clinical audit including how findings were actioned and reviewed.
- The provider had a training plan for the practice. However, we found that the provider did not evidence that all staff had completed essential training.
- A policy for staff development and retention was not in place.
- Systems to support clinicians and monitor their competence were not formalised.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients' treatment was regularly reviewed and updated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Monthly clinical and practice meetings were held and chaired by the GP clinical lead. Meetings were planned across the year and attended by all clinical and non-clinical staff. Minutes of meetings showed that NICE guidance and updated prescribing guidance were discussed. Minutes showed that all staff were updated about the monthly monitoring audits undertaken by the provider for the management of high-risk drugs.• Patients continued to have access to mental health services at this practice. A dedicated mental health clinician and support was available most days. They were able to prioritise and treat patients well and able to signpost and refer them to secondary care and support as needed.	

- At our last remote assessment, we raised concerns that the system to ensure patients received timely reviews of their long-term medication was not effective. We also found there was no formal process for identifying patients who needed a medication review. A review of the practice EMIS system showed the provider had acted on this and the numbers of patients who did not have this completed when necessary had improved. Patients' treatment was regularly reviewed and updated.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	542	533.9
Overall QOF score (as a percentage of maximum)	97%	95.5%
Overall QOF PCA reporting (all domains)	11%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y

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

- Improvements had been made since the last remote assessment and there was evidence of clinical audit including how findings were actioned and reviewed.
- We found that quality improvement activity was targeted at the areas we had identified in the last remote assessment. For example, medication reviews and audits of monitoring of patients prescribed high risk medicines.
- A programme for audits which reflected local, national and service priorities was being developed.
- All results were discussed at monthly practice meetings and minutes showed that actions were taken when needed and monitored for improvements.

Effective staffing

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

	Y/N/Partial
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Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- Following the last remote assessment, the system for staff induction had been reviewed to provide a clearer process. A staff handbook was in place that provided guidance on working for the provider and policies and procedures. An induction checklist was in place for locum clinicians and there was a locum pack available for them to refer to. This included information about the staff team, equipment, triage system and how to manage blood tests and referrals. However, the locum pack did not list the policies and procedures they may need to refer to.
- We reviewed the records of staff training considered to be mandatory by the provider which included safeguarding adults and children, infection prevention and control, resuscitation, health and safety, fire safety and data security. We found some nurses and long-term locum GPs had not completed level 3 safeguarding for adults and children as per national and best practice guidance. We also found records showed locum GPs had not completed all the mandatory training.
- The provider had a training plan for the practice. This included clinical and non-clinical training. This covered a number of areas including respiratory training, findings from in-house audits, changes to clinical guidelines, asthma, basic life support, domestic violence and chaperone training.
- The provider did not have a policy for staff development and retention. This was in the process of being developed. Some staff told us that they would like more support to develop their skills. Some staff told us that a lack of staffing meant they were not able to develop in other areas. Since the last remote assessment, a nurse lead was working across the provider's services two days a week. Their role included working with the provider and clinical director to develop the nursing team and provide supervision, mentorship and appraisal.
- We looked at the records of staff appraisals. Two had been completed in 2021 and the dates for five staff members were to be confirmed. There was no record of long-term locum GPs being scheduled for an appraisal. The provider told us that the clinical director (appointed since the last remote assessment) would be carrying out GP appraisals including long-term locums.

- Some staff told us that they had no contract of employment and that they were unsure what the expectations were of them as they did not have a clear job description.
- At the last remote assessment, we identified that there was no formal system to review the consultations, referrals and prescribing of salaried, locum GPs or non-medical prescribers. Documentation had been produced to enable this, but the system was not in place at the time of this review.

Responsive

Rating: Not assessed

We carried out a remote assessment on the 9-12 November 2020. This did not result in the practice being rated or a change to the current rating. We identified concerns and issued the provider with enforcement actions to: -

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We carried out a further review on 28 and 29 June 2021 to assess the actions the provider had taken.

At this review we found the following:

- Improvements had been made to the operation of the clinical triage system. A clearer policy was in place and staff were receiving formal training.
- The system to calculate staffing levels did not clearly demonstrate how staffing levels were decided upon.
- Improvements had been made to how complaints were managed.

Responding to and meeting people's needs

The practice could not fully demonstrate how it 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.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a triage system. Patients spoke to a receptionist who took the presenting information and allocated the patient to a triage list. The system in place required receptionists to identify any patients needing urgent attention so that the clinician could prioritise their needs. The clinicians reviewed the patients on the triage list and either offered a telephone, video consultation, home visit or a face to face appointment. Receptionists booked appointments for patients who needed to see a practice nurse, a mental health practitioner or receive childhood immunisations. There was a system for the pharmacist to manage medication requests and for clinicians to manage fit notes, urgent results, referrals and contact other services about patient care. The receptionists also sign posted patients to other services when they did not require general practice-based services, such as to a local pharmacy. The aim of the model was for patients to expediently access the appropriate clinician who could help them manage their condition.	

- A clinician monitored the volume of patient requests and contacted the provider if there were any concerns about the demand for access. The system for patient access had been developed to try to meet patients requests on the day. Staff told us that occasionally patients could have their consultation moved to the following day. They told us this was risk assessed to ensure patient safety. The triage system allowed for urgent appointments to be factored in.
- The triage system had also been designed to enable a patient to be referred to the right clinician to meet their needs. At the GP Practice at Riverside a paramedic carried out the clinical triage. There was access to a GP and an assistant nurse practitioner. There was also access at GP Practice at Riverside to staff who worked across other sites operated by the provider such as practice nurses, pharmacist and pharmacy technician, mental health practitioner and immunisers.
- Some staff told us that the workload generated by the triage system was high, there was not always enough clinical staff for the volume of work and there was a lack of continuity of staff. Staff told us there was not enough practice nurses and not enough long-term GPs.
- Following the last remote assessment, we asked the provider to develop a system to determine how many staff and the skill mix needed to meet patient demand. At this review, the provider told us that they had carried out an assessment of the number of patient appointments being offered and found they were providing above the national average. They had altered their appointment system to reflect this and to offer a more manageable amount of routine appointments alongside any urgent appointments required. They told us that staffing levels were in place to meet the demands for patient access. However, how this was calculated remained unclear and we were unable to see that this considered all clinicians, such as practice nurses, additional responsibilities of clinicians (other than patient consultations) and times of increased patient demand.
- Patients had good access to mental health services at this practice. A dedicated mental health clinician and support was available most days. They were able to prioritise, treat patients and signpost and refer them on to secondary care and support as needed.
- The practice's website had links to translation services and enabled translation of the website information. A translation service could be used to support patients during consultations.

Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm The practice offers additional appointments from 7.15am until 8am every Tuesday.
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y

Explanation of any answers and additional evidence:

- Improvements had been made to the triage system since the last remote assessment. The protocol was clearer and training on the system had improved. There was also regular monitoring to ensure that reception staff were allocating patients to the correct list. These checks were not recorded. A two-week audit was undertaken in May 2021 and identified areas for improvement. Staff feedback had also been sought. As a result, changes to the triage system were planned.
- At the last remote assessment clinicians told us that a WhatsApp group was used frequently to communicate about any shortfalls in the service daily. At this remote assessment we were told that this was no longer used.
- Staff told us that patients could be moved to another service operated by the provider from the one they were registered at. The staff we spoke with told us this did not happen often and how they would ensure this was carried out safely and to ensure a patient gave their consent. A procedure was not in place to provide clear guidance to staff.
- Overall, staff told us that they felt patients had their needs met and that care was prioritised depending on the risks to patients.
- In response to the Coronavirus pandemic the Practice had suspended appointments that could be booked on-line through offered through Patient Access/My GP Services. All appointments were booked through the reception team.

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 (01/01/2020 to 31/03/2020)	51.6%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	56.7%	67.1%	65.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	60.7%	67.2%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	63.9%	74.2%	72.7%	No statistical variation

Any additional evidence or comments

- The triage model was introduced to the practice in 2019. Some staff told us that once the triage system had been explained to patients, they thought it was a good idea. Some staff told us patients had made complaints about waiting a long time for the telephone to be answered. However, patient feedback about the triage system had not been formally sought, for example via a questionnaire. The provider had developed a survey, but this had not been sent out as imminent changes to the triage system were planned.

Source	Feedback
For example, NHS Choices	In the last 12 months three reviews had been left one referred to difficulty getting through by phone and getting an appointment, one referred to a delay in accessing a scheduled appointment and one reported a positive experience.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received since the last remote assessment.	5
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.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Following the last remote assessment improvements had been made to how complaints were managed. The policy and procedure for the management of complaints had been reviewed, this had been communicated to all staff. There were clearer processes for investigating clinical and non-clinical complaints and responding to patients and the outcome of complaints and any action needed was shared at staff meetings. A review of complaints had taken place to identify any trends and quarterly reviews were planned going forward. We looked at the procedure for the management of complaints. This detailed the process for staff to refer patients to and included timescales and external organisations that patients could approach. We looked at one complaint. This responded to the issues raised by the complainant and directed the complainant to the Parliamentary Health Service Ombudsman (PHSO) should they have been dissatisfied with how the practice had dealt with the issues raised. The complaint was investigated by the clinical lead for complaints. At the last inspection some of the staff interviewed told us there was no formal feedback of complaints to staff unless they were involved in the complaint. At this inspection complaints were discussed at staff meetings and any learning shared. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
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Change made to medication.	Advice taken from hospital consultant regarding repeat medication which was communicated to staff.
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Well-led

Rating: Not assessed

We carried out a remote assessment on the 9-12 November 2020. This did not result in the practice being rated or a change to the current rating. We identified concerns and issued the provider with enforcement actions to: -

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We carried out a further review on 28 and 29 June 2021 to assess the actions the provider had taken. At this review we found the following:

- The provider had made a number of improvements to the service. These systems now needed to be imbedded and a clearer system developed to determine staffing levels, staff continuity and support.
- Improvements had been made to leadership. Staff had been appointed to lead roles and they had clear responsibilities to assist with improving oversight of the service and staff development.
- There was evidence of clinical audit including how findings were actioned and reviewed.
- The provider had not formally consulted patients to find out their views about the clinical triage system.
- Staff felt able to report any concerns to the provider without fear of repercussions.
- The provider had made further changes to engage with staff and include their views in the operation of the service.
- Policies and procedures had been reviewed and protocols put in place to provide clearer guidance to staff.
- There were effective arrangements for identifying, managing and mitigating risks.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• There was a senior management structure identified and documented which was led by the provider Dr Don Jude Mahadanaarachchi. Since the last remote assessment, the provider had taken on new staff for the GP and nurse lead roles. Leadership responsibilities were part of the	

new job descriptions. For example, the Clinical Director (lead GP) had the responsibilities of being the clinical advisor for all practices. They had the role of developing the GP team and developing supervision, mentorship and appraisal. They were responsible for working with the management team to ensure regular communication with GPs across the provider's services. At the time of this review some of this was in place. The lead GP had oversight of patient complaints and significant event reporting and was ensuring regular communication.

- Monthly practice meetings were now taking place and staff we spoke with stated they felt more supported than previously. Appraisals for clinical staff had commenced however, this did not include long term locum staff. Informal supervision arrangements were evident and formal supervision took place at monthly meetings. However, we were not assured that there was effective leadership at the practice. There was a high usage of GP locums and we identified that on a day to day basis, there was a lack of close support for clinical and non-clinical staff resulting in no designated time for supervision.
- Detailed actions plans were submitted to us following the last remote assessment. They identified the actions needed to address the areas we had concerns about. Since the last remote assessment, the action plans were closely monitored by the provider and the senior management team.
- The provider and members of the senior management team interviewed had some understanding of the issues and concerns around staffing and quality monitoring. They understood that they did not have enough staff and had to utilise a number of long-term locum clinicians. However, they had not formally monitored, analysed or reviewed staffing ratio/dependency needs or the triage model of care and treatment in place.
- Most of the staff interviewed reported that leaders and senior managers were visible and accessible, and they felt well supported by them and by their line managers. They reported they were able to contact senior managers when needed, especially the provider who was available by telephone, if not on site. However, some staff reported that they did not feel very well supported and concerns raised were not dealt with relating to staffing levels and the clinical cover at this practice.
- The provider told us about plans he had for development of the leadership, management and governance structure for the next few years, however these were not yet formalised or in place.

Vision and strategy

The practice had a clear vision, which was overall supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider could articulate their vision and values for providing high quality, accessible care and treatment through a triage model approach using a multi-disciplinary team of skilled clinicians. Feedback on the vision and values of the organisation had been sought from staff. • Following the remote assessment in November 2020 the strategies to support the provision of high-quality sustainable care had been revised and more thorough arrangements were in place. For example, there was a more detailed triage procedure, better staff training on the triage system and closer monitoring, a clearer organisational staffing structure and clearer arrangements for monitoring and responding to any issues or concerns raised by staff and patients. We saw action plans were in place which were periodically reviewed. The provider told us that staff consultation had taken place regarding organisational changes and improvements to be made. Formal consultation with patients had not taken place and was planned. • The provider had made a number of improvements to the service following the last remote assessment in November 2020. These systems now needed to be imbedded and a clearer system developed to determine staffing levels, staff continuity and support. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The organisation and the practice were supported by a culture strategy. Arrangements were in place to deal with any concerns about staff behaviour or performance. Staff reported that they felt able to raise concerns without fear of retribution. They knew about the whistle blowing policy and procedures and would raise concerns if needed. They were confident that concerns would be dealt with appropriately and knew how to access external support if needed. The practice had a whistle blowing policy and staff had access to a Freedom to Speak Up Guardian. The provider had taken steps to promote a positive culture at the practice. They had put in place a newsletter for staff which began in December 2019. This provided information for staff about operational issues, clinical updates, staffing, updates on policies and procedures, training, and staff welfare matters. The provider had an employee of the month system to recognise the achievement of staff. The provider also had a documented policy for obtaining staff feedback, for example, through annual engagement meetings and encouraging feedback via the newsletter by providing contact details of relevant staff. At the last remote assessment, we found that improvements were needed to how patient complaints were managed to ensure there was appropriate oversight, recording and patients knew what to do if they were dissatisfied with how their complaint was managed. At this review we found improvements had been made. At the last remote assessment, we also found that the systems for managing and responding to complaints by staff needed improvement. At this review we found that a clearer process had been put in place for staff to raise concerns and complaints. Also, an anonymous staff survey had been produced and sent to all staff in July 2021, which had a closing date at the end of September 	

2021. The provider planned to use the information obtained from the survey to make improvements to the service.

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

Source	Feedback
Staff interviews	Staff told us that patients had their needs met and that the service was safe. Staff said they felt able to raise concerns and that the provider would respond appropriately. Some staff told us that the workloads were high and there was more patient demand than there were staff available.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the last remote assessment, we found that the governance framework was not clearly defined or identified. Arrangements for reviewing governance systems needed to be improved. At this inspection improvements had been made. There was a clear organisational structure in place which showed who would deputise in the absence of the provider. A clinical director had been appointed and their role and responsibilities supported the governance of the providers services in terms of oversight, monitoring and review. The clinical director had introduced systems to improve governance such as regular meetings across the providers practices, a system for undertaking regular audits and better systems for the management and oversight of significant events and complaints. They planned to undertake appraisals of the GPs and reviews of clinician’s referrals, prescribing and consultations, however, this was not yet in place. Since the last remote assessment, the provider had employed a lead nurse to provide support to the nursing team. They were carrying out appraisals and planned to look at developing the skills of the nursing team. The provider was also working with an experienced practice manager to improve the services provided. At the last remote assessment, some of the policies and procedures that we looked at required review and improvements. At this review we looked at the protocols relating to governance, the recruitment procedure, the whistle blowing procedure and the significant event procedure and found that they contained sufficient information to provide clear guidance to staff. A policy and procedure were in place for the safe use of personal telephones for the What’s App Group and for the use of the What’s App group for communication. 	

- Since the last remote assessment, there had been an improvement to the procedures and protocols for managing patient medication and managing test results such as blood tests.
- A formalised procedure for moving patients to another service operated by the provider had not been put in place. Staff told us that this did not occur often and what they would do if this needed to take place.

Managing risks, issues and performance

There were clearer processes for managing risks, issues and performance, however, further improvements were needed.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Explanation of any answers and additional evidence:	
<p>At our last remote assessment, we found there was a lack of assurance that robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. At this inspection improvements had been made.</p> <ul style="list-style-type: none"> • There was a systematic programme of clinical and internal audit with good clinical oversight of results and patient outcomes. However, this did not reflect local, national and service priorities. Discussions were had at monthly practice meetings chaired by the lead GP and results were shared with clinical staff to drive improvement. Since the last remote assessment these had focused on areas, we had identified required improvements. Audit reports were detailed with clear outcomes to drive improvements. • The management of significant events and patient complaints had improved since the last remote assessment. They were discussed at monthly meetings and plans were in place for them to be reviewed quarterly for trends. Detailed minutes were kept showing the event, actions taken and any learning. Patient complaints and significant events had clinical oversight to determine what actions were required. • WhatsApp communications had greatly reduced, and clearer reporting structures were in place. New policies were developed to support staff for reporting risks and monthly meetings took place to learn from events when significant events and complaints were reported. • Improvements had been made to the triage system since the last remote assessment. The protocol was clearer and training on the system had improved. There was also regular monitoring to ensure that reception staff were allocating patients to the correct list. A two-week audit was 	

undertaken in May 2021 and identified areas for improvement. Staff feedback had also been sought. As a result, changes to the triage system were planned.

- The practice did not have permanent General Practitioners (GPs) and had locum GPs. The provider did not have effective oversight of their recruitment, training and appraisal. We found that locum staff were allowed to operate at the practice without any written agreement or contract in place. There were gaps identified in their training and appraisals for the longer-term locums had not taken place.

Engagement with patients, the public, staff and external partners

The practice involved staff to sustain high quality and sustainable care. The processes for obtaining patient feedback needed to be developed.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Patients views were invited via the practice website. The website gave details of how to complain and how to provide other feedback or suggestions. Staff told us that overall, they had received positive feedback from patients about access to the service. Some patients had raised the issue of difficulty getting through to the practice by telephone. The provider had not gathered the views of the wider patient population in a structured way. The provider was planning on sending a survey to find out patients views about the services offered and in particular the triage system. • Staff reported that there had been improvements to communication and their involvement in the operation of the service. Staff meetings were now held more frequently, and the staff spoken with felt able to give their views at these meetings. Staff also told us they felt able to approach a member of the senior management team with any concerns or complaints. • The staff newsletter continued to be sent to all staff working for the provider. We reviewed these and found that changes to the organisation, policies and procedures and processes had been communicated. A staff survey had been sent to all staff in July 2021. The provider was planning to use information obtained from this to make improvements where they were needed. • The provider had introduced a staff engagement planner. This included activities to bring the staff team together socially and improve team working, recognise individual performance through rewards and educational sessions. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

At our last remote assessment of this service we identified that a number of improvements needed to be made. At this review the provider has made a number of changes to improve the service provided:

- There has been an improvement to how medication was managed. There were more staff to support the review of patient medication, policies and procedures had been reviewed or introduced to give better guidance to staff. Audits were regularly taking place to ensure patients had their health needs met.
- Changes had been made to the governance of the service. A clinical director had been appointed who had a clear role in relation to improving the service. For example, regarding how significant events and complaints were investigated, learning shared and action taken. Significant events and complaints were now better managed.
- There were improved systems for communicating with staff. There were formal documented meetings at which significant event analysis, incidents and complaints learning could take place. Further improvements to communication were planned with the introduction of GP Team Net (a web-based platform).
- Policies and procedures had been reviewed. There was clearer information for staff to refer to about the triage system. Training in this system had improved as had the process for monitoring that this was working safely.

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.
- **PHE:** Public Health England.
- **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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.