

Care Quality Commission

Inspection evidence collection tool

Location name: Shakespeare Road Medical Practice

Inspection date: 18- 27 July 2022

Date of data download: 14 July 2022

Previous overall rating: **Not previously rated**

We did not rate the provider following this inspection because there were some outstanding registration processes which meant we were unable to rate until they were completed. In 2018 we inspected the service and rated it as Good overall. In 2020 we also carried out a remote inspection of this service which did not result in any ratings.

Following the July 2022 inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. This was because of concerns we had around a lack of effective systems and processes to enable the service to assess, monitor and improve the quality and safety of the services, governance arrangements which were not always clear or effective, a backlog of patient records that had not been summarised, patients not being able to access care and treatment in a timely way, a lack of clinical oversight and supervision for staff who were responsible for coding patient records, lack of an effective system to manage blank prescription forms, and patient feedback which was not always positive.

Safe **Inspected but not rated**

We did not rate the provider following this inspection because there were some outstanding registration processes which meant we were unable to rate until they were completed. In 2018 we inspected the service and rated it as Good overall. In 2021 we also carried out a remote inspection of this service which did not result in any ratings.

Following the July 2022 inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. We took enforcement action under these regulations asking the provider of services to take action in order to become compliant with the regulations. The concerns we had are set out in the "Previous Overall Rating" section of this evidence table as well as in the accompanying Quality Report.

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	Yes
Safeguarding	Y/N Partial
communicated to staff.	
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
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> All staff had a Disclosure and Barring Service (DBS) check in place appropriate to their role. If a child did not attend an immunisation appointment the nurse would contact the family by telephone and follow up with a text message if no reply. The child would then be noted for an additional follow up if no response was received and also to notify the health visitors. The clinical team and admin support for safeguarding met quarterly with the local Integrated Care Board (ICB) Safeguarding Team. This gave an opportunity to discuss updates and review individual cases where appropriate. All staff had undertaken safeguarding training appropriate to their role. 	

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 Public Health England (PHE) guidance if relevant to role.	Yes

Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had access to a centralised recruitment team. The practice team interviewed new staff and the central team completed the appropriate background and pre employment checks post interview. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2021	Yes
A fire risk assessment had been completed. Date of completion: June 2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A Fire risk assessment had been completed in June 2022 by an external provider with immediate remedial actions noted as high priority. Two actions were noted to have a timescale of one day assigned to them, regarding signage which had been completed. However, four other actions were noted as a high priority and should be completed within one month, from 14 June 2022. These were to make staff aware of their responsibilities, a designated role should be identified to contact the emergency services, put in place further training and allocate and train new and additional fire marshals and all staff should be informed as to who these individuals were. These actions had not been completed but we were told that training was scheduled for 31 July 2022. • The fire risk assessment was undertaken by an external company and identified that for a building the size of the practice five fire marshals were insufficient. Not all staff felt confident in the level of training and in the practice's processes to be fire marshals. We reviewed fire training records and noted that the list of trained fire marshals was inaccurate as it contained staff who no longer worked at the practice. Some new staff had been identified to be fire marshals but had not received training at the time of our inspection. The training log we reviewed stated that only two of the three nominated individuals had undertaken training. • Risk assessments whilst completed were insufficient because no formal action plan was in place. • Controls documented in the risk assessments showed all status as green but there were no timescales for any of these to identify who was responsible for ensuring the action takes place. 	

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 (IPC).	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 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

Explanation of any answers and additional evidence:

- We saw evidence of an action plan from the last IPC audit which included implementing a cleaner's schedule and making spill kits available. We checked the actions and saw that the cleaners' schedule was in place and spill kits were in each of the clinical rooms and the reception area.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to deal with 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.	Partial
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Explanation of any answers and additional evidence:

- On inspection staff told us there was a rota system in place to ensure that no more than two members of staff were on annual leave at the same time to ensure sufficient cover. However, data we received in relation to waiting times in relation to the length of time patients waited on the phone before it being answered by the practice showed there was a high level of abandoned calls. This indicated staff numbers were not sufficient to meet the demands of the service.
- However, the practice had recently increased admin/reception staff to increase the number of staff able to answer telephone calls and to improve telephone access.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	No
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.	Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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Explanation of any answers and additional evidence:

- During the inspection staff told us they were not supported and did not feel confident in relation to the coding of patient records. Following the inspection, the service sent us information informing us that staff had access to clinical supervision in relation to coding patient records. This information contradicted what we found on inspection. We were therefore not assured that the systems and processes in place at the time of the inspection were operated effectively to ensure staff were able to code correctly and were supported in relation to coding queries.
- On the day of inspection, we found that 2,794 patient records had not been summarised. Following the inspection, we were sent additional information indicating as of 26 July 2022 a total of 2,724 records had not been summarised, including 134 records relating to patients who had joined the practice in the previous two to 12 months. The systems and processes in place to ensure patient records were summarised in a timely manner had not been operated effectively.
- There was no clear process to manage the backlog or how to prioritise the outstanding patient records. The risk of failing to summarise patient records is that clinicians do not have access to patients' full medical history to ensure they are able to deliver safe care and treatment.
- Due to the backlog of patient records that had not been summarised, we were not assured there were effective systems for sharing information with staff and other agencies to enable the practice to deliver safe care and treatment.
- Whilst we saw referrals to specialist services were documented, due to the backlog of records to be summarised, we could not be assured that referrals contained the required information. However, there was a system in place to monitor delays in referrals.
- The practice used a remote GP to review test results. A task would be sent from the admin team on receipt of a test result. The remote GP would then either call or send a task back to the admin with instructions on how to proceed. If the results required urgent action the remote GP would contact the duty GP to action.

Appropriate and safe use of medicines

The practice did not always have adequate systems in place for the appropriate and safe use of medicines, including medicines optimisation.

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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	Partial
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. No	N/A

Medicines management	Y/N/Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Partial
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

- We found prescriptions were locked away securely. However, we also found that the process for prescription security was not embedded.
- A new log had been implemented on 11 July 2022. This was designed to allow only the required prescriptions to be removed and logged and then if unused they were returned and logged back in. We found an instance where a prescription had been returned when it had actually been used. The prescribing admin staff accounted for where the prescription was used. Staff acknowledged the error and corrected the log. We were informed by the practice manager and prescribing manager that none of the prescriptions were stored anywhere else in the building overnight. There was a backlog of 10 boxes of blank prescription stationery in the locked storage.
- We reviewed two examples and Patient Group Directives (PGDs) were in date, authority was provided and signed by three nurses operating under the directive.
- We were informed by the regional nursing manager that healthcare assistants (HCAs) are the only staff members who work under patient specific directives (PSDs), this is an instruction to administer medicine to a list of individually named patients for example, the flu vaccination. We were told by staff that the authority was requested prior to the requirement for a PSD and this was mainly for vitamin B12 injections. We were shown a PSD they had used recently. It had been authorised by a GP on the patient's record.
- The practice had a locum advanced nurse practitioner (ANP) who was a prescriber. Notes and prescribing audits were completed to check competencies.
- Due to the volume of patient notes that had not been summarised, we could not be assured that the 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 was being carried out.
- There had been errors in actions completed by the remote clinical pharmacist. For example, over prescribing inhalers for a patient with asthma. Although the errors had been recorded as significant events there was no comprehensive action plan to address this.

Track record on safety and lessons learned and improvements made

The practice had a system in place to record and review safety. However, lessons were not always learned and there was a lack of evidence that improvements were made when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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.	No
Number of events recorded in last 12 months:	40
Number of events that required action:	40
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a system in place to record significant events and the process was followed. We were told that shared learning was a standing agenda item at monthly meetings. All practice staff were invited and in addition specific clinical events discussed at weekly clinical meetings. However, in the records we reviewed there was a lack of information regarding lessons learned and completed actions. For example, a patient was prescribed amoxycillin, but the patient had a penicillin allergy. There was no alert within the patients notes. The allergy was picked up by the local pharmacy and the medicines had not dispensed. We reviewed the significant event and the action was identified as “allergy added to alert box” but we found no evidence of any further actions put in place to prevent a recurrence for example, completing an audit or notes review. 	

Example of significant event recorded and actions by the practice.

Event	Specific action taken
The practice was informed by the local care home that a patient’s clinical summary had been sent to the care home in error.	<ul style="list-style-type: none"> The patient at the care home and data breach subject had the same first name but no other similarities. Data was destroyed by the care home, patient informed, and apology issued. The practice reiterated to staff the importance of three- point identification checks. Information Governance training was redone, and staff were monitored to ensure the practice were at 100% compliant and staff understood and followed the process.

<p>An electrical outage occurred affecting the practice systems and ability to view the appointment system.</p>	<ul style="list-style-type: none"> • The business continuity plan was revised and circulated across senior management team to ensure correct teams were informed of issues with access to surgery in the event of an electrical failure. • The Reception team were instructed to print appointment books the evening before to ensure paper copies of patients who will be attending the practice were available in the event of network outage.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice shared Medicine and Healthcare products Regulatory Agency (MHRA) and patient safety alerts with the clinical team and actions including patient searches and any changes to prescriptions or medicines, were completed by the clinical pharmacist. We saw the remedial team completed audit of alerts. 	

Effective

Inspected but not rated

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Our findings in relation to the effectiveness of the service are set out below.

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

Effective care for the practice population

Findings
<ul style="list-style-type: none">The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.Health checks, including frailty assessments, were offered to patients over 75 years of age.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long-term conditions

Findings

Prior to the inspection the provider had undertaken the task of clearing a large number of reviews for patients with long-term conditions. This was part of the work the practice undertook in order to make improvements following a review by CQC in December 2020.

The Integrated Care Board put a remedial team in place for the purposes of undertaking overdue reviews. The remedial team was still in place at the time of our inspection in July 2022.

Patients with long-term conditions were offered a structured annual review by the practice clinical team to check their health and medicines needs were being met. This was an ongoing process due to be completed by November 2022.

- 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 nurse, the local diabetes specialist nurse and a local GP with a specialist interest in diabetes met regularly to discuss patients.
A Health care assistant from the practice undertook home visits to complete initial assessments if required.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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Any additional evidence or comments

- Data relating to child immunisations at this service was not available at the time of our inspection due to the way the service was registered at the time. We have therefore not included that information in this report.

Cancer Indicators	Practice	ICB average	England average	England comparison
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Any additional evidence or comments

- This data was not available to us at the time of our inspection due to the way the service was registered at the time. We have therefore not included that information in this report.

Monitoring care and treatment

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

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

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

Any additional evidence or comments

The provider had been caretaking the practice since December 2021 and had undertaken several audits. Their main focus was immediate patient safety and ensuring patient reviews had been undertaken.

We reviewed one of the audits, a respiratory disease audit which had been completed to identify:

- those patients with asthma that have had 2 or more courses of oral prednisolone in the last 12 months,
- those patients that have not had an asthma review, and

- to book asthma review appointments or follow up for patients identified as needed.

In July 2022, a review of 38 patients' notes was completed. Out of these 17 patients had already had a review and 14 had an appointment booked. The practice had not been able to contact the remaining seven patients but had sent a message inviting them to book an asthma review. Where digital messaging was not suitable a task was sent to reception staff to contact the patient to book their review, or a letter was sent. The practice told us they planned to re audit a month after the initial contact was made to ensure patients asthma was being well managed.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, there were some gaps in clinical supervision and oversight.

	Y/N Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
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
Some staff had access to regular appraisals, one to ones, coaching and mentoring and revalidation. They told us they were supported to meet the requirements of professional revalidation. Some staff reported that they didn't have adequate clinical supervision and oversight specifically in relation to coding patient records.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff were given protected time each week to complete any outstanding or additional training. This had been in place for several months and has been approved by the Integrated Care Board (ICB). Alternatively, roles could be covered by other staff members to allow time for any additional training. • Nurses undertook notes audits of other members of the team and health care assistants. These were reviewed every three months and staff were expected to achieve a 90% accuracy rate and if this was not achieved notes would be reviewed on a monthly basis until 90% was achieved. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health. Refer to social prescribers.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Patients were signposted to local services to help and support them in maintaining a healthy lifestyle for example, weight management groups and the stop smoking service.• Clinicians could also refer patients to local social prescribers.• The practice had access to staff who specialised in Health & Wellbeing so patients could be supported with advice and guidance.	

Consent to care and treatment

The practice 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.	Yes

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
DNACPR decisions were made in line with relevant legislation and were appropriate	Yes

Caring

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Our findings in relation whether the service was caring are set out below.

Kindness, respect and compassion

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

	Y/N Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial

Patient feedback	
Source	Feedback
Online feedback from NHS Choices	We saw negative feedback about the attitude of reception staff, including the managing of bereaved patients. It was reported that staff appeared to be rude and uncaring. The practice had not responded to these comments.
NHS Friends and Family Test Results	Between July 2021 and July 2022, there had been 798 responses. If the 798 responses, 88% would recommend the practice to family and friends.

National GP Patient Survey results

We did not have data for the current provider as they had only held the contract since December 2021. We have removed the indicators as it is not representative.

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

Any additional evidence

- No in-house surveys had been carried out since the provider took over the contract in December 2021.

Involvement in decisions about care and treatment

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

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

	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice used a range of translation services to support patients including using text messages in English and or the patients preferred language. 	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> • 2%, of the practice population, 279 carers of all ages identified by a clinical system search.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • The practice provided information and gave patients access to local authority resources and contact points. • Carers were offered appointment flexibility to enable them to meet their own health needs whilst in a caring role.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • Local bereavement services were displayed in reception.

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

Responsive

Inspected but not rated

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Our findings in relation whether the service was responsive are set out below.

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.	Yes
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 practice were working with the Integrated Care Board (ICB) mental health and wellbeing teams to look at support for patients.• The practice staff used an online application to translate for patients when sending text messages.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
<ul style="list-style-type: none"> Patients were directed to the out of hours service when the practice was at full capacity and if the patient did not feel that the issue could wait until the following day. Cases were discussed with the Duty Doctor to ensure it would be clinically safe to pre-book for the following morning or to ascertain whether the patient would need to be seen at the practice on the same day. The practice had one hour protected time on Tuesdays between 1pm and 2pm this had been approved by the Integrated Care Board (ICB). 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic. However, patients were not always able to access the service.

Access to the service

	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	Partial
There were recovery plans in place to manage backlogs of activity and delays to treatment	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff supported to work at home if possible, equipment was made available and regular meetings were arranged to ensure staff kept in touch with any changes at the practice. • During the COVID-19 pandemic the practice had a separate room to treat patients who may be COVID-19 positive. • During the latest rise in COVID-19 infections, the wearing of face masks had been reintroduced. • Data obtained from the practice's telephone system, showed there were large numbers of abandoned calls every day. This indicated that patients were often not able to get through to the practice on the telephone or had a lengthy waiting time before their call was answered. 	

Further information about how the practice is responding to the needs of their population	
<ul style="list-style-type: none"> • Patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • There was a medicines delivery service for housebound patients. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. • People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travelers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. 	

People were not able to access care and treatment in a timely way.

	Y/N Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs?	Partial
There were systems in place to support patients who face communication barriers to access treatment.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Data provided by the practice indicated that there was a high volume of calls with a large number showing as abandoned. There were also long call wait times showing and little evidence that patients who had abandoned calls had been contacted by the practice. We could not be assured 	

that patients who required urgent appointments would be prioritised as they may not be able to get through to the practice on the telephone.

- We reviewed a significant event where paramedics had attended to a patient from the practice, who lived in a local care home. They needed to speak with a GP but were not able to get through to the practice on the bypass number used by community services.

National GP Patient Survey results

This data was not available in full in relation to this service and as such we have not included it in this evidence table.

Any additional evidence or comments

- We were told by the practice that they were in the process of moving towards a new model of access for patients. This would include telephone consultations and face to face appointments. Patients were encouraged and asked at time of booking what their preferred method of consultation would be. Double appointment slots were booked for multiple or complex conditions. Double slots were also booked if patients required translation services.

Listening and learning from concerns and complaints

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

Complaints	Y/N Partial
Number of complaints received in the last year.	20
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
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.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice shared incidents and complaints during team meetings. Incidents were anonymised and steps were put in place to ensure that there was no recurrence for example, additional training and communication to all staff. 	

Complaint	Specific action taken
A patient complained that although they were exempt from wearing a mask during the COVID-19 pandemic they were challenged numerous times by staff within the practice.	The practice held a staff meeting and discussed how to deal with patients who had mask exemption and had put in place a designated waiting area for patients who fell into this category.
A patient was unhappy with their consultation on the information that was given to them.	This issue was discussed at a clinical meeting and staff meeting to reiterate that staff needed to communicate the outcome of a consultation with the patient in a clear and concise manner and to ensure that the patient understood what they were being told before they left consultation.

Well-led

Inspected but not rated

We did not rate the provider following this inspection because there were some outstanding registration processes which meant we were unable to rate until they were completed. In 2018 we inspected the service and rated it as Good overall. In 2020 we also carried out a remote inspection of this service which did not result in any ratings.

Following the July 2022 inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and good governance. We took enforcement action under these regulations asking the provider of services to take action in order to become compliant with the regulations. The concerns we had are set out in the “Previous Overall Rating” section of this evidence table as well as in the accompanying Quality Report.

Our findings in relation whether the service was well led are set out below.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care. However, there were concerns over the availability and visibility of leaders.

	Y/N Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Yes

- The management team understood the challenges of care taking a practice for a short period of time where they were responsible to address actions identified in previous CQC inspections.
- There had been significant staff changes and leaders reported some resistance to the changes had resulted in some staff leaving. However, they felt that the new changes in the reception team were now making a real positive difference. They had also changed the appointment system to enable patients to book appointments in advance.
- In the interviews we had with staff, they told us that leaders were not always visible and approachable. Also, there was uncertainty amongst staff as to the security of their employment due to the care taking arrangements. We were told by managers that it had been difficult to retain and recruit staff because of this.

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with told us they were not clear about the practice's strategy given that the provider was in a care taking arrangement with the Integrated Care Board (ICB) for a period of time staff anticipated would be short. This meant staff were uncertain about their ongoing employment. 	

Culture

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

	Y/N Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with during the inspection told us that they did not feel listened to, for example, when they reported incidents. We were told of an incident where a member of staff felt they had been blamed for a significant event rather than the accountability sitting with the leadership team. All staff had recently completed Duty of Candour training, this had included an interactive session with examples so that staff could demonstrate their understanding The Freedom to Speak up Guardian had recently been introduced, however some staff we spoke with were not sure of who the individual was and how to contact them. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> We were told that there had been many changes since the new provider had taken over the contract in December 2021. This had been a challenging time. One member of staff told us they felt this had been a huge learning curve from their previous role but felt well supported and it was good to work with clinicians who were passionate about patient care.

Governance arrangements

The overall governance arrangements were not always effective.

	Y/N Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice held regular meetings but there were inconsistencies in who was invited and communication to relevant staff following meetings, especially regarding the remedial team. Nurses were given protected time to carry out admin tasks. During the inspection, the governance arrangements were not clear. From information gathered as part of this inspection we were unclear on who had responsibility or oversight in relation to some of the risks we identified as part of this inspection, in particular responsibility and oversight on the summarising of patient records, risk assessments, action plans, and improving patient access. From speaking to staff, it was unclear whether this sat the remedial team or with the practice team. Staff responsible for coding patient records told us that they felt they had not had sufficient training and did not feel supported in their role and there was not clinical oversight. 	

Managing risks, issues and performance

There were no clear and effective processes for managing risks, issues and performance.

	Y/N Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes

There was a quality improvement programme in place	Yes
There were effective arrangements for identifying, managing and mitigating risks.	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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Risk assessments had been completed but there was no evidence of action plans or timelines for the completion of actions. Specifically, a fire risk assessment had been carried out by an external company with urgent actions to be carried out. This had not happened and as a result when a recent incident had occurred and the fire alarm had been activated, staff reported to us that the fire evacuation had not been carried out in line with the practice's policies. Fire marshals were not clear in their responsibilities including closing windows and checking all rooms in the building. 	

Appropriate and accurate information

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

	Y/N Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice used call data and on the day of inspection provided a selection of data that showed a large number of abandoned calls. This demonstrated that there were not enough staff answering calls despite the practice telling us that they ensured that staff levels were sufficient and, that if the live data showed long call wait times that staff were reminded to assist the reception team. We could not be assured that patient who required urgent appointments would be prioritised as they may not be able to get through to the practice on the telephone. 	

Governance and oversight of remote services

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards	N/A
The provider was registered as a data controller with the Information Commissioner's Office	No

Patient records were held in line with guidance and requirements.	No
Patients were informed and consent obtained if interactions were recorded.	Yes

The practice ensured patients were informed how their records were stored and managed.	No
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the time of the inspection the provider was not correctly registered with CQC, however the correct application had been submitted and was in process. On inspection we found that there were 2,794 patients record that had not been summarised and there was no apparent order in the records storage. Following the inspection, we asked the provider to ensure that they had a structured plan to have all the notes summarised appropriately and accurately. 	

Engagement with patients, the public, staff and external partners

The practice had limited involvement with the public, staff and external partners to sustain high quality and sustainable care.

	Y/N Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence	
<ul style="list-style-type: none"> The practice did not have an active Patient Participation Group (PPG) although the practice manager told us that they had been trying to arrange a meeting with previous members of the PPG. We could find no evidence of engagement with patients. Online feedback including social media reviews gave poor feedback and low levels of patient satisfaction. 	

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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There had been little quality improvement activity although the practice has only been caretaking since December 2021. However, the practice had arranged communication, customer care and care navigation training for non-clinical staff to improve how to speak to patients. • The practice diabetes specialist nurse was supported by the specialist clinical team at the sister practice and had monthly meetings to providing leadership. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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