

## Inspection Evidence Table

Richmond Medical Centre

(1-565411742)

**Inspection Date: 6/12/2024**

Date of data download: 14/12/2023

## Overall rating: Requires Improvement

We inspected this service on 25 May 2023 and rated it as Inadequate overall and specifically Inadequate for providing safe and well-led services. We rated it as Requires Improvement for providing effective and responsive services and Good for providing caring services. The practice was placed into Special Measures.

On 6 December 2023, we conducted a follow up inspection of the practice to follow up on matters included in Warning Notices issued for breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and review the Special Measure status to determine if sufficient progress had been made to enable Special Measures to be removed.

We rated the practice as Requires Improvement overall. It was rated as Inadequate for providing safe services and Requires Improvement for providing, effective, responsive and well-led services, with the rating for providing caring services of good carried over from the inspection in May 2023.

## Context

Richmond Medical Centre n is situated in North Hykeham, a town in the North Kesteven district in Lincolnshire. The practice provides services on two sites within the town for approx. 18,000 patients; a larger percentage of older patients are registered at the practice when compared with the national average.

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the 9th decile (9 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is, 96% White, 1.6% Asian, 1.4% Mixed, 0.6% Black, and 0.3% Other.

Recruitment has been ongoing at the practice since our previous inspection. The practice had not been able to recruit to the vacant GP posts, this is a national problem within healthcare with the concerns identified during their previous inspection potentially further impacting.

## Safe

## Rating: Inadequate

At the inspection in May 2023, we found areas of concern that impacted on patient safety. This key question was rated as Inadequate, and this was due to:

- Recruitment procedures were not carried out in accordance with regulations.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the storage, management and safe use of medicines.
- There was limited evidence of sharing of learning from incidents, complaints and adverse events.
- Not all staff were trained in areas deemed essential by the provider and competency checks were not carried out.
- Several policies had not been reviewed and were out of date.

At this inspection on 6 December 2023, we found that issues had been resolved or the situation had been improved. However, there were still some concerns in regard to safeguarding, recruitment, environmental risk, infection prevention and control and communication of learning from significant events.

During the inspection we also identified issues regarding:

- A back log of notes awaiting summarisation.
- Management of blank prescriptions.

Therefore, the rating is remains Inadequate for providing safe services.

### Safety systems and processes

**The practice had some systems, practices and processes in place to keep people safe and safeguarded from abuse.**

| Safeguarding   | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Partial     |
| Partners and staff were trained to appropriate levels for their role.                                | Y           |
| There was active and appropriate engagement in local safeguarding processes.                         | Partial     |
| The Out of Hours service was informed of relevant safeguarding information.                          | Y           |
| There were systems to identify vulnerable patients on record.  | Y           |

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|---|---------|
| Disclosure and Barring Service (DBS) checks were undertaken where required.   | Y       |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.  | Partial |
| <p>At our previous inspection in May 2023 we saw gaps in safeguarding training completed by staff. A monthly safeguarding meeting had been instigated just before our inspection with one meeting having taken place.</p> <p>At our inspection in December 2023, we saw evidence all partners and staff were trained in safeguarding to the appropriate levels for their role.</p> <p>The provider had safeguarding policies in date which identified safeguarding leads and how to contact external support and refer concerns. The policies either did not include the training required, or the levels of training identified were incorrect. The Safeguarding Policy for Children and Young Persons does not contain references to all aspects identified in the intercollegiate documents gold standard framework. For example, modern day slavery was not covered.</p> <p>Safeguarding meetings were undertaken on a regular basis at no more than 6 weekly intervals. Attendance at meetings was poor, 3 practice staff attended and invited external key stakeholders had not been present at the meetings we reviewed. Managers told us they had encouraged external stakeholders to attend but had not been successful. However, all staff we spoke with could tell us how they would contact the appropriate MDT professionals on an individual basis with any concerns as they arose. We saw documented evidence of appropriate discussions and actions taken in patient notes.</p> <p>Review of safeguarding meeting minutes showed ongoing monthly updates for some cases, but not all. Minutes were anonymised but lacked information relating to actions undertaken and outcomes. We saw evidence during our inspection that the attendee list had been widened to include more internal and external parties with changes made to the minute taking process to include more information.</p> <p>All patients identified with a safeguarding concern were flagged and linked on the clinical system for ease of identification. The practice had not undertaken a validation process with the local authority safeguarding team to ensure information held was correctly replicated, consistent and up to date.</p> |         |

| Recruitment systems  | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).  | Y           |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.  | Partial     |
| <p>At our previous inspection in May 2023 we found issues relating to the safe recruitment of staff and the lack of immunisation and vaccination records held by the provider.</p> <p>During our inspection in December 2023 we saw evidence the provider had introduced a system to gather the vaccination and immunisation status of staff employed at the practice. Whilst the data held at that time was not complete, the position was improved from the previous inspection, and we saw plans in place to continue to gather the information required.</p> <p>We reviewed the recruitment files of 5 randomly selected staff members and all recruitment checks were carried out in accordance with regulations.</p> |             |

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| Safety systems and records   | Y/N/Partial |
|--|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken.   | Partial     |
| Date of last assessment:<br>Main Site – July 2023<br>Branch Site - July 2023   | Y           |
| There was a fire procedure.  | Y           |
| Date of fire risk assessment:<br>Main Site – 30 May 2023<br>Branch Site - 30 May 2023  | Y           |
| Actions from fire risk assessment were identified and completed.   | Y           |
| <p>At our previous inspection in May 2023 the provider did not have up to date health and safety risk assessments in place. Risk assessment for Control of Substances Hazardous to Health (COSHH) were not readily available to staff at point of use of the associated substances.</p> <p>At our inspection in December 2023, up to date health and safety risk assessments had been carried out. Actions identified in the risk assessments had been completed but the management of risk related to water borne infections had not been adequately mitigated.</p> <p>The monitoring of water temperatures had been undertaken monthly for hot and cold outlets at both sites. The hot temperature required to mitigate the risk of infections for the furthest away (sentinel) outlets had not been reached on 5 of the 6 occasions reviewed. Action was not taken to review or mitigate the risk posed to service users and staff or escalate concerns to management.</p> <p>Staff carrying out monitoring of water temperatures had not received training to ensure they understood potential risks and the legislative requirements. Water temperature monitoring sheets did not identify the required temperature range nor actions required to mitigate the risk posed to service users and staff if not reached.</p> <p>The provider now had appropriate COSHH risk assessments in place and available to staff for the cleaning products used at the practice. Risk assessments for other COSHH products used in the provision of care by practice staff were not in place.</p> <p>There was evidence of regular checks of the fire alarm systems and equipment to be used in the event of fire. There were records of fire drills which included the recorded evacuation of the premises on both sites.</p> |             |

**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.   | Y       |
| Infection prevention and control audits were carried out.  | Y       |
| Date of last infection prevention and control audit:   | Y       |
| The practice had acted on any issues identified in infection prevention and control audits.  | Partial |
| The arrangements for managing waste and clinical specimens kept people safe.   | Y       |
| <p>During our previous inspection in May 2023, we identified concerns relating to the infection prevention and control practices (IP&amp;C). These included, out of date policies, policies not covering all aspects required, actions not completed from audits, management of clinical waste and clinical specimens, repeated use of items identified as single use, failure to order disposable items to ensure equipment was safe following use, no cleaning schedules in place, curtains not changed within the specified time, limited cleaning time and no dedicated time for IP&amp;C lead to fulfil requirements.</p> <p>At our current inspection in December 2023 we found IP&amp;C practices had significantly improved.</p> <ul style="list-style-type: none"> <li>• The lead nurse now had dedicated time in their work plan to allow them to fulfil the requirements associated with the lead role.</li> <li>• Policies had been updated and reviewed to include the appropriate requirements to mitigate the risk to patients from poor practice.</li> <li>• Review of clinical waste management showed this was now effective.</li> <li>• Actions for the IP&amp;C audit had been completed in all clinical areas. We identified 2 actions outstanding in staff areas. Managers were made aware of this during our inspection and actions commenced to resolve.</li> <li>• Staff we spoke with told us equipment was now ordered and used appropriately and we saw this in process during our site visit.</li> <li>• All curtains had been changed within the dedicated time scale and were clean with dust free rails.</li> <li>• Whilst cleaning time had not been increased the provider had liaised with the cleaning company who had reorganised the way they worked to improve the service delivery.</li> </ul> <p>During our inspection we saw pillows that were not IP&amp;C compliant with a sealed waterproof cover in place.</p> <p>The provider had introduced a new system to receive specimens for testing at the practices. To prevent staff handling samples, a push opening swing top box was kept in front of the reception screens, in which patients were requested to place samples for testing. Staff told us because of the position of the box it was not possible to check to ensure samples were appropriately labelled, the box was not secure and there was a risk patient details would be visible. During our inspection we saw the box was in use and patient details were visible to any one at the reception desk.</p> |         |

### Risks to patients

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

|   | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods.        | Y           |
| There was an effective induction system for temporary staff tailored to their role. | Y           |

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|--|---|
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.  | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.  | Y |
| There were enough staff to provide appointments and prevent staff from working excessive hours.  | Y |
| <p>At our previous inspection in May 2023, we identified concerns regarding lack of GPs, lack of basic equipment, inconsistency in availability of emergency equipment and medicines, failure to check accuracy and lack of calibration for equipment, medical bag in place with no checks of equipment undertaken and concerns related to staff removing emergency equipment from the designated trolley.</p> <p>At our inspection in December 2023, vacant GP posts at the practice had not been filled despite ongoing recruitment. Difficulty in recruitment to GP posts is a known national issue and not just specific to the provider. The doctor's rota was reviewed by the HR manager and lead GP Partner, rules were in place to manage planned absence and leave by limiting the number of GPs off at any one time. Locum GPs were used, when available to cover any gaps. Staff told us the management of the GP rota was not always completed in time to ensure locum cover was available. Since our inspection the provider has strengthened the processes in place to manage staffing.</p> <p>The practice was equipped to respond to medical emergencies with appropriate staff training undertaken and appropriate medicine and emergency equipment now in place. Tamper proof bags were in use to prevent emergency equipment being used inappropriately and not replaced.</p> <p>Equipment had been appropriately and regularly checked for accuracy and calibration had been undertaken.</p> |   |

**Information to deliver safe care and treatment**

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

|   | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y           |
| There was a system for processing information relating to new patients including the summarising of new patient notes.                          | Partial     |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.                     | Y           |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.     | Y           |
| There was a documented approach to the management of test results and this was managed in a timely manner.                                      | Y           |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.  | Y           |
| During our previous inspection in May 2023 we found abnormal blood results which had not been actioned in a timely way.                         |             |

The process in place to manage test results included a requesting clinician review for abnormal results on the day they were received. If a requesting clinician were absent abnormal results would be shared amongst the clinicians on duty. During our inspection in December 2023 review of the clinical systems showed all abnormal blood results had been reviewed on the day of receipt.

During our inspection in December 2023 it was identified that 1025 new patient notes and 1625 legacy patient notes had not been summarised. This led to a risk that not all patient information would be available to clinicians when delivering care. The provider had a policy, training and competency checks in place to allow staff to undertake the notes summarisation. Due to staff turnover it had not been possible to reduce the backlog, recruitment for 2 new staff to summarise the notes had taken place. The provider had a plan in place to prioritise the summarisation of notes with a realistic timescale to monitor progress against.

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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

| Indicator  | Practice | SICBL average | England | England comparison       |
|--|----------|---------------|---------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)  | 1.12     | 1.16          | 0.91    | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2022 to 30/09/2023) (NHSBSA)                                       | 12.4%    | 11.3%         | 7.8%    | Variation (negative)     |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2023 to 30/09/2023) (NHSBSA) | 5.53     | 5.31          | 5.19    | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)  | 167.3‰   | 226.7‰        | 130.7‰  | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)   | 0.71     | 0.72          | 0.53    | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)   | 8.2‰     | 8.3‰          | 6.8‰    | No statistical variation |

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

|                      |             |
|----------------------|-------------|
| Medicines management | Y/N/Partial |
|----------------------|-------------|

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|--|---------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff.   | Y       |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance.  | Partial |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).  | Y       |
| 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.   | Y       |
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1   | 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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2  | Y       |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).  | Y       |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.  | Y       |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.   | N/A     |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.  | Y       |
| For remote or online prescribing there were effective protocols for verifying patient identity.  | Y       |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.  | Y       |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.   | Y       |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.  | Y       |
| <p>At our previous inspection in May 2023, we found competence of non-medical prescribers was not checked, failure to monitor patients on medicines that required monitoring, lack of appropriate emergency medicines and risk assessment, concerns relating to emergency equipment, storage of medicines, management and storage of vaccinations.</p> <p>Blank prescriptions were kept in locked printers and locked rooms in line with national guidance. Stock was kept on the main site with an appropriately completed log to monitor and record usage. Prescriptions were transferred to the branch site, as required and recorded as such in the main site log. Once received at the branch site, prescriptions were logged into specific printers. There was no record kept at the branch site to give an overview of all the prescriptions received. This meant the system in place to monitor the movement of prescriptions was not wholly effective.</p> <p>The practice had introduced a system to monitor the prescribing competence of non-medical prescribers since our previous inspection in May 2023. A policy supporting this clinical supervision and peer review was in place</p> |         |



with checks identified as being carried out at a maximum of 8 week intervals by an identified clinician. We saw evidence the checks had been completed from October 2023 and repeated for some staff at the prescribed timescales. We saw future dates identified, and sessions blocked for clinical supervision in the diaries of appropriate staff.

The provider had introduced systems and processes that had improved the care of patients on medicines which required on going monitoring. The clinical searches identified further improvements were required but the amount of patients identified that had not been monitored appropriately had reduced.

The clinical searches identified a total of 27 patients taking Azathioprine, a medicine which may be used to treat immune disorders. We sampled 5 patient records and found 4 had been appropriately monitored and test results recorded. One patient had their recent blood test carried out at a hospital outside the area and the provider was not able to access the results so could not record that these indicated it was safe to continue prescribing the medicines. The provider was endeavouring to get the blood results provided to them.

The clinical searches identified a total of 48 patients taking warfarin, a medicine which may be used to treat blood clotting disorders. Of these, 3 patients were identified who appeared to be overdue appropriate monitoring. We sampled the 3 records and found that there may have been problems with the care for 1 patient. This patient had their blood tests carried out at a hospital outside the area and the provider was not able to access the results. Therefore, they could not be assured it was safe to continue prescribing the medicines. The provider was endeavouring to get the blood results prior to our inspection.

The provider recorded medicine reviews had been conducted for 1348 patients in the 3 month period prior to our inspection. We reviewed a sample of 5 completed reviews, one of which did not have sufficient information documented. The provider undertook a review of the patient and found no concerns relating to prescribing safety.

The provider had reviewed and improved the system and processes in place to manage the vaccination fridges and vaccination management. We found the 6 vaccination fridges in use to be clean, not over stocked and had evidence of stock rotation, all vaccines were in date with fridge temperatures monitored consistently to ensure safety. This was supported by a written protocol which staff could explain to us. Dedicated time was now identified for staff to manage the process in line with the providers policy and guidance.

An audit into the appropriate use of anti-microbials was carried out monthly by the pharmacy team to allow ongoing monitoring of prescribing practices. Findings and improvements identified are presented and discussed at the practices clinical meeting. Review of the actions and impact of implementation are reviewed 2-3 months later, we saw evidence of this in meeting minutes.

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

**The practice had a system to learn and make improvements when things went wrong. However, this was not always effective in ensuring all staff received the information.**

| 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.  | Partial |
| Number of events recorded in last 12 months:  | 11      |
| Number of events that required action:  | 11      |
| <p>During our previous inspection in May 2023, a new system to manage significant events (SEs) had been introduced which included all SEs being discussed in clinical meetings to maximise learning. This was not always effective as numerous staff told us they had not received any information about outcomes from recent SEs.</p> <p>During our inspection in December 2023, we were told that a greater range of staff were now included in the attendance at the clinical meetings. A representative from each area was invited, with a remit to feedback to the rest of the staff. Some staff we spoke with told us that whilst this change had been made, they still did not receive information related to significant events.</p> <p>We reviewed clinical meeting minutes and saw evidence SEs had been discussed, but no details of what had happened, actions or outcomes from SEs was included. The provider did not have a system in place to assure themselves that staff at all levels and those not on duty at the time of any feedback received appropriate information.</p> |         |

| Event   | Specific action taken   |
|---|---|
| Poor care delivered to a child with respiratory symptoms.   | Changes to processes included visual aids to clinicians regarding paediatric respiratory rates.   |
| Prescribing errors.   | Prescription checks have been implemented and a Pharmacy Administrator role established to alleviate the risk of information being missed.  |
| Failure to use pathways and available templates led to tasks not being generated to deliver appropriate care. | Staff education and training to re-enforce the need to use templates so automatic prompts to send tasks are generated. Extra administrative staff recruited to mitigate staff issues. |

| Safety alerts  | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts.  | Partial     |
| Staff understood how to deal with alerts.  | Y           |
| <p>There was a system for recording and acting on safety alerts. A policy was in place to manage the distribution and cascade of new alerts to ensure they were received by the appropriate staff.</p> <p>The provider was unable to demonstrate that all historic safety alerts had been repeated to ensure any new patients to the practice had been identified. We saw that 379 patients were prescribed a medicine to treat diabetes that increased their risk of complications, of the 5 sampled 3 patients did not have anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments</p> |             |

considered. The provider responded to this immediately once identified and sent a batch text alert to all patients.

## Effective

## Rating: Requires Improvement

At the inspection in May 2023, we found areas of concern that impacted on effective care delivery. This key question was rated as Requires Improvement, and this was due to:

- There were 144 patients with an undiagnosed long term condition following blood results.
- A majority of clinical staff had not had an appraisal in the previous 12 months.
- Out of five clinical records viewed three patients had not been consulted or consented having a Do Not Attempt Cardiac Pulmonary Resuscitation request (DNACPR) put in place, although their records indicated they did not want to be resuscitated in the event of their death.
- Formal clinical supervision was not in place to support staff working in advanced roles.

At this inspection on 6 December 2023, we found that issues had been resolved or the situation had been improved. Further review and development of the newly introduced systems and processes was required to provide sufficient evidence all outcomes had been sustainably improved.

During the inspection we also identified issues regarding:

- The management of patients with asthma.

Therefore, the rating remains Requires Improvement for providing effective services.

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

### Effective needs assessment, care and treatment

**Patients' needs were mostly assessed, and care and treatment 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. | Partial     |

|   |         |
|---|---------|
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.  | Y       |
| We saw no evidence of discrimination when staff made care and treatment decisions.  | Y       |
| Patients' treatment was regularly reviewed and updated.   | Partial |
| There were appropriate referral pathways to make sure that patients' needs were addressed.  | Y       |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.  | Y       |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic.  | Y       |
| The practice prioritised care for their most clinically vulnerable patients.  | Y       |
| Systems were in place to review patients' treatment regularly; this was effective or improved since our previous inspection in May 2023 in most areas. Patients who had experienced an exacerbation of asthma were not always reviewed in line with guidance. |         |

## Effective care for the practice population

| Findings   |
|--|
| <ul style="list-style-type: none"> <li>• Those identified received a full assessment of their physical, mental and social needs.</li> <li>• Patients with long term conditions were offered annual health and lifestyle reviews. Patients were invited to attend in their birth month and a recall team was in place who focused on ensuring these patients are called and cared for safely.</li> <li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> <li>• 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.</li> <li>• All patients with a learning disability were offered an annual health check.</li> <li>• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Monthly meetings were undertaken with members of external multi-disciplinary teams to discuss all patients living with end of life care needs. We saw evidence in meeting minutes of appropriate discussion relating to patients' conditions, reviews undertaken and outcomes.</li> <li>• The practice demonstrated that they had a system to identify people who misused substances.</li> <li>• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorders.</li> <li>• Patients with poor mental health, including dementia, were referred to appropriate services. Mental Health Practitioners were in place to support all patients with poor mental health.</li> <li>• A frailty team was in place to manage elderly patients residing in the care home registered with the practice. The frailty team undertook regular care home ward rounds and blood tests were taken in the home. Residents were given priority GP appointments and had appropriate chronic condition and medicine reviews, vaccinations, wound care and palliative care support.</li> <li>• The clinical searches identified a total of 1985 patients who were prescribed short acting inhalers for the treatment of asthma. Of those, 37 patients were identified who had been prescribed more than 12</li> </ul> |

inhalers in 12 months. We sampled 5 patient records and found 3 had not been managed appropriately and reviewed to assess treatment remained appropriate to prevent long term harm.

## Management of people with long term conditions

### Findings

- During our previous inspection in May 2023, we found 144 patients with a potentially missed diagnosis following blood tests indicating they may have undiagnosed diabetes or kidney failure. At the inspection in December 2023, clinical searches did not identify any patients having a potential missed diagnosis for diabetes or kidney failure.
- Clinical searches identified that 708 patients were living with hypothyroidism. Monitoring of the condition should take place every 12 months, the searches identified that all patients had been appropriately managed.
- We saw there were 91 patients with Chronic Kidney Disease Stages 4 or 5, the searches identified that all patients had been appropriately managed.
- Clinical searches identified 62 patients with diabetes who already had a complication associated with this condition and also had significantly poor blood glucose control when last tested. A random review of 5 of the 62 patients showed 4 patients had been offered appropriate care, one was overdue some monitoring.
- Patients requiring high dose oral steroid treatment for exacerbations of asthma were not always followed up in line with national guidance to ensure they received appropriate care. A random sample of 5 patients records from the 113 who had received 2 or more courses of rescue steroids in the last 12 months were reviewed and all 5 records had issues regarding care:
  - Three of the 5 patients were overdue an annual asthma review. Invitations to attend had been sent to 2 of these patients. No documented evidence was recorded to confirm actions taken following a patient not responding.
  - One patient had been issued high dose steroids as a repeat prescription with no review of the patient's condition at point of issue, this meant no clinical baseline to assess effect and ensure safety was known.
  - The five patients had not been followed up following exacerbation of asthma.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

| Child Immunisation  | Numerator | Denominator | Practice | Comparison to WHO target of 95% |
|---|-----------|-------------|----------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 185       | 192         | 96.4%    | Met 95% WHO based target        |

|  |     |     |       |                          |
|--|-----|-----|-------|--------------------------|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)           | 166 | 173 | 96.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 165 | 173 | 95.4% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)  | 167 | 173 | 96.5% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)   | 198 | 207 | 95.7% | Met 95% WHO based target |

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

| Cancer Indicators   | Practice | SICBL average | England | England comparison                   |
|---|----------|---------------|---------|--------------------------------------|
| Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)  | 76.1%    | N/A           | 62.3%   | N/A                                  |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)   | 77.6%    | N/A           | 70.3%   | N/A                                  |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)  | 72.3%    | 58.1%         | 54.9%   | Tending towards variation (positive) |
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (6/30/2023 to 6/30/2023) (UKHSA) | 78.2%    | N/A           | 80.0%   | Below 80% target                     |

#### Any additional evidence or comments

The practice had increased appointments to allow for extra cervical screening availability to give greater access for patients following a backlog from the Covid pandemic.

|  |
|--|
|  |
|--|

**Monitoring care and treatment**

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

|  | Y/N/Partial |
|--|-------------|
| Clinicians took part in national and local quality improvement initiatives.  | Y           |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.   | Y           |
| Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:<br><br>The practice did not have a formal quality improvement plan in place at the time of our inspection. They did undertake regular audits within the practice into a wide range of both clinical and administrative topics. Audit outcomes were discussed at the clinical meetings and improvement identified and reviewed.<br><br>The practice undertook a six month audit of complaints from January 2023. This identified 26 complaints in total. No clinical trends were identified with 55% of complaints relating to lack of access and telephone waits. The provider had amended the way telephone calls were dealt with and had recruited more staff to the administration team to improve the situation. |             |

**Effective staffing**

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

|  | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment.   | Y           |
| The practice had a programme of learning and development.  | Y           |
| Staff had protected time for learning and development.   | Y           |
| 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.         | Y           |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.  | Y           |

During our previous inspection in May 2023, we found staff had not completed essential training on subjects the practice deemed necessary, regular appraisals had not been completed for all staff, senior staff had no dedicated protected time to support colleagues undertaking training and processes were not in place to monitor staff working at advanced clinical level.

During our inspection in December 2023 we found the issues previously identified had been resolved:

- Forty seven out of the 50 staff employed had received an appraisal within the previous year, we saw evidence a plan was in place to complete the remainder.
- Essential training had been completed appropriately by all staff within the previous 13 months.
- Dedicated time was now in place to allow senior staff to support colleagues as required.
- A process was now in place to monitor staff working in advanced clinical practice. We saw this included on staff rotas and staff told us the time was protected and routinely in place.

### Coordinating care and treatment

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

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

### Helping patients to live healthier lives

**Staff 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.                                    | Y           |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health.  | Y           |
| Patients had access to appropriate health assessments and checks.  | Y           |
| Staff discussed changes to care or treatment with patients and their carers as necessary.  | Y           |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.   | Y           |
| The practice supported national priorities and initiatives to improve the population's health. Patient information was available on the practice website. Though waiting rooms did not have a wide range of information leaflets for patient without digital access. |             |



### 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.  | Y           |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.  | Y           |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.  | Y           |
| <p>During our previous inspection in May 2023, we identified concerns related to DNACPR decision forms completed by professionals outside the practice's team. We found not all completed forms had been scanned onto the practice's system and some added without a record of any conversation having been undertaken to the appropriateness of any decision continuing.</p> <p>The provider had updated the policy on coding and scanning of ReSPECT forms (on which the DNACPR decision is recorded) to ensure up to date information was available, patients' views considered and reflected in documentation in line with legislation and guidance.</p> <p>We reviewed a random selection of 5 sets of patient records where a DNACPR decision had been recorded. Of these we found 4 of the 5 notes reviewed had been completed accurately in line with legislation. The 5<sup>th</sup> set of notes did not have a scanned copy of the ReSPECT in place as this was completed in a hospital setting. We saw evidence the practice had taken steps to obtain the appropriate information.</p> |             |

## Responsive

## Rating: Requires Improvement

At the last inspection in May 2023 the Responsive key question was rated Requires Improvement and this was due to:

- Patients were unable to access care in a timely manner

At this inspection on 6 December 2023, we found that issues had been resolved or the situation had been improved. Further review and development of the newly introduced systems and processes was required to provide sufficient evidence all outcomes had been sustainably improved.

Therefore, the rating remains Requires Improvement for providing responsive services.

### 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.   | Y           |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided.  | Y           |
| The facilities and premises were appropriate for the services being delivered.   | Y           |
| The practice made reasonable adjustments when patients found it hard to access services.   | Y           |
| There were arrangements in place for people who need translation services.   | Y           |
| The practice complied with the Accessible Information Standard.  | Y           |
| <p>The facilities and premises were appropriate for the services being delivered and reasonable adjustments were in place at the main site to allow physical access to services for all patients living with specific individual requirements.</p> <p>We saw the lower desk area at the reception, suitable for patients in wheelchairs, at the branch site had been blocked. Staff told us this had been carried out to allow safety screens to be fitted during the Covid pandemic. Staff confirmed they would always approach a patient in a wheelchair to allow them to deal with any concerns</p> <p>Literature was available in different languages when requested and a member of the reception team was able to use sign language to aid in communication.</p> |             |

### Practice Opening Times

| Day | Time |
|-----|------|
|-----|------|

|                |              |
|----------------|--------------|
| Opening times: |              |
| Monday         | 8am – 8pm    |
| Tuesday        | 8am – 6.30pm |
| Wednesday      | 7am – 6.30pm |
| Thursday       | 8am – 6.30pm |
| Friday         | 7am – 6.30pm |

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

- Patients living in care homes registered at the practice were supported by a dedicated frailty team.
- 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.
- Longer appointments or home visits took place and was dependent on the patient's needs.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8 pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. Appointments were reserved in the after school period to allow parents to book children into these slots.
- A range of different types of appointments were available including telephone and face to face to suit clinical and patient needs
- Appointments were available in the evenings and at weekends to allow working age patients to access appointments at a convenient time.
- Pre-bookable appointments were also available to all patients at additional locations within the area, outside the practice working hours. This included weekends and on bank holidays, as the practice was a member of a Primary Care Network (PCN).
- The practice had a dedicated emergency phone line which the emergency services, district nurses or care home staff could use if they wanted to speak to a clinician or get advice on any patients who were registered at the practice.
- The practice had increased the uptake of screening for cervical cancer by increasing the hours available for appointments and directly contacting eligible patients.
- The practice had increased the uptake of childhood immunisations through publicity and education by staff.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

People were 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.   | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).   | Y |
| Patients were able to make appointments in a way which met their needs.   | Y |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).  | Y |
| Patients with most urgent needs had their care and treatment prioritised.   | Y |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages).   | Y |
| <p>Patient survey results relating to GP appointments at the practice, whilst still slightly below local and national averages, had improved since our previous inspection in May 2023. The latest data showed all 4 relevant indicators identified an increase in patient satisfaction. For example, ease of getting through to the practice on the phone had increased from 25% to 33.2% and patient satisfaction with the appointment offered had increased from 63.7% to 67.7%.</p> <p>During our inspection we found there were available appointments for urgent on the day consultations and for routine follow up appointments. We spoke to 3 patients who told us they had received an on the day appointment that day and had not had problems with booking.</p> <p>Information was available in the practice and on the provider's website relating to the services on offer. This included how to request a longer appointment, interpreter and chaperones, appointments available and how to access out of hours routine appointments.</p> <p>During our inspection, staff told us they were concerned about the availability of urgent on the day appointments, to manage the recognised increased activity during the approaching bank holiday period. Managers told us appointments during this time were blocked to protect urgent on the day availability. Review of the clinical system identified staff had overridden the safeguards to protect availability and some routine follow up appointments had already been booked. The GP partners were unaware of this. Following our inspection, we saw evidence further actions had been implemented to increase the available appointments and staff on duty.</p> |   |

### National GP Patient Survey results

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

| Indicator   | Practice | SICBL average | England | England comparison       |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023) | 33.2%    | N/A           | 49.6%   | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall  | 47.6%    | 57.4%         | 54.4%   | No statistical variation |

|  |       |       |       |                          |
|--|-------|-------|-------|--------------------------|
| experience of making an appointment (01/01/2023 to 30/04/2023)   |       |       |       |                          |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023) | 46.6% | 55.0% | 52.8% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)          | 67.7% | 76.1% | 72.0% | No statistical variation |

### Any additional evidence or comments

The practice had changed the way in which appointments were allocated and introduced a care co-ordinator role to allow patients to be allocated appropriately. The on-call GP triaged all clinical requests which were prioritised for urgency and allocated to the appropriate clinician.

| Source  | Feedback   |
|---|--|
| NHS.uk website (formerly NHS Choices).          | Two reviews have been posted since our inspection in May 2023. One of which is wholly positive and 5 stars, the second of which is negative about the withdrawal of a service and 1 star. The provider had not responded to either review.   |
| People's Experience Link on provider's website. | We received 6 sets of patient feedback following announcement of our inspection. These included a range of negative, positive and mixed comments. Feedback identified: <ul style="list-style-type: none"> <li>• Praise for polite, caring and efficient staff</li> <li>• Identification of some communication and care issues</li> <li>• Mixed reviews related to the waiting times for telephones to be answered. With some improvement noted by some patients.</li> </ul>    |
| Care home feedback                              | The CQC spoke with managers at the care home who had residents registered with the practice. A weekly care round was undertaken which reviewed concerns, ongoing care needs, and undertook long term condition reviews. They confirmed they were able to easily access the frailty team who provided support to their residents outside the weekly rounds for any urgent concerns. Medicines for both routine prescriptions and for any urgent issues was timely and effective |

### 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 in the last year.                                    | 11 |
| Number of complaints we examined.  | 3  |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2  |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman.   | 1  |

|  | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available.   | Partial     |
| There was evidence that complaints were used to drive continuous improvement.  | Y           |
| Information on how to make a complaint was available on the practice's website but information was not available in waiting rooms in written format. |             |

| Complaint                             | Specific action taken  |
|---------------------------------------|--|
| Complaint relating to telephone waits | Changes to system use of an on line system to communicate with patients and the way the administration and reception team work |
| Access to appointments concerns       | Recruitment of another GP and locum use while this is achieved.  |

## Well-led

## Rating: Requires Improvement

At the last inspection in May 2023 we rated the practice as Inadequate for providing well-led services because:

- Staff told us they did not feel part of the overall practice but were managing within their teams without leadership. Staff told us the GP partners were not visible within the practice and there was a disconnect between the management and GP Partners
- Governance arrangements and policies were not always up to date, lacked clarity or not complied with.
- There was no available time for leadership within teams to support and develop staff, or non-clinical time to complete administrative tasks within the practice.
- There was a lack of systems in place to provide appropriate onsite supervision of non-medical prescribers, locum GPs and nurses, increasing risk to patients.
- There was a vision for the practice and staff we spoke to were aware of this, however there was no strategy to achieve it or monitor its delivery.
- Practice risk registers and action plans had been put in place however, they did not reflect all the risks we identified as part of our inspection.

At this inspection on 6 December 2023, we found that issues had been resolved or the situation had been improved. However, there were still some concerns in regard to leadership, governance, risk management and communicating learning and development. Newly implemented systems and processes needed to be reviewed, developed and embedded within the practice to ensure their effective leadership and sustainability.

The practice is therefore now rated Requires Improvement for providing well led services.

## Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at some levels.**

|  | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability.  | Partial     |
| They had identified the actions necessary to address these challenges.   | Partial     |
| Staff reported that leaders were visible and approachable.   | Y           |
| There was a leadership development programme, including a succession plan.   | Partial     |
| <p>At our previous inspection in May 2023, staff told us clinical leadership and support was poor, with the GP partners described as unapproachable with ineffective communication skills. Development of staff to take on new roles was not seen as a priority.</p> <p>During our inspection in December 2023 staff told us support within the practice from the leaders had improved in some areas with protected time to complete tasks related to lead roles and support more junior staff.</p> <p>A range of regular meetings between clinicians and staff within the practice had been put in place on a monthly basis. We saw evidence in the minutes of meetings that these occurred regularly.</p> <p>Not all staff felt that the GP Partners had the leadership skills and exhibited behaviours that staff themselves were expected to adhere to.</p> <p>A number of staff at all levels told us they continued to feel unsupported by the GP Partners leadership methods, despite the fact that they were more visible and approachable. All staff were supportive of the practice management team.</p> <p>The GP Partners' behaviours and ineffective communication had been highlighted as a concern by staff in a recent staff survey. Minutes reviewed from the Partner and Management Meeting from October 2023 noted the partners were unsupportive of findings and felt the questions had been open to interpretation. Plans were in place to carry out an IT based survey on a regular basis to build a developing picture of trends and required improvements.</p> <p>Plans were in place to recruit another doctor to the practice with a long term plan in place to increase the number of GP Partners this had proved difficult over recent months. Whilst the provider felt the management of the practice was stable the lack of a recognised deputy practice manager posed a risk to stability in the event of the practice manager's long term absence.</p> |             |

## Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

|  | Y/N/Partial |
|--|-------------|
|--|-------------|

|  |         |
|--|---------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners.  | 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>At our previous inspection in May 2023, it was identified there was a vision to improve the health, wellbeing and lives of patients. However, patients had no input into the agreed vision as no feedback had been obtained to reflect their views.</p> <p>During our inspection in December 2023 the Patient Participation Group (PPG) were in the process of carrying out a patient feedback exercise to allow patients to comment on how the practice were performing and submit suggestions for improvement.</p> <p>Staff now attended regular clinical meetings within the practice during which concerns, improvements and learning were discussed, shared and actions evaluated to measure improvements.</p> |         |

## Culture

**Further improvements were required to embed the recent changes in culture.**

|  | 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 had access to a Freedom to Speak Up Guardian.   | Y           |
| Staff had undertaken equality and diversity training.  | Y           |
| At our previous inspection in May 2023 not all staff had undertaken equality and diversity training, at this inspection we saw evidence all staff had now completed this training. |             |

| Source             | Feedback  |
|--------------------|---|
| 6 Staff interviews | Staff told us there had been improvements and changes in systems and processes since our previous inspection in May 2023. Staff now had dedicated time to carry out specific roles, leaders were more visible, communication had improved, and staff felt more involved and autonomous. Five of the staff felt they were listened to and appreciated and expressed views on how good the teamwork was. Two members of staff told us the leadership from the GP partners continued to be poor. They told us, whilst visibility of the GP partners had increased, the leadership skills had not developed to appropriately support staff. |



|                         |   |
|-------------------------|---|
|                         |   |
| 22 staff questionnaires | We received 22 staff questionnaires from a wide range of different staff working at all levels. Of the 22 received, 13 were positive, 7 were mixed and 1 was negative. Five responses suggested communication and inclusion by the GP Partners could be improved further. Two responses indicated they did not always feel supported, others identified being well supported both professionally and with any personal issues they may have.  |
| Staff survey            | The practice carried out a staff survey with a staff completion rate of 30%. The survey covered a variety of subjects including staff engagement, teamworking, leadership and management, personal development and staff wellbeing. Results identified staff were committed to working at the practice, teamworking and personal growth opportunities were positive. Staff wellbeing was mostly positive with a minority of staff identifying more could be done to promote employee wellbeing. Staff identified leadership and management could further improve communication and the GP Partners behaviour was not modelled on the expectations placed on others. |

### Governance arrangements

**Further development of governance arrangements was required to provide appropriate governance in all areas.**

|  | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed.  | Y           |
| Staff were clear about their roles and responsibilities.   | Y           |
| There were appropriate governance arrangements with third parties.   | Y           |
| There are recovery plans in place to manage backlogs of activity and delays to treatment.  | Y           |
| <p>At our previous inspection in May 2023 we found governance structures and systems did not give the practice leaders oversight of all areas within the practice.</p> <p>During this inspection we found governance arrangements at the practice had been reviewed and improved. However, further development of the systems and processes was required to cover all areas. We found issues remained relating to the leadership, communication, oversight of some environmental safety issues and management of appointments at identified times of increased activity.</p> |             |

### Managing risks, issues and performance

**Management of risks, issues and performance were clear in relation to some areas. There remained gaps with the processes for managing all 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.  | Y           |
| There was a quality improvement programme in place.  | Y           |
| There were effective arrangements for identifying, managing and mitigating risks.  | Partial     |
| A major incident plan was in place.  | Y           |
| Staff were trained in preparation for major incidents.   | Y           |
| When considering service developments or changes, the impact on quality and sustainability was assessed.   | Y           |
| <p>At our inspection in May 2023, support for development and audit of clinicians' competence, staff appraisal was not supported due to lack of dedicated time for clinical leads.</p> <p>At our current inspection we saw assurance systems had been reviewed and improvements had been implemented.</p> <p>Whilst the practice did not have a formal quality improvement plan in place at the time of our inspection. They did undertake regular audits within the practice into a wide range of both clinical and administrative topics. Audit outcomes were discussed at the clinical meetings and improvement identified and reviewed.</p> <p>The provider had a risk register in place, stored on the clinical system which included the known identified risks. The risk register was not included in practice meetings for review, discussion and updating. This meant not all staff were aware of the risks facing the practice and actions being taken to provide safe, effective and sustainable care.</p> <p>Not all risks were understood, and staff did not always have the knowledge to identify and manage risks. For example, in relation the risks posed by Legionella and control of substances hazardous to health.</p> <p>A comprehensive action plan had been put in place to manage improvements within the practice and a range of audits had been undertaken since our previous inspection in May 2023 to improve patient care and mitigate some risks.</p> |             |

### Appropriate and accurate information

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

|   | Y/N/Partial |
|---|-------------|
| Staff used data to monitor and improve performance.   | Y           |
| Performance information was used to hold staff and management to account.   | Y           |
| Staff whose responsibilities included making statutory notifications understood what this entailed.   | Y           |
| <p>At our previous inspection in May 2023, we found data collected was not used to hold staff and managers to account and improve services.</p> |             |

The provider had reviewed and amended the systems in place to collect and review patient feedback at our current inspection in December 2023.

The Friends and Family Test (FFT) had been added to the practice website and staff monitored this daily. We saw evidence in meeting minutes that FFT feedback had been discussed and led to improvements. For example, recruitment and further training had been undertaken as a direct result from patient feedback about access to services.

All patients were sent a link following any interaction with the practice to allow them to leave an on line review. The practice had invested in a dedicated on line system to collate the feedback from both patients and staff.

The PPG were in the process of completing a patient survey on behalf of the practice and feedback forms had been left in the reception areas of both surgeries with “You said, we did” posters displayed in the surgery to inform service users of changes made.

### Governance and oversight of remote services

|   | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y           |
| The provider was registered as a data controller with the Information Commissioner’s Office.                                      | Y           |
| Patient records were held in line with guidance and requirements.   | Y           |
| Patients were informed and consent obtained if interactions were recorded.  | Y           |
| The practice ensured patients were informed how their records were stored and managed.  | Y           |
| Patients were made aware of the information sharing protocol before online services were delivered.                               | Y           |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.              | Y           |
| Online consultations took place in appropriate environments to ensure confidentiality.  | Y           |
| The practice advised patients on how to protect their online information.   | Y           |
| Staff are supported to work remotely where applicable.  | Y           |

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

**The practice had begun to involve the public, staff and external partners to sustain high quality and sustainable care.**

|  | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Partial     |
| The practice had an active Patient Participation Group.      | Y           |

|   |   |
|---|---|
| Staff views were reflected in the planning and delivery of services.  | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.  | Y |
| <p>At our previous inspection in May 2023 we were told engagement was not effective with the Patient Participation Group (PPG), involvement of the GP partners was poor, and the PPG was described a dormant.</p> <p>Managers were involved with the Primary Care Network (PCN) to develop ways in which access could be improved in the area and new ways of working with other practices. For example, the practice was working with the PCN to provide accessible services to patients for contraceptive services.</p> |   |

#### Feedback from Patient Participation Group.

| Feedback  |
|---|
| <p>The PPG told us that the relationship between them and the provider was greatly improved since our previous inspection visit in May 2023. The practice manager was noted to be pivotal in this process and had led the change, this had meant the PPG did have concerns that a full team approach had not been embedded. It also raised concerns about sustainability in the event of the practice manager being absent from the practice for any length of time.</p> <p>The GP partners were more involved with the group and had started to attend meetings and provided written reports. The PPG told us they are not always made aware of the changes occurring within the practice. This lack of information meant they could not forewarn patients and explain the reasons for any changes to help facilitate a smooth change process.</p> |

| Any additional evidence  |
|--|
| The PPG were in the process of reinstating fund raising initiatives at the practice with the support of the practice management and leading a patient feedback exercise. |

#### Continuous improvement and innovation

#### There were 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.   | Partial     |
| <p>During our inspection in May 2023, we did not see evidence of learning and improvement being prioritised. Staff told us learning was not always shared and improvements difficult to make.</p> <p>The provider had improved the systems and processes in place to support learning, continuous improvement and innovation. Further time was required to ensure these were embedded within normal working practice.</p> <p>Whilst further development of the skills related to some managers and leaders we saw evidence of a much improved and strong focus on learning and improvement within the practice. For example, we saw evidence and staff told us of improvements in the way staff worked following patient feedback, implementation of</p> |             |

dedicated time for staff to complete essential tasks and lead roles, more meetings in place, competency audits and clinical support for staff working in advanced clinical practice, development of staff feedback collection, improved relationships with the PPG, actions taken from audits. The provider had plans in place to improve learning and continuous improvement in the future.

### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the 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)     | $\leq -3$              |
| Variation (positive)                 | $> -3$ and $\leq -2$   |
| Tending towards variation (positive) | $> -2$ and $\leq -1.5$ |
| No statistical variation             | $< 1.5$ and $> -1.5$   |
| Tending towards variation (negative) | $\geq 1.5$ and $< 2$   |
| Variation (negative)                 | $\geq 2$ and $< 3$     |
| Significant variation (negative)     | $\geq 3$               |

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

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

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

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

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

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

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

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