

## Inspection Evidence Table

Lees Medical Practice

(1-12783302204)

Inspection Date: 25 and 29 August 2023

**Overall rating: Requires improvement**

We carried out an inspection to Lees Medical Practice on 7 September 2022. Overall, the practice was rated requires improvement, all key questions were rated requires improvement. We found breaches of Regulations 12 (Safe care and treatment) and 17 (Good governance), and requirement notices were issued.

At this inspection, on 25 and 29 August 2023, we saw that the required improvements had been carried out. However, other non-clinical concerns were identified. The practice is again rated requires improvement overall and for all key questions. There are 2 breaches of regulation, for regulation 17 (Good governance) and regulation 19 (Fit and proper persons employed).

**Safe Rating: Requires improvement**

The key question of safe was rated requires improvement following the inspection on 7 September 2022. Clinical searches identified that some medicine reviews were carried out without addressing the required monitoring or changes to treatment that should have been identified during a comprehensive review.

At this inspection we have continued to rate the key question safe as requires improvement. Although the practice had taken action to make the required improvements, further areas of concern were found:

- Required pre-recruitment checks were not carried out.
- There were typographical errors on the health and safety and fire risk assessments, and the health and safety risk assessment had not been completed accurately.
- Routine checks stipulated in the fire safety policy were not carried out.
- The infection prevention and control policy and statement gave conflicting information.
- Significant events were not managed effectively.

### Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse but these were not always followed.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y

Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

- The inspection of 7 September 2022 found there was no proactive review of patients on the child protection register, and there were no regular meetings with health visitors. At this inspection we saw registers were reviewed monthly and when health visitors could not attend meetings, they provided input into cases.
- The majority of permanent staff had completed safeguarding training at the appropriate level. One staff member had started work at the practice 1 August 2023 and had not completed any safeguarding training at the time of the inspection. The practice manager told us they were working through their required training in alphabetical order.
- The practice manager told us all training records for long-term locum clinicians were held in their personnel files. We saw no evidence of any safeguarding training for 1 long-term locum clinician, and another long-term locum clinician had last completed safeguarding adults training over 3 years ago.
- The practice manager told us they did not hold Disclosure and Barring Service (DBS) certificates for staff members but did note the reference number and the date of the check, along with evidence they had been carried out. There was no record of any DBS check for 3 of the 4 long-term locum clinicians. We saw a DBS certificate was held for the 4th long-term locum clinician; this was dated May 2018. The practice's recruitment policy stated, "Clinical roles or those that otherwise involve contact with patients will usually require a DBS check before the successful candidate starts in the position". We saw no evidence of a DBS check being carried out for the practice manager.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
Explanation of any answers and additional evidence:	

- Prior to the inspection we informed the practice that we would need to see all their staff personnel files including induction and appraisal information. We also stated we would need to see the personnel files for their long-term locum clinicians. The practice manager confirmed to us the evening prior to the inspection that these would be available for us to see.
- When we arrived at the inspection the practice manager told us none of the files were available as they were kept on another site, but they had provided an example of what they requested from staff during the recruitment process. We attended the site where the personnel files were said to be kept and were told access to the files was not available. We attended the site the following week to examine the files.
- The practice's recruitment policy stated, "The organisation only accepts applications on its standard job application form or online application". All of the 6 newly recruited permanent staff members' files we checked contained this form. However, 2 application forms were signed after the start date, 2 at the interview date, 1 after the offer letter but before the start date and 1 on the start date. The earliest they had been signed was at interview, so job applications had not been made on the form. Very little information was contained on the application forms, with most boxes on them stating to 'refer to the curriculum vitae (CV)'.
- We examined the personnel files of 6 permanent staff members who had been recruited in the previous year. We found discrepancies in all files, including:
  - One clinician had provided a CV with their employment history. A practice application form had also been partially completed. This contained information about a recent job which was not mentioned on the CV, so their full employment history was unclear. There was no reference from this recent employer to demonstrate satisfactory evidence of conduct in this previous employment as a clinician. There was no record of this discrepancy being observed or questioned.
  - One clinician had provided a CV with their employment history. Their most recent employment was stated to be in 2 GP practices. These practices were not named. The personnel file also contained a partially completed application form. This stated the clinician's most recent employment was in a hospital. There was no reference from this recent employer to demonstrate satisfactory evidence of conduct in this previous employment as a clinician, and their employment history was unclear. There was no record of this discrepancy being observed or questioned.
  - A member of the administrative team had provided a CV with their employment history. The personnel file also contained a partially completed application form. The application form gave information about another job in a GP practice that was not mentioned on the CV. A reference had not been sought from a recent employer where the staff member had worked for several years. There was no record of this discrepancy being observed or questioned.
  - A member of the administrative team had provided a CV with their employment history. Dates of employment showed the staff member had worked at establishments in different areas of the country at the same time. There was no record of this discrepancy being observed or questioned. This staff member started work at the practice in July 2023. At the time of the inspection no references had been received to demonstrate satisfactory evidence of conduct in previous employment with children.
  - A reference had been sought from the most recent employer of a member of the administrative team. This gave different dates of employment to those provided by the staff member on their application form. The practice's recruitment policy stated, "All reference responses will be cross-checked back to the original application". Only 1 previous job was mentioned on the application form. The form stated to refer to their CV for other employment details. The CV stated the staff member had worked in doctors' practices for many years. No practices were named. There was no record of these discrepancies being observed or questioned.
- We examined the personnel files of 4 long-term locum clinicians working at the practice. None of their personnel files contained all the required information. Evidence of qualifications, professional registration, previous employment and a DBS certificate was not routinely seen. A locum clinician had

provided a UK photo driving licence as evidence of their identity. A UK driving licence is not evidence that an individual has the right to work in the UK. There were no other checks completed to check the status of the individual who was born abroad.

- The practice manager told us they held evidence of the vaccination of staff, but this was not provided during the inspection.

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:	01/02/2023
There was a fire procedure.	Y
Date of fire risk assessment:	01/02/2023
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The fire risk assessment and health and safety risk assessment stated the assessment had been undertaken 6 March 2023 and was due for review 1 February 2023. The practice manager stated this was a typographical error and the assessment had been completed 1 February 2023.</li> <li>• The question “Health and safety induction training is carried out, recorded and refreshed on an annual basis?” on the health and safety risk assessment had been answered “Yes”. The practice manager supplied us with training information for all staff. We saw no evidence any staff member had completed health and safety training and it was not included in the list of required training that was supplied to us.</li> <li>• The fire safety policy was not dated but was stated to be for review in July 2026. This stated a daily check was: “Routine checks of final exit doors to ensure clear and mechanism to open is functioning, check emergency light indicators are showing, light is in working order and check fire panel is in normal mode”. The practice manager told us this was a typographical error; they carried out weekly checks of the fire alarm and 12 weekly fire evacuations.</li> </ul>	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met but governance needed to be improved.**

	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:	13/02/2023
The practice had acted on any issues identified in infection prevention and control audits.	Y

The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The infection prevention and control policy was not dated but was stated to be for review in January 2025. This stated staff would receive training every 36 months. It stated the infection prevention and control lead was the practice manager.</li> <li>The practice provided us with an infection prevention and control statement signed by the practice manager and dated May 2023. This stated all staff would be trained on induction and the training would be refreshed annually. It stated the practice nurse was the infection control lead. This was different information to that contained in the policy.</li> <li>We saw that the majority of staff had completed infection prevention and control training in the previous 36 months, but not all had completed it in the previous year.</li> <li>The infection prevention and control statement dated May 2023 detailed risk assessments which had been completed between 1 April 2021 and 31 March 2022. It stated a risk assessment had been completed in August 2021. Although the statement was dated May 2023 the information contained in it had not been updated. The most recent infection prevention and control risk assessment had been completed 13 February 2023.</li> </ul>	

**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
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

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y

There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The inspection of 7 September 2022 found the lead GPs did not know where the referral records were kept, and urgent referrals were not managed safely. Our clinical searches had found deficiencies in the monitoring of patients prescribed high risk medicines, with appropriate blood tests not always being carried out.</li> <li>At this inspection we found the provider had taken appropriate action. The system for managing urgent referrals had been updated so staff checked the referrals had been made and then patients had been seen.</li> <li>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor remotely. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice.</li> <li>Our review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.</li> </ul>	

### 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) (01/04/2022 to 31/03/2023) (NHSBSA)	0.75	1.04	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). (01/04/2022 to 31/03/2023) (NHSBSA)	5.8%	6.1%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and	4.29	4.50	5.23	Tending towards

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>				variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	160.4‰	183.9‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	1.01	0.78	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	5.5‰	7.2‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
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
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
Explanation of any answers and additional evidence, including from clinical searches.	

- The inspection of 7 September 2022 found the practice did not have systems for the appropriate and safe use of medicines. The patient recall process had not been monitored effectively, medicine reviews had been conducted without carrying out the required checks, and some patients prescribed high risk medicines had not always had the required checks. In addition, Patient Specific Directives, to allow certain trained staff to administer named medicines, were not used appropriately.
- At this inspection we found the provider had taken action and we found no repeat issues.
- As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor remotely. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice.
- There were medicine management and prescribing policies and procedures in place.
- The practice continually reviewed their systems and processes for the administration and supply of medicines, and regular reviews for repeat prescribing for the benefit of the patient population.
- We saw evidence that the majority of patients prescribed high risk medicines received frequent monitoring to ensure prescribing was safe.

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

**The practice did not have an effective system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	17
Number of events that required action:	Unclear
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The inspection of 7 September 2022 found the practice did not have a system to learn and make improvements when things went wrong. Only 1 significant event had been recorded in the previous year.</li> <li>• At this inspection, the practice manager supplied us with information of significant events which had been raised in the previous 12 months. They told us there had been 17 significant events, and these were recorded on the practice’s electronic system.</li> <li>• The practice had held staff meeting on 18 May 2023. It was stated there were many incidents of information not being passed to GPs. It also stated a pile of paperwork had been found on a desk, some unscanned and some undated. The meeting minutes were noted “This is dangerous and sloppy work and we will not tolerate sloppy work. This seems to be a recurring theme”.</li> <li>• We asked the practice manager if a significant event had been raised regarding the paperwork. They told us as far as they were aware it had but not all staff knew how to use the electronic system so they</li> </ul>	



may have recorded it on a paper form. On the day of the inspection the practice manager told us it had been written up by a staff member on paper and they had now recorded it electronically, so they amended the number of significant events in the past year to 18. They told us that as far as they knew no other significant events had been missed off their electronic recording system.

- We saw no record of a significant event being raised relating to information not being passed to GPs.
- The significant events and incident policy was not dated but was stated to be for review in July 2026. The policy gave examples of what constituted a significant event. Examples included new cancer diagnoses, positive cervical smears, positive mammography and sudden unexpected hospitalisation of a patient. This was not being followed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a process for taking action when safety alerts were received, and we saw evidence appropriate action had been taken.</li> <li>• The pharmacy technician took appropriate action when safety alerts were received, and they carried out regular searches as required.</li> </ul>	

## Effective

## Rating: Requires improvement

The key question of effective was rated requires improvement following the inspection of 7 September 2022. The uptake data for cervical screening and child immunisation were both below the national average. Patient care needs were not always assessed and follow up appointments were not always provided.

At this inspection we have continued to rate the key question effective as requires improvement. Although the practice had taken action to make the required improvements, further areas of concern were found:

- The practice had completed induction documents for staff, but these were generic and not linked to individual roles. Dates on induction forms were not always correct.
- The system for managing training was not effective.
- Training was not carried out in accordance with the practice's recorded procedures.
- Probation reviews were not carried out in line with the practice's procedures.
- Although the uptake for cervical screening had increased since the previous inspection it was still below 70%.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients 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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

## Explanation of any answers and additional evidence

- The inspection of 7 September 2022 found patients were not always coded correctly so they did not receive the necessary care, treatment or referrals. Information was not held of meaningful medicine reviews.
- At this inspection we saw the provider had taken all the required action and medicine reviews contained all relevant information.

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The lead GP had a weekly ward round at a care home to help reduce unplanned hospital admissions.

## Management of people with long term conditions

### Findings

- The inspection of 7 September 2022 found patients with some long term conditions did not all have appropriate reviews.
- As part of this inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required assessment and reviews were taking place. These searches were visible to the practice. The records we examined provided evidence that the majority of patients with long term conditions had been monitored and reviewed appropriately.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews for 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 influenzae 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)	50	59	84.7%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	59	61	96.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	61	98.4%	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)	59	61	96.7%	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)	61	69	88.4%	Below 90% minimum

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

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	57.1%	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)	62.9%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot 31/03/2023) (UKHSA)	66.4%	N/A	80.0%	Below 70% uptake

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	42.9%	52.0%	54.9%	No statistical variation
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Any additional evidence or comments
<ul style="list-style-type: none"> <li>• The practice had increased their childhood vaccination rate in 4 of the 5 categories since the inspection of September 2022.</li> <li>• We saw that cervical screening data had improved over the past 12 months. The data on 31 March 2022 was 62.4%, and this had increased to 66.4% at 31 March 2023.</li> <li>• The practice manager told us nurses telephoned patients who did not attend cervical screening appointments to explain the process and see if they could make any adjustments to the service to encourage patients to attend. They felt this had been successful.</li> <li>• The practice was in the process of arranging some health campaigns and the practice manager told us they hoped to have a cervical screening campaign soon to help improve their figures.</li> </ul>

### 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
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>• The inspection of 7 September 2022 found there had been no recent 2 cycle clinical audits. There was no formal system in place for continuous clinical audits used to test the effectiveness of the service and to monitor quality and to make improvements.</li> <li>• At this inspection we saw the practice had a programme of clinical audits in place.</li> <li>• We were provided with examples of audits which had been completed. These included reviews of patients prescribed high strength opioids, monitoring of patients prescribed high risk medicines and the request of additional tests for patients with certain urgent referrals.</li> </ul>	

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw an induction document was held in staff personnel files. Of the staff files we examined, in all except 1, all aspects of induction were completed on their first day of work. However, the document for a staff member who started work in November 2022 was dated November 2023. The induction recorded was generic and not relating to individual staff roles.</li> <li>The practice manager provided us with staff training information 7 days prior to our site visit. At this time not all training was up to date, and there was no evidence of some training for a clinician who started work several months earlier. On the day of the inspection, we saw most required training had been completed.</li> <li>The practice provided us with a checklist titled, "New Starter Teamnet Day of Commencement 2023". This listed 34 documents such as the safeguarding policy, business continuity policy, the employee handbook and the governance handbook. These were listed as "MANDATORY – on date of commencement". It also stated, "Before staff member can commence employment, online training must be completed". We did not see this document in any of the personnel files we checked, and our review found that training was not completed prior to employment commencing.</li> <li>The practice manager told us they had spoken to staff about completing training several times and may have to take disciplinary action if they still did not complete it.</li> <li>We saw that 1 staff member had completed 29 training courses since we announced the inspection. 15 courses had been completed in 1 day.</li> <li>The practice manager told us staff had a probation review 6 months after starting at the practice, then appraisals were carried out every year. They provided us with reviews which had been carried out. There was no probation review for a clinician who had been employed for over 7 months.</li> <li>The GP partners explained their process of carrying out clinical supervision for staff, including long-term locum clinicians. Some of this supervision was informal and some recorded. Staff told us they felt well supported by the partners, who were available to give advice when needed. Annual appraisals were carried out for clinical staff by the partners.</li> </ul>	

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Our inspection of 7 September 2022 found patients at risk of diabetes were not always recalled so managing their condition could be discussed, and patients with thyroid problems did not always have the required tests.</li><li>• At this inspection we saw the provider had taken appropriate action and patients received the required advice and follow-up tests.</li></ul>	

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
Explanation of any answers and additional evidence	
<ul style="list-style-type: none"><li>• The inspection of 7 September 2022 found DNACPR decisions had not always been reviewed, and other agencies had not always been informed of decisions.</li><li>• At this inspection, our clinical review of notes where a DNACPR decision had been recorded identified that the patients' views had been sought and respected. We saw that information had been shared with relevant agencies.</li><li>• Clinicians had completed Mental Capacity Act training.</li><li>• We saw evidence of consent being discussed with patients during consultations.</li></ul>	



## Caring

## Rating: Requires improvement

The key question of caring was rated requires improvement following the inspection of 7 September 2022. The data for patients' overall experience of the GP practice, and patients' views of the way they were treated by clinicians, was lower than local and national averages.

At this inspection we have continued to rate the key question caring as requires improvement:

- Patient satisfaction had declined in some areas.
- There was some conflicting information in the in-house patient survey.

### Kindness, respect and compassion

**Staff usually treated patients with kindness, respect and compassion, but feedback from patients about the way staff treated people was not always positive.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The inspection of 7 September 2022 found patients with severe mental illness were not always referred to appropriate services, and patients' ongoing needs were not fully assessed. At this inspection we saw the provider had taken action to ensure referrals and ongoing needs were fully assessed and appropriate referrals made.</li> </ul>	

### 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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	61.1%	80.4%	85.0%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	69.6%	78.6%	83.8%	Tending towards variation (negative)

The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	77.2%	89.1%	93.0%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	50.1%	64.8%	71.3%	Tending towards variation (negative)

**Any additional evidence or comments**

- The practice provided us with a document comparing their national GP patient survey results from 2022 and 2023, showing an increase in patient satisfaction for 9 of the 13 questions analysed. However, the incorrect data had been used for each year so there had actually been a decline in satisfaction for 9 questions. For example:
  - In 2022 the percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them was 70%. In 2023 this was 61%.
  - In 2022 the percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to was 82%. In 2023 this was 77%.
  - In 2022 the percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern was 71%. In 2023 this was 70%.
- There had been an increase in satisfaction of the overall experience of the GP practice from 40% to 50%.
- The practice provided us with a document titled “GP patient survey response 2022”. This analysed the data from the national GP patient survey, stating what improvements the practice had made or would make. The document stated the current partners had taken over at the practice in December 2021, and they felt the GP patient survey results were based on the previous owners. It also stated, “It is important to take into account that the GP Survey only reflects the views of 1% of our list size” (117 surveys had been returned).

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

**Any additional evidence**

- The practice had carried out an in-house patient survey in June 2023 and provided us with the results. There had been 66 responses.
- The practice stated the results of their in-house survey was more positive than the 2022 national GP patient survey. The 2023 national results were not published until 13 July 2023.
- There was a discrepancy in the in-house patient survey results, with 2 very similar questions having different responses. The practice provided us with the document produced to show their results. One question was “Did you find the *practice team* professional and helpful?”. There had been 60 responses, 52 responding ‘yes’ and 8 ‘no’ (87% vs 13%). Another question was “Did you find the *team* professional

and helpful?” It was difficult to determine the results; It was noted that there had been both 64 and 32 responses, with both 75% and 87% of responses being ‘yes’.

### 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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
NHS.uk website (formerly NHS Choices)	There had been 8 reviews on the NHS website in the last 12 months, but some had been duplicated. Of the 6 actual reviews, 1 patient gave the practice 1 star, 1 patient gave the practice 3 stars, 1 patient gave the practice 4 stars, and 3 patients gave the practice 5 stars.  One patient commented that staff were polite and provided a good service.

### 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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	76.7%	86.4%	90.3%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>There was a large display in the waiting area titled “Health A – Z Scan Me”. This listed various conditions such as varicose veins, weight loss, kidney infection and high cholesterol. There was a QR code next to each, so patients were directed to appropriate advice, usually on the NHS website.</li> <li>There were other posters in the waiting area giving information about how to access support and giving information about issues such as suicide prevention and domestic abuse.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had 124 registered carers, which was 2.5% of the practice population.
How the practice supported carers (including young carers).	The practice offered flu vaccinations to carers and directed them to local support services. The practice did not have any young carers at the time of the inspection.
How the practice supported recently bereaved patients.	<p>The practice had a palliative care register. GPs told us they tried to involve relatives towards the end of a patient's life, so they were able to give personalised support. They contacted bereaved patients to offer condolences and support, with a GP appointment being given if requested.</p> <p>There was a pop up on the screen of recently bereaved patients, so all staff knew to be particularly sensitive to their needs.</p>

### 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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Requires improvement

The key question of responsive was rated requires improvement following the inspection of 7 September 2022. The data for patient access to the service and the way patients were treated by clinicians was lower than local and national averages.

At this inspection we have continued to rate the key question responsive as requires improvement:

- Patient satisfaction had declined in some areas.
- Improvements were required around complaints' governance and learning from complaints.

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The inspection of 7 September 2022 found the needs of patients with severe mental illness were not always identified which resulted in referrals to appropriate services not being made. The needs of patients with hypertension were not met. At this inspection we found the provider had taken appropriate action to ensure patients' needs were met.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

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

- The lead GP told us that as they had expanded their clinical team in order to meet the changing needs of patients. The clinical team included 2 GP partners, 2 long-term locum GPs, 2 practice nurses, 2 physician associates, an advanced clinical pharmacist, and an advanced care practitioner. The Primary Care Network (PCN) also employed a physiotherapist who attended the practice.
- GPs did not have appointments for every clinical session but there was always a GP on site who was able to see patients if required. There were clinical appointments for all sessions during the week.
- There were practice nurse appointments from 8am one day a week, and healthcare assistant appointments from 8.30am twice a week.
- There was a weekly ward round by a GP to a local care home to help prevent unplanned hospital admissions and urgent appointment and visit requests.
- Extended hours access was available via the PCN from 6.30pm until 8pm Monday to Friday and 9am until 5pm on Saturdays.
- The practice had planned a Saturday open day for 30 September 2023. This was primarily so flu vaccinations could be administered but the practice was using it as an opportunity to have a 'digital day' to assist patients and provide information on how to access for example appointments and prescription requests electronically. They hoped to have other stands so other information could be provided. This included information for carers and Andy's Man Club (a men's suicide prevention charity that provides a safe environment for men to speak about issues important to them).
- 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 easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- 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.
- Same day appointments were given when required for children under the age of 5 years.

### Access to the service

**Although it appeared that people were able to access care and treatment in a timely way, patient survey results were not positive.**

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>At 9.30am on the day of the inspection we saw the next available urgent appointment was the following working day. The next available routine appointment was in 5 working days.</li> <li>The practice manager told us that there was always a GP available to see patients if they thought this was necessary. We saw evidence that a patient had been seen outside a normal appointment slot on the day of the inspection.</li> </ul>	

### 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)	36.9%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	27.9%	45.1%	54.4%	Tending towards variation (negative)
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)	33.8%	45.5%	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)	54.0%	65.9%	72.0%	Tending towards variation (negative)

### Any additional evidence or comments

<ul style="list-style-type: none"> <li>The inspection of 7 September 2022 found GPs were aware of the data from the 2022 national GP patient survey results and they stated they had taken action by recruiting more clinical staff.</li> <li>The 2023 national GP patient survey results showed a decline in satisfaction in 9 of the 13 questions analysed. For example: <ul style="list-style-type: none"> <li>In 2022 the percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment was 29%. In 2023 this was 28%.</li> <li>In 2022 the percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times was 42%. In 2023 this was 34%.</li> <li>In 2022 the percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered was 57%. In 2023 this was 54%.</li> </ul> </li> <li>In 2022 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 was 24%. In 2023 this was 37%. The practice stated a new improved telephone system had been installed in February 2022.</li> </ul>
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- The practice told us they had increased their clinical staffing over the past few months so they thought satisfaction with appointments would increase. However, this had been stated in response to the previous survey also.
- The practice carried out an in-house patient satisfaction survey in June 2023, prior to the national 2023 survey results being published. Their own in-house results were:
  - 49% of patients rated getting through to the practice on the telephone as good or very good.
  - 75% of patients rated the overall experience of making an appointment as good or very good.
- The practice had carried out an analysis of telephone calls answered between 1 February 2022, when the new telephone system was installed, and 23 August 2023, the week of the inspection. The analysis showed that 70% of calls had been answered in under 5 minutes, and 30% of calls had been answered in less than 1 minute.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There had been 8 reviews on the NHS website in the last 12 months, and these were mixed.</p> <p>One patient commented that they were notified by text if they needed a blood test, and another commented that it was difficult to access the practice by telephone.</p>

**Listening and learning from concerns and complaints**

**Complaints were listened and responded to but not always used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	6
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The inspection of 7 September 2022 found the amount of information recorded in each complaint log was different, so it was not clear what action had been taken during the complaint investigation or details of the response sent to the complainant.</li> <li>• At this inspection we saw that written complaint responses were saved on the practice’s electronic system with details of the complaint.</li> </ul>	



- The complaints' procedure was not dated but was noted to be for review in July 2026. The procedure was unclear, giving information about the difference between complaints and concerns, and informal and formal complaints. The practice manager told us they were all treated the same, and we saw that complaints were all recorded on a spreadsheet.
- The policy stated that where verbal complaints were dealt with by telephone or in person, and to the satisfaction of the patient, a written response was not required. The spreadsheet stated the verbal complaints recorded had been resolved by telephone or in person. However, the practice manager provided us with written responses to verbal complaints the patients appeared satisfied with the outcome. One of these written responses was dated prior to the verbal complaint being made.
- We examined a complaint from June 2023. The practice meeting minutes from 21 June 2023 mentioned the complaint but there was no record of any discussion about the complaint or any required learning.
- Our feedback from staff told us not all staff were made aware of any complaints made regarding the practice. Following the inspection, the provider told us that all complaints were visible to staff on the practice's electronic system so staff were able to view them. They also told us they were all discussed in practice meetings.
- The practice website named the person patients should contact to make a complaint. This person had not worked at the practice for some time.

## Well-led

## Rating: Requires improvement

The key question of well-led was rated requires improvement following the inspection of 7 September 2022. The risk management approach was applied inconsistently and was not linked effectively into the review and monitoring systems of patients' health care issues.

At this inspection we have continued to rate the key question well-led as requires improvement. Although the practice had made improvements related to the clinical aspects of patient care, we found issues with the governance of the practice. For example:

- We found several areas where improvement was required in governance procedures.
- Some policies were inaccurate or not being followed.
- Significant events and complaints were not used to encourage continuous improvement.
- Processes for managing non-clinical risk were not clear.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The inspection of 7 September 2022 found leaders had some systems in place to understand the quality of practice administration, but clinical challenges were not fully understood. Risks relating to sustainable care and patient monitoring had not been understood.</li><li>• At this inspection we found the GP partners had successfully worked to make the clinical improvements that had been required. However, we found several areas relating to the governance of the practice that needed to be improved.</li><li>• Although there was no leadership development programme the GP partners had started to think of succession planning. At the time of the inspection the leadership team was stable with no imminent changes anticipated.</li></ul>	

## Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The inspection of 7 September 2022 found progress against the delivery of the strategy and plans was not consistently or effectively monitored or reviewed, with no evidence of progress being made.</li> <li>At this inspection we saw the practice had a robust action plan in place to address the improvements required following that inspection, and this plan had been regularly monitored.</li> <li>Although actions relating to clinical improvements required were accurate and we saw evidence of improvement, this was not the same for non-clinical improvements required. For example, 1 specific action identified was to maintain a comprehensive library of policies to cover all aspects of running the business. We saw policies were in place but some, such as the fire safety policy and the infection prevention and control policy, were either inaccurate or not being followed.</li> </ul>	

## Culture

**The practice culture usually supported high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The partners provided evidence that they sought support and took action following the CQC inspection on 7 September 2022. The majority of issues identified had improved at this inspection.</li> <li>We saw evidence that the partners had taken action to deal with any behaviour inconsistent with the vision and values.</li> </ul>	

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

Source	Feedback
CQC staff feedback forms	Staff feedback was positive about the culture of the practice. Staff reported that they felt supported and that managers had an open door policy. Any issues were said to be resolved quickly.

**Governance arrangements**

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The inspection of 7 September 2022 found governance arrangements were inconsistent. There was a lack of clarity about which GP partner had overall responsibility for clinical disease areas and medicines management. There was also no consistent approach to recall and the quality of care planning and review did not ensure patients received the care and treatment they needed.</li> <li>At this inspection we saw improvements relating to clinical governance had been made.</li> <li>Governance around administrative issues and practice management was not effective. For example, we found failings in the way significant events were managed, risk assessments were not always accurate, some policies were not accurate or not being followed.</li> </ul>	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The inspection of 7 September 2022 found the risk management system was applied inconsistently, and some protocols were not clear.</li><li>• At this inspection we found improvements in all clinical areas of the practice. However, we identified concerns in non-clinical areas of risk management.</li><li>• The recruitment policy was not followed, and information collected from staff during their recruitment was not in line with legislation.</li><li>• We found failings in the way fire safety, health and safety, and infection prevention and control were managed.</li><li>• The system to monitor staff training was not effective.</li><li>• We saw evidence of some performance management taking place in the practice.</li></ul>	

### 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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The inspection of 7 September 2022 found systems to monitor patient care were not effective. Patient reviews and monitoring of patient care were not consistent, and referrals to secondary care were not overseen by a clinician.</li><li>• At this inspection we saw improvements had been made in all these areas. We saw that clinically, data and information was used proactively, and information had been acted on.</li><li>• Although the practice had acted on information identified during the September 2022 inspection, we found other concerns relating to non-clinical aspects of the practice. For example:<ul style="list-style-type: none"><li>○ Improvements were required to the system of identifying and recording significant events.</li><li>○ Improvements were required to the procedures in place to manage complaints.</li></ul></li></ul>	

## 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 involved 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.	Y
The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection of 7 September 2022 there was no PPG. At this inspection we saw a PPG had been started and 3 meetings had been held, the first in March 2023.</li> <li>We saw that the PPG was keen to know more about the practice and to help with patient surveys and open days.</li> <li>The PPG was involved in arranging a future open day to coincide with delivering the flu vaccine in 2023. They planned to have information stands to provide relevant information to patients, with a particular focus on digital inclusion. They planned to provide assistance to patients who may be able to access services and advice electronically with some support.</li> <li>The practice manager monitored comments received from patients and we saw that these were discussed with the team as appropriate.</li> </ul>	

### Continuous improvement and innovation

The systems and processes for learning, continuous improvement and innovation were not always effective.

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

### Examples of continuous learning and improvement

- The inspection of 7 September 2022 found due to the systems in place clinicians could not accurately learn from their mistakes or share good practice for the purpose of continuous improvement.
- At this inspection we found improvements had been made in this area. The partners had sought advice and monitored the improvements they were making.
- Although we saw evidence there was a focus on learning and improvement, evidence found during this inspection did not demonstrate a full understanding of processes required for non-clinical aspects of practice continuous improvement. Significant events were not well-managed and not all staff were aware of complaints made.

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

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

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

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

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

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

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