Care Quality Commission

Inspection Evidence Table

Hawthorn Medical Practice (1-592683393)

Inspection date: 18 and 23 August 2022

Date of data download: 17 August 2022

Overall rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good overall and Good in all key questions.

Safe Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Safe services.

At this inspection we have rated it as Inadequate because:

- Not all staff were trained in safeguarding to appropriate levels.
- Recruitment procedures were not effective.
- There was no assurance that Health and Safety, and infection prevention and infection control measures were effective.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimization.
- There was no assurance regarding the safety of dispensing services.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: Information supplied to us by the practice indicated that some members of staff had not completed safeguarding training. For example, five of the eight GP partners were not recorded as having completed Children's Safeguarding Level 3.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No (1)
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: (1) Some staff were employed as locums; however, the provider did not always undertake the appropriate recruitment checks or keep any records.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial March 2021
There was a fire procedure.	Partial
Date of fire risk assessment: Actions from fire risk assessment were identified and completed.	March 2021
(1) A Health and Safety Risk and Fire Risk assessment had been carried out by the practice's landlords of the main Skegness site in March 2021, but the practice was unable to provide us with a copy or details of any actions arising from it. An assessment had taken place at the main site on the day prior to our inspection but no details were available. The practice informed us that as far as they were aware no Health and Safety Risk Assessments had ever been completed for the branch site.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	No (1)

Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Partial (2) August 2022
The practice had acted on any issues identified in infection prevention and control audits.	No (3)
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

(1) We saw that one GP was recorded as not having completed infection and prevention control training. However, they approached us after the inspection and said that they had but it had not been recorded on the practice systems.

(2) There had been an audit completed in 2020 for the main site which had identified actions that needed to be taken.

(3) There was no evidence that the actions identified had been completed.

A further audit had been completed in August 2022 of the Skegness site which had again identified areas for improvement, however no action plan had been raised. Staff who had undertaken the audit told us they were unaware they needed to develop an action plan.

The practice was unable to provide any evidence that the branch site at Burgh Le Marsh had ever had an infection prevention and control audit.

The patient reception area at the Skegness site had a significant build up of dust, cobwebs and dead flies on high level surfaces. The provider told us that high level cleaning was in the hands of the building landlords and that they had changed cleaning contractors. They could not tell us when they were last cleaned.

We found some areas of the Skegness site showed visible signs of dirt and inadequate cleaning. For example, in clinical rooms we saw desks and computers were dusty, waste bins visibly dirty and cleaning records not consistently completed, one had not been completed since 9 August.

Some doors had a sticky residue from removed labels that were not cleanable.

In one room there was a sharps bin that was not dated as to when it was taken into use.

In the male staff toilet, we saw that the wall immediately adjacent to the urinal was heavily stained with inadequate cleaning.

Fabric covered chairs were in use throughout the Skegness building including in two clinical rooms we looked in. Additionally, the arm of a treatment chair in one room had been repaired with sticky tape. In another room the treatment chair had a damaged covering, negating effective cleaning. We noted that Vinyl covered chairs for every clinical room had been requested at the nurses' meetings in June and July 2022, but the request had not been taken up.

Amongst the equipment used to deal with a medical emergency there was an aurascope which was visibly contaminated with what appeared to be ear wax. The checklist for the emergency equipment listed it as a required item and indicated that it was present and ready for use. It was shown as having last been portable appliance tested in 2018.

Infection prevention and control (IPC) was a standing agenda item at clinical governance meetings but the IPC lead, a nurse, did not attend the meetings. We looked at the minutes of five meetings and in only one was there any reference to infection prevention and control, and that concerned some out-of-date stock.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial (1)
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial (2)
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial (3)

Explanation of any answers and additional evidence:

(1) Staff we spoke with confirmed that when fully staffed, there were just enough to cover the workload, including planned leave, albeit that the shortage of reception staff meant that there were delays in telephone answering. However, if there was any staff absence through sickness then the workload became overwhelming.

Recruitment of staff, reception staff had proved extremely difficult. The reception manager told us that they needed a minimum of five additional full time staff, preferably more.

(2) Reception and administration staff had completed sepsis training but were not up to date with basic life support training with some having last completed the training in 2014 or had never completed it according to the practice training records.

(3) We put it to the provider that the level of staffing across the practice, excluding GPs, was lower when compared to comparator practices within their primary care network. The practice employed 2.7 whole time equivalent nurses. This gave a nurse to patient ratio of 1:6559. The other two practices in their primary care network, with similar patient demographics, had nurse to patient ratios of 1:2289 and 1:1986. The Integrated Care Board (ICB) average ratio was 1:2469.
The direct patient care ratio was 1:3275 compared to the ICB average of 1:1934

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. [1]	Yes

There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.30	1.01	0.79	Variation (negative)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	9.6%	11.6%	8.8%	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 Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	7.46	5.42	5.29	Significant Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	349.2‰	218.7‰	128.2‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.03	0.84	0.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	9.5‰	8.5‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No (1)
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. [1]	No (2)
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.	Yes
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. [2]	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No (3)
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	No (4)
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence, including from clinical searches.

(1) The practice told us there was no audit to demonstrate the prescribing competence of non-medical prescribers, and there was no review of their prescribing practice supported by clinical supervision or peer review.

Medicines management	Y/N/Partial
(2) The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Patients were having blood tests arranged via the hospital, but the provider was not routinely recording that these indicated it was safe to continue prescribing the medicines. There were 34 patients with hypothyroidism who have not had thyroid function test monitoring for 18 months or more. We looked at the records of five patients and saw one had last had a thyroid stimulating hormone (TSH) test in June 2019, but prescriptions for thyroxin had been issued as recently as August 2022. None had a medication review coded within the last 12 months and there was no evidence that monitoring had been checked prior to issuing the last prescription for any of the five patients records we looked at. There were 60 patients who were prescribed methotrexate. Of those, two had not had the required monitoring. However, we saw that the practice had been proactive in ceasing prescribing for these patients who had not responded to requests for monitoring. There were 26 patients prescribed Azathioprine. Of these, two had not received the appropriate monitoring. One had last had a blood test in December 2021 and the other in January 2022. The guidance is that monitoring should be carried out at least every 12 weeks. There were eight patients in receipt of lithium of which four had not received the required monitoring. Five patients prescribed Amiodarone had not received the required monitoring which was for a liver function test and thyroid function test (TFT) every six months. One patient had no record of a TFT ever being done, for one patient it was last done in 2015, one in 2018 and two in 2021. (3) Although the data showed that the practice had a significantly higher rate of prescribing Nitrofurantoin , Pivmecillinam and Trimethoprim they did not provide us with any evidence to show that had taken steps to ensure the appropriate prescribing of these antimicrobials. (4) The medicines to be used in the case of a medical emergency did not include midazolam and Diclofenac. There were no risk assessments in place to cover the omission of these two medicines.	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Partial (1)
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial (2)
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	No (3)
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes

Medicines management	Y/N/Partial
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	No (4)
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	n/a
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	n/a
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Partial
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes

Explanation of any answers and other comments on dispensary services:

(1) There was a lead GP for the dispensary, which was located at the Burgh Le Marsh branch site. The dispensary manager was also the reception manager. They had no previous experience of dispensing and had not been offered any training to upskill in this area. They did not work at the same site as the dispensary. When asked, they were unable to tell us how many dispensing patients there were or how many items were dispensed monthly.

(2) Whilst Standard Operating Procedures were in place, they were due for review.

(3) The practice did not take part in the Dispensing Services Quality Scheme and for that reason had not undertaken annual competency checks of the dispensers. The practice was unable to provide any explanation or assurances they had as to the competency of the dispensers.

(4) At the time of our visit the room temperature in the dispensary where the medicines were stored, and prescriptions prepared was 27 degrees. There was no policy or protocol in place to direct staff regarding regulating the temperature to ensure the efficacy of some medicines stored above the maximum recommended storage temperature of 25 degrees. There was a portable air conditioning unit in the adjoining room from which medicines were dispensed but no guidance of when it should be taken into use and no records kept of the ambient temperature. It was not operating during our inspection.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes

Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Six
Number of events that required action:	Six

Explanation of any answers and additional evidence:

The significant events recording and investigation was not particularly well recorded and it was not clear any learning had been disseminated. However, when we looked at the minutes of the clinical governance meetings, we saw that they had been discussed. As nurses, advanced nurse practitioners and nurse practitioners were not present at these meetings it was unclear as to how they would receive the learning, other than, as one member of staff told us, that if they wanted to see the minutes they could ask for them.

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

Event	Specific action taken
A patient with temporary weakness in one hand, suffered a transient ischemic attack (TIA) following surgery. They were known to have atrial fibrillation, but the facts had not been communicated to secondary care.	All GPs & ANP's should consider a TIA when a patient presents with or mentions weakness. They should make the appropriate referrals.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. [1]	Partial
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts, for example, regarding women of childbearing age prescribed teratogenic medication. However, we saw that an audit required in response to one alert regarding teratogenic medicine had been repeatedly put off for 14 months. It was documented that alerts were discussed at clinical governance meetings.

Effective Rating: Requires Improvement

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.

At our last inspection of this service on 8 September 2016 it was rated as Good for providing effective services.

At this inspection we have rated the service as Requires Improvement for providing effective services. This was because:

- The management of people with long term conditions was not always effective.
- The practice was not always unable to demonstrate staff had the skills, knowledge and experience to carry out their roles

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No (1)
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No (2)
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No (1)
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: (1) Patients with long term conditions did not have immediate and ongoing needs assessed by regular review or treatment updated due to backlogs in completion. Home visits for patients with long term conditions had not recommenced since the pandemic. (2) Not all patients with symptoms which could indicate a serious illness were followed up appropriately. For example, not all patients with an acute worsening of their asthma receive a timely follow up	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a dedicated telephone line for nursing and residential homes, community staff and East Midlands Ambulance Service to contact the practice.
- Advice and guidance were provided following requests for emergency contraception
- Referral to smoking cessation service and other locally commissioned community health and wellbeing services.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured 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. However, we saw that there was back-log of reviews. For example, between April 2022 and the day of our visit out of 3716 patients suffering from hypotension 260 had been reviewed and out of the 1524 patients suffering with diabetes 833 had received Hb1c to monitor the average blood sugar level to prevent deterioration in health.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. We reviewed the records of five patients with asthma who had two or more courses of rescue steroids in the last 12 months. One patient had not been followed up to check the response to treatment within a week of an acute exacerbation of asthma.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	118	131	90.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	131	146	89.7%	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	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	69.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	18.9%	67.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.3%	70.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	51.6%	56.8%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
Eligible patients were invited to take part in cancer screening programmes centrally and were outside of the control of the practice, although staff told us that they actively encouraged patients to take part.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

The practice had a suite of clinical audits that were run and re-run periodically. These included searches for patients prescribed sodium valproate, lithium and Sulfasalazine and patients with mechanical heart

valves. The practice had also completed two-cycle audits on patients prescribed the anticoagulant Apixaban and patients diagnosed with osteopenia.

Effective staffing

The practice was not always unable to demonstrate 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 (1)
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	No (2)
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No (3)
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

(1) A newly appointed manager had not been offered any training or up-skilling to enable them to effectively carry out their duties.

(2) Staff we spoke with told us they did not have any protected time for learning and had to do it (including the provider's essential training) in their own time without remuneration despite being told they would be paid for the time spent.

(3) Although we were provided with a timetable showing when staff appraisals were due to take place, the practice could not supply us with details of when the last appraisals had been carried out.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: Our clinical review of notes where a DNACPR decision had been recorded had identified where possible the patient's views had been sought and respected. We saw that information had been shared with relevant agencies.	

Caring Rating: Requires Improvement

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Caring services.

At this inspection we have rated the service as Requires Improvement for providing effective services. This was because:

- The provider could not demonstrate that they had taken any action to understand the deterioration in satisfaction levels or any actions to improve

Kindness, respect and compassion

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

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

Patient feedback	
Source	**Feedback**
CQC Share your experience	Although much of the feedback we received was negative in terms of access, both telephone and for face-to-face appointments, we received a high volume of comments that were complimentary about the caring attitude of clinicians and the standard of treatment and care.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	68.1% (78.4%)	83.4%	84.7%	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	68.5% (76.4%)	83.1%	83.5%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2022 to 30/04/2022)				
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 (01/01/2022 to 30/04/2022)	85.8% (92.9%)	92.8%	93.1%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	58.9% (75%)	72.3%	72.4%	No statistical variation

Any additional evidence or comments
All of the values in this part of the GP Patient survey had decreased since the last survey. The previous results are shown in brackets in each indicator. The practice could not demonstrate that they had taken any action to understand the deterioration in satisfaction levels or any actions to improve.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes (1)

Any additional evidence
(1) The practice carried out a continuing programme of gathering the views and feedback from patients using the digital triage and remote consultation system. Results were positive with high levels of satisfaction.

Involvement in decisions about care and treatment

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

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

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	86.1%	89.5%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	671 which was 3.8% of the practice list.
How the practice supported carers (including young carers).	The patient registration pack asked whether new patients are carers or have carers. The practice offered flexible appointments for patients who need carers and for carers working around the people they look after. The practice used and actively promoted a form to enable the person with care needs to give consent to sharing information with their carer. When patients have dementia or suspected dementia, GPs advised that it is important to get a diagnosis as this can also help support the carer. The patients and their carers should be signposted to Dementia Support Services. In addition to the needs of the patient, carers were also asked about any stress they might be under and whether they have had any time off. This enabled GP to assist in arranging respite care to give carers, especially if they are partners, a break.
How the practice supported recently bereaved patients.	One nurse told us that a letter of condolence was sent to the deceased's next of kin, but they did not know what other staff did.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing Responsive services.

At this inspection we have rated the service as Inadequate for providing Responsive services. This was because:

- People were not always able to access care and treatment in a timely way
- The practice had not responded to deteriorating levels of patient satisfaction
- It was unclear how learning from complaints they had been used to improve the quality of care.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	No
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

The premises were purpose-built as a GP surgery in 2003 to cater for a patient list of 9,000. The list was now virtually double that size. When we last inspected the practice in 2016 there were 13,889 patients. Lack of space for consultation rooms as well as administration functions were a barrier to improving services, for example providing minor surgery, but also to recruitment as there was nowhere to accommodate staff. Evidence showed that negotiations for the practice to extend into adjoining unused space in the same building and formerly used by community nursing, had been protracted and gone on for about three years. Staff expressed their frustrations about the delays and the negative effect it was having on staff and their desire to enhance patient services.

Practice Opening Times	
Day	**Time**
Opening times: Skegness	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm

Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Opening times: Burgh Le Marsh branch surgery	
Monday	8.30am to 5pm
Tuesday	8.30am to 5pm
Wednesday	8.30am to 5pm
Thursday	8.30am to noon
Friday	8.30am to 5pm
Extended hours appointments are available on two evenings a week.	
Extended access appointments are also provided by another provider at a surgery in a nearby village Monday to Friday 6.30pm to 8am and at weekends and Bank Holidays. These can be either face-to-face or telephone consultations.	
On-line GP consultations were available to patients by smart phone from 7am to 9.45pm.	

Further information about how the practice is responding to the needs of their population
• Patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • Before and after school appointments available with a GP or through Extended Hours, Extended Access and on-line appointments. • 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 adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more

flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	No
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes (1)
Patients were able to make appointments in a way which met their needs	No
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

Explanation of any answers and additional evidence:

Prior to the inspection we asked the practice to invite patients to provide feedback to CQC through our on-line tools. We received feedback from 299 people. Of those, 130 were positive comments. Of the remaining 169 negative comments, the themes that were evident were difficulty in getting through to the practice by telephone, lack of face-to-face appointments, rude reception staff, failure of GPs to call patients back when told that would happen and an inability to get long-term condition reviews.

We asked the practice to provide us with details of the number and type of appointments that had been completed by GPs, Advanced Nurse Practitioner (ANPs) NP and Nurse Practitioners (NPs) in three weeks, namely 13-17 June, 11-15 July and 15 -19 August 2022.

- For 13-17 June there had been a total of 884 appointments of which 295 (33.34%) had been face-to-face consultations.
- For 11-15 July there had been a total of 760 appointments of which 285 (37.5%) had been face-to-face consultations.
- For 15-19 August there had been a total of 739 appointments of which 312 (42.2%) had been face-to-face consultations.

The widely accepted number (as per, for example, The British Journal of General Practice) is between 70 and 72 appointments per 1,000 patients per week. These figures would indicate that for a list size of 17,777 one could expect to see around 1,239 appointments per week. In addition, the patient demographics and higher than average disease prevalence (the list is weighted to 22,958 as a reflection of enhanced need) would indicate the need for more appointment availability.

There was a back-log of long-term conditions reviews. Home visits to the housebound to conduct long-term condition reviews had not re-started post pandemic.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	21.0% (22.3%)	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	35.6% (45.8%)	59.2%	56.2%	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 (01/01/2022 to 30/04/2022)	38.5% (53.8%)	56.6%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	68.0% (77.4%)	76.4%	71.9%	No statistical variation

Any additional evidence or comments
Data from the GP Patient survey showed that positive patient feedback had decreased since the last survey. The previous survey figures are shown in brackets in each indicator. The provider informed that as a result of the known issues regarding telephone access the telephony system had been upgraded. The practice could not provide us with any evidence or audit of telephone performance such as average call waiting times, longest call waiting times or call abandonment rates that might indicate any improvement or worsening of performance.

Source	Feedback
For example, NHS Choices	There were three reviews posted on the NHS website since August 2021. Two were negative and concerned access and one positive which was complimentary about the care and treatment the respondent had received.

Listening and learning from concerns and complaints

Complaints were listened and responded to, but it was unclear how they had been used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	18 (1)
Number of complaints we examined.	18
Number of complaints we examined that were satisfactorily handled in a timely way.	18
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Unknown

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial (2)

Explanation of any answers and additional evidence:

(1) We were provided with details of complaints that had been received between May 2021 and March 2022. Complaints for each month were recorded on separate documents.

(2) There had been no analysis to help identify common themes and although learning had been identified from some complaints there was no evidence of how or when it had been cascaded to staff. We could not identify if any of the complaints had been referred to the Ombudsman

Example(s) of learning from complaints.

Complaint	Specific action taken
	We were unable to ascertain how learning from complaints had been embedded.

Well-led Rating: Inadequate

At our last inspection of this service on 8 September 2016 it was rated as Good for providing well-led services.

At this inspection we rated the service as Inadequate for providing well-led services. This was because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- There was no credible strategy to provide high quality sustainable care.
- The overall governance arrangements were ineffective.
- There practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- In the absence of a patient participation group or other patient forum the practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes (1)
They had identified the actions necessary to address these challenges.	Yes (2)
Staff reported that leaders were visible and approachable.	Yes (3)
There was a leadership development programme, including a succession plan.	No

Explanation of any answers and additional evidence:

1. It was clear from staff that we spoke with, and feedback forms we received, that leaders prioritised patient care and wanted to improve accessibility to and improve services. The physical constraints of the building made this challenging, as it had been purpose built to cater for 9,000 patients. The practice now had 17,777 patients. Negotiations to occupy more rooms within the building but not currently used by the practice had proved very protracted and frustrating. There was a desire to provide additional services, for example minor surgery, but these were on hold due to the accommodation constraints. The partners were clear that the additional space would be a major factor in them improving services, but it was unclear how this would help, bearing in mind the low staffing levels.
2. Staff at all levels also told us that they were very short-staffed, especially on reception which resulted in excessive demands being made of them and the expectation of them providing the necessary cover. One person occupied the reception desk at the Skegness site, and we observed that the self check-in machine was out of order, placing additional unnecessary demands on the receptionist. For example, during our visit we noted that patients were queuing outside of the building and into the car park in order to check in for their appointment. The practice employed 33 staff in total. Of those 10.85 WTE were reception and dispensary staff, but these were spread

across both sites. It is acknowledged that recruitment at all levels was difficult on the Lincolnshire coast and not confined to this practice. Staffing levels were low when compared to similar practices.

3. Staff feedback indicted that generally GPs were visible, especially as the duty GP was located behind the reception area.

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No (1)
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial (1)
Progress against delivery of the strategy was monitored.	No

Explanation of any answers and additional evidence:

(1) We were not provided with the practice's vision in a written format. There was no mention of it on the practice website. It was clear however that the partners were keen to expand the range of services they offered, for example minor surgery but had been prevented for doing so by the constraints imposed by the limited accommodation.

(2) Of the 20 staff feedback forms we received, five respondents said that the practice had a vision, three stated they were unsure, and the remainder stated there was no vision. None of the 20 said they had been involved in developing the strategic planning (mission statement, vision or values) of the practice.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes (1)
Staff reported that they felt able to raise concerns without fear of retribution.	Yes (2)
There was a strong emphasis on the safety and well-being of staff.	Partial (1)
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes

Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

(1) All staff we spoke with and written feedback we received expressed concerns regarding the low numbers of staff, in particular reception staff. We were told that this group of staff were working at the limit of what was possible. Although we accept that recruitment was a major issue in this part of Lincolnshire, we were not provided with any assurances by the practice that they had taken steps to seek an alternative solution. Low numbers of reception staff resulted in long delays in telephone answering and staff told us that this in turn had a knock-on effect in heightening tension and the potential for conflict with patients when they eventually got through to the practice. Although the practice had installed a revised telephone system there appeared to be a reliance on a call-back option to mitigate the situation. The practice could not provide any evidence that this was the case.

(2) Staff feedback indicated that they would be confident in reporting any concerns and the majority thought they would be listened to.

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

Source	Feedback
CQC staff feedback forms	Prior to the inspection we invited all 33 members of staff to provide written feedback, anonymously if they so wished. We received 20 responses. Generally, respondents were positive about working relationships and team working. Common themes that ran through the responses was short staffing, increased pressure of work and lack of physical space within the practice to enable them to improve the patient experience. Some respondents had stated that they did not think that the GP partners supported the managerial staff sufficiently.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No (1)
Staff were clear about their roles and responsibilities.	No (2)
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

(1) We were provided with a list that showed which of the eight GP partners, and some staff, were responsible for each area of service delivery. This included prescribing and dispensary, safeguarding, infection prevention and control, long-term conditions etc.

We noted that the lead for infection and prevention and control was a nurse and that no GP had oversight. The nurse lead did not attend clinical governance meetings, despite the IPC being an

agenda item. We looked at the minutes of five meetings and in only one was there a record of an infection prevention and control related matter, which was in respect of some out-of-date stock in a consulting room.

There was no named lead for performance or quality improvement.

The records of the clinical meetings indicated that perhaps not enough time was set aside for them and many matters were not resolved or even discussed and were postponed to subsequent meetings. For example, we saw in the minutes of the meeting held in October 2021 an item had been brought forward from March 2021 which concerned an audit of patients prescribed carbimazole being changed from 10mg to 5mg. This action was still outstanding as recorded in the minutes of the meetings held on 23 February 2022 and 25 May 2022.

Nursing staff, nurse practitioners and advanced nurse practitioners did not attend clinical governance meetings.

(2) Whilst staff that we spoke with knew what was expected of them, in one case they had been tasked with managing the dispensary when they had no experience and had not been offered any training in that area, regardless of whether the demands of their other duties would have facilitated that.

We found instances of 'silo' working, with nurses for example, adopting a methodology without knowing what other nurses were doing in the same circumstances.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No (1)
There were processes to manage performance.	Partial (2)
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No (3)

Explanation of any answers and additional evidence:

(1) The practice IT system, not the clinical IT system, was described as not secure. We were made aware of an occasion recently where a GP inadvertently deleted a nurse clinic and another instance of a member of staff deleting compliance records. The practice did not have resilience built into their governance systems. For example, some members of senior staff held information that was inaccessible to other members of staff. This posed a risk to the practice.

(2) We were made aware of a performance issue in relation to a member of staff. No formal investigation was carried out and not actions identified to help prevent re-occurrence.
(3) There was no evidence that the practice had an effective quality improvement programme.

The practice did not always have systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	No (1)
There were recovery plans in place to manage backlogs of activity and delays to treatment.	No (2)
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: (1) The issues with telephone access and lack of audit or analysis made active monitoring unquantifiable. (2) There were back-logs in long-term condition reviews that had not been addressed. For example, for patients diagnosed with hypertension, 260 of 3,716 reviews had been completed. The practice had not recommenced the reviews of patients with long-term conditions who were housebound or living in care homes.	

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.	No
Performance information was used to hold staff and management to account.	No
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The partners were aware of the patient dissatisfaction regarding access to services as demonstrated in the GP patient survey. They had installed a new telephone system but had not used the data available from the system to monitor and improve performance. We were informed that nobody knew how to	

collect the data. They had not been in contact with the equipment providers to receive the necessary instruction and training.

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice did not always 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 (1)
The practice had an active Patient Participation Group.	No (2)
Staff views were reflected in the planning and delivery of services.	No (3)
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: (1) Although the practice had gathered patients' feedback though the Friends and Family survey, there was no evidence to show that any views expressed had been considered. There were some changes evident resulting in the investigation of patient complaints. The practice had reacted to mounting pressures regarding the telephone system and had updated it in March 2022, including a call-back facility. The practice had not carried out any survey or feedback exercise to gauge any impact of the change.	

(2) The practice informed us that there had been no Patient Participation Group for some years, stating there was no interest from patients.
(3) Feedback from staff was mixed. Some said they thought their views were considered, others that they were not. We were provided with an example of a staff suggestion resulting in a change in the telephone answering message.

Feedback from Patient Participation Group.

Feedback
There was no patient participation group

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No

Explanation of any answers and additional evidence:
Staff told us and the practice confirmed that there was no protected learning time and staff were expected to complete their training, including the providers essential training outside of working hours. The dispensary manager who was newly appointed and without any experience had not been offered training in dispensing or dispensing management.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have 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.