

# Care Quality Commission

## Inspection Evidence Table

**Dr Azim Khan (1-534575840)**

Inspection date: 5 and 12 July 2022

Date of data download: 27 June 2022

**Overall rating: Inadequate**

**Safe**

**Rating: Inadequate**

At our previous inspection we rated the practice as Good.

At this inspection we have rated it as Inadequate. This is because:

- The practice could not provide assurances that they followed recruitment procedures that ensured the suitability of staff to work in a health care setting.
- There was no evidence of staff being vaccinated in line with the UK Health and Security Agency guidance.
- Effective infection and prevention control measures could not be assured.
- There was no system to ensure that in the absence of key members of staff, patient care and treatment was not compromised.
- Temporary staff had not received induction upon commencing work at the practice.
- Not all clinical staff had completed training to help identify and deal with sepsis.
- The practice could not demonstrate the prescribing competence of non-medical prescribers, including clinical pharmacists.
- The process for monitoring patients' health in relation to the use of medicines including high risk medicines had not been effective.

**Safety systems and processes**

**The practice did not 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.	No
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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Disclosure and Barring Service (DBS) checks were undertaken where required.	P (1)
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 (2)
<p>Explanation of any answers and additional evidence:</p> <p>(1) Of the three recruitment files we examined, one for a salaried GP did not have any evidence of a DBS check, another GP had a DBS check for 2016 and the other for another member of the clinical team had a DBS from another employer. There was no risk assessment in place for staff who had not had a DBS check.</p> <p>(2) Although health visitors were invited to attend meetings the provider informed us that they very rarely did so. The practice had access to the Multi Agency Safeguarding Hub to progress any concerns.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>(1) Generally, recruitment files were not well kept and did not contain the information required under Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014. For example one of the recruitment files for a member of the clinical team did not contain an application form or C.V., no contract, no employment history, no proof of identity, no references, no evidence of a DBS check, no induction checklist, no appraisals and no record of immunisation status. Further there was no evidence of them having received the confidentiality policy. A file for a locum GP, who had been a regular locum since 2017 had no evidence of references being taken up, no DBS check, no induction checklist, and no record of immunisation status.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes 23 June 2022
There was a fire procedure. Date of fire risk assessment:	Yes
Actions from fire risk assessment were identified and completed.	Yes April 2022
<p>Explanation of any answers and additional evidence:</p> <p>(1) Information supplied to us by the provider showed that four of 12 members of staff had completed fire safety training.</p>	

## **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.	Partial (1)
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit:	22 May 2018 (2)
The practice had acted on any issues identified in infection prevention and control audits.	No (2)
The arrangements for managing waste and clinical specimens kept people safe.	No (3)
<p>Explanation of any answers and additional evidence:</p> <p>(1) Information supplied to us by the provider showed that five of 12 members of staff had completed infection prevention and control training. Of the seven who had not done the training, three were GPs and one an HCA who undertook phlebotomy. The practice policy on Infection Prevention and Control stated that training is included for all staff at induction and that hand hygiene training is mandatory and offered annually. We saw no evidence of hand hygiene audits or training.</p> <p>(2) There was no evidence that any infection prevention and control audit had been undertaken since 22 May 2018. At that audit several areas were highlighted for improvement and although an action plan had been drawn up to address the issues there was no evidence of the actions being completed. A 'mini' audit had last been completed in December 2019, but this did not include the treatment room where surgical procedures were carried out.</p> <p>The Unity Practice Infection and Prevention and Control Policy stated that the treatment room, where surgical procedures were carried out must have an Infection Prevention and Control audit every three months, to include hand hygiene. The practice provided us with an audit of minor surgery for 64 procedures carried out between June 2021 and June 2022. The audit did not touch upon infection prevention and control. When we discussed the frequency of infection and prevention control audits with the provider, they stated that didn't know that their own policy stated every three months.</p> <p>We saw that there were children's toys in the patient waiting room. The practice policy stated they should be cleaned monthly. The last recorded cleaning of the toys was on 20 July 2020. When we pointed this out the toys were immediately removed.</p> <p>(3) In the treatment room we saw that the sharps bin was shown as having been taken into use on 6 August 2021. Sharps bins should be replaced after three months use or when 2/3 full, whichever is the sooner.</p>	

## 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.	No (1)
There was an effective induction system for temporary staff tailored to their role.	No (2)
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial (3)

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	No (1)
<p>Explanation of any answers and additional evidence:</p> <p>(1) There was no process in place to cover practice nurse absences as a result of sickness or annual leave. The provider informed us that they had been unable to get any nurse cover for a period at the start of 2022 when the practice nurse was absent for a protracted period of time. The lack of practice nurse cover had resulted in a backlog of work upon their return, including over 100 long term conditions reviews. The provider had reduced nurse appointment times from 15 to 10 minutes to try and reduce the backlog. Staff told us that this did not provide enough time to effectively clean consultation rooms between face-to-face appointments with patients. The ratio of patients to nurse was 5,209:1. The local average was 3,480:1. The health care assistant covered blood samples and dressings normally done by the nurse. The care assistant covered blood samples and dressings normally done by the nurse.</p> <p>(2) The one temporary member of staff had no record of any induction.</p> <p>(3) The practice was equipped to deal with medical emergencies; however, we saw that three of 12 staff had completed sepsis training. One GP, the nurse and HCA had not completed the training.</p>	

#### 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.	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**

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) <small>(NHS Business Service Authority – NHSBSA)</small>	0.70	0.80	0.79	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). (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>	6.2%	8.1%	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) <small>(NHSBSA)</small>	5.05	4.61	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	76.4‰	130.0‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>	0.51	0.52	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	5.0‰	6.3‰	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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.	No (2)
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
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>(1) Although the provider told us that they maintained oversight of non-medical prescribers, this was not formalised and there were no written records or audit. This included prescribing pharmacists who worked on behalf of the practice but were employed by another provider.</p> <p>(2) The practice did not have an effective system to ensure the appropriate monitoring. For example, there were 64 patients prescribed an ACE inhibitor or Angiotensin II receptor blocker who had not been monitored within the last 18 months in line with current guidance. The earliest one dated back</p>	

Medicines management	Y/N/Partial
a further three years making them 4.5 years overdue. Additionally for three of these patients overdue blood monitoring, blood pressures had not been recorded either in the last five years.	

## 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:	Four
Number of events that required action:	Four
Explanation of any answers and additional evidence: All had been dealt with thoroughly and comprehensively. Actions had been followed through to implement learning.	

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

Event	Specific action taken
Nasal flu spray given instead of vaccination	Medicine to be administered must be checked carefully for each individual. Issues discussed at clinical meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: Although the practice dealt with such alerts, there was no system in place to ensure searches were periodically re-run. For an MHRA alert advising against prescribing the combination of clopidogrel, a blood thinning agent with omeprazole, an antacid, six patients were found on this combination which placed them at increased risk of a stroke or arterial thrombosis.	



## Effective

## Rating: Inadequate

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.

**The service is rated as inadequate for providing effective services because:**

- **Most patients received effective care and treatment that met their needs, however, some patients with long term conditions or potential long-term conditions had not received up to date monitoring and review.**
- **Not all staff had completed training essential to their role.**
- **Staff had not received induction.**

**Effective needs assessment, care and treatment**

**Patients' needs were not assessed, and care and treatment was not 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.	Yes
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.	No (2)
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 always receive an annual review in a timely manner and the monitoring through blood tests of some patients was not always within the recommended guidelines.  (2) Patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months were not routinely followed up (safety netting).	

**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.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- All patients with a learning disability were offered an annual health check. The practice had 16 patients listed on its learning disability register. Of those, 11 had received an annual health check in 2021/22. Of the remainder, one had refused and five had been subject to multiple contacts from the practice to encourage them to attend.
- There were 21 patients recorded on the mental health register. All had been contacted regarding a health review and ten had a review completed. The others had declined to attend.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- There were 23 patient prescribed Angiotensin-converting enzyme inhibitor (ACE inhibitors) or Angiotensin II receptor blockers (ARBs) who had not had a renal function test in the last 18 months. Five of those patients had not had a test in the last five years.
- Not all patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For example, we looked at the records of five patients with diabetes. Three of those patients were overdue an annual diabetic review. In one case the last review was in July 2019. Several of the medication reviews were overdue and when they had been done by a GP were not structured so it was difficult to see the content of the review clearly. Where they had been done in terms of a nurse led annual diabetic reviews or structured medication reviews, they were of very good standard as they were template driven.
- We looked at the records of five patients with hypothyroidism who have not had thyroid function test monitoring for 18 months. We saw that one patient had not had a blood test since December 2017 and of the other four we looked at two had been done in 2019 and two in 2020. It was clear that in the days leading to our inspection the practice had identified those due monitoring and had sent text messages to them. This does not provide any assurance that the monitoring is adequate in terms of safety of patients.
- We looked at the records of five patients with asthma who have had two or more courses of rescue steroids in the last 12 months. Some of the consultation records at the time of issue of the Prednisolone were not detailed enough and didn't cover surrogate markers for the level of

oxygen saturation and airway resistance. Only one patient had been followed up to check the response to treatment within a week of an acute exacerbation of asthma. (safety netted).

- In the absence of the practice nurse for a six week period in early 2022 there had been no process in place to ensure that the reviews were done, resulting in a substantial back-log of over 100 long term condition reviews when the nurse returned to work.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs.

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)	33	36	91.7%	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)	29	31	93.5%	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)	29	31	93.5%	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)	28	31	90.3%	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)	42	45	93.3%	Met 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: 31/12/2021) (UK Health and Security Agency)	77.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	28.9%	64.5%	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)	70.0%	67.7%	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)	65.4%	55.7%	55.4%	No statistical variation

## Monitoring care and treatment

**The practice had a 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

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

<p>The practice provided us with three clinical audits, one regarding anticoagulation therapy in patients with atrial fibrillation, one concerning patients with diabetes mellitus during the covid pandemic and one concerning outcomes from minor surgery performed at the practice.</p> <p>The minor surgery audit highlighted that the expiry dates of local anaesthetic in two cases was not recorded. This was highlighted and a stricter regime implemented to ensure 100% compliance.</p>
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Any additional evidence or comments
The practice rate of accident and emergency attendances was lower than both the Integrated Care Board and national average.

## Effective staffing

**The practice was 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.	No (1)
The practice had a programme of learning and development.	No (2)
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	No (3)
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.	Yes
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.	n/a
Explanation of any answers and additional evidence:	
<p>(1) The practice provided us with a details of the training completed by staff which was undertaken both online and in protected learning time. Of the provider's mandatory training none of the 12 members of staff had completed the confidentiality training, five had done information governance, four fire safety, seven infection prevention and control, two Mental Capacity Act, one consent, none had completed Health and Safety training, six children's safeguarding and seven adult safeguarding. Three had completed equality and diversity training. Those that had not completed the mandatory training included clinicians.</p> <p>(2) For Heath Care assistants (HCA) employed since April 2015 we expect to see evidence of how induction programmes include Care Certificate standards. There was no such evidence and the HCA we spoke with told us it had never been mentioned and they were not aware of it.</p> <p>(3) The staff files we looked at did not include any evidence of induction records.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <p>The provider informed us that the intermediate care team was under-resourced, but there was a Community Matron as part of the frailty team. There was no occupational therapist, so patients had to be referred to secondary care. The practice did have access to social prescribers, first contact physiotherapy and paramedics who completed home visits who were provided by the primary care network.</p>	

## 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 (1)
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
<p>Explanation of any answers and additional evidence:</p> <p>(1) We saw evidence of an audit carried out into minor surgery where consent was considered and found to be present in all cases. DNACPR (ReSPECT) forms we viewed showed in every case that consent had been appropriately sought and obtained.</p>	



## Well-led

## Rating: Inadequate

At our last inspection we rated the practice as Good for providing well-led services.

At this inspection we have rated it Inadequate. This is because:

- The provider did not have clear oversight of the systems and processes required for the safe and effective delivery of the regulated activities
- Effective practice management was hampered through lack of experience and knowledge of systems and process and time constraints.
- Patient records held in paper format were not stored securely and so as to ensure their protection from loss or damage.

### 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
They had identified the actions necessary to address these challenges.	No (1)
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No (2)
Explanation of any answers and additional evidence:	
(1) The provider employed an assistant practice manager for 17 hours per week. The provider told us categorically that he was not the practice manager and that there was no other person undertaking that role. The assistant practice manager had been in post since January 2022 having never previously worked in a practice. They told us that handover from the previous post holder had been problematical, with insufficient time or opportunity to learn and familiarise themselves with the process and systems. They told us they frequently worked additional un-paid hours.	
(2) The provider told us that the covid 19 pandemic, difficulty in recruiting staff and an increase in the list size all impacted on the practice and the workload of staff. We found the provider to be optimistic and positive about the future. As a result of difficulties in recruiting GPs partners, succession planning was extremely difficult.	

### 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.	No
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: (1) Some staff who provided us with feedback stated that there was no vision or strategy. None of the six respondents stated that they had been involved in the strategic planning of the practice.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	No (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.	Partial (1)
Explanation of any answers and additional evidence: (1) Following a period of prolonged sickness, during which no arrangements were made to cover their workload, a member of staff returned to work to find that their patient appointment times had been reduced by a third in an effort for them to catch up on the back-log generated during their absence. (2) Information supplied to us by the provider showed that three of 12 members of staff had completed equality and diversity training.	

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

Source	Feedback
CQC pre-inspection feedback forms	We received six feedback forms from staff. Four of the respondents stated that they did not think there was a clear vision for the future of the practice and four stated that they did not feel supported by higher management. Five commented on staffing shortages, especially when trying to cover periods of staff sickness.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management. / 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.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: (1) The provider did not have a clear picture of the effect that employing a new, inexperienced assistant practice manager for 17 hours a week could potentially have on the practice. However, it was also noted that the issues pre-dated the employment of this member of staff and were out with their knowledge or / and control.	

## 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.	No (1)
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No (2)
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 provider did not have oversight or assurance that staff recruitment was appropriate or that staff were up to date with training they required be completed.  (2) The practice carried out minor surgery but had been no infection prevention and control audit completed since May 2018. We were provided with an audit of minor surgery outcomes; this did not encompass any infection prevention and control issues. The practice policy stated that there must be an audit every three months of areas used for minor surgery.  (3) We saw that patient records held in paper format were stored on open shelving in the reception area and in an upstairs unlocked room. There was no protection from foreseeable incidents such as fire or flood. There was no risk assessment in place. Contractors and other non-practice staff who had not been subject to a DBS check or other risk assessment, had access to the records.	

(4) Practice nurse appointments had been reduced from 15 to 10 minutes in order to catch up on a backlog of long-term condition reviews that had not been completed by the practice during the nurse's absence. This reduction did not provide sufficient time to effectively clean down between face -to-face appointments.

### The practice had 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 (1)
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.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	n/a
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 practice had a mixture of appointment types; however, the provider had taken the decision to remain open to face to face consultations throughout the pandemic period.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

## 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
Digital 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 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.	No (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) We were not provided with any evidence that patient views were taken into consideration, however we acknowledge that patient feedback received through the GP Patient survey was very positive. (2) The patient participation group was not active and had not met for some time, the last recorded meeting being in September 2019. The assistant practice manager told us they were in the process of trying to re-invigorate the group and recently received a request from a patient to join. (3) There was no evidence of staff being involved in shaping the planning and delivery of services. Staff feedback forms confirmed this. There were no practice meetings where staff could express their views, even though there was the opportunity during protected learning time when the practice closed for one afternoon a month.	

Feedback from Patient Participation Group.

Feedback
We spoke with a member of the PPG who told that prior to the pandemic they had been meeting every four to six weeks, but meetings had ceased and not re-commenced. They told us that the practice had been engaged with the group. They told us that the patients they represented considered the practice to be good and patients had been there for many, many years.

## Continuous improvement and innovation

**There were systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes (1)
Learning was shared effectively and used to make improvements.	Yes (2)
Explanation of any answers and additional evidence: (1) The practice hosted medical students from Nottingham University. One was present during our inspection. (2) Medical students were encouraged to undertake medical audit whilst on their placement at the practice, the results of which were shared with other clinicians.	

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