

# Care Quality Commission

## Inspection Evidence Table

**Dr Touseef Safdar (1-548913045)**

Inspection date: 7 July and 26 July 2022

Date of data download: 23 June 2022

## Overall rating: Inadequate

The practice has been rated as inadequate overall. We identified concerns with the governance of the practice to ensure the provision of safe, effective and well led services. In particular:

- Governance systems were not fully embedded and not all risks were proactively assessed and managed.
- There was a lack of a structured approach in the management of patients care and treatment with limited clinical oversight.
- There was insufficient governance oversight to monitor the quality and effectiveness of the service.
- There was a lack of leadership oversight.
- There was an absence of comprehensive systems and processes to monitor the quality and effectiveness of the service and care provided.

## Safe

## Rating: Inadequate

The practice is rated inadequate for providing safe services due to a range of concerns including, safeguarding, recruitment, safe systems and records, fire and health and safety, information to deliver safe care and treatment, medicines management and management of safety alerts.

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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
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.	N
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection:</p> <ul style="list-style-type: none"> <li>We found gaps and inconsistencies in safeguarding systems. We were unable to evidence that safeguarding was regularly reviewed and appropriate action was taken.</li> </ul> <p>At this inspection:</p> <ul style="list-style-type: none"> <li>We found some evidence of safeguarding systems in place, but we continued to identify gaps and inconsistencies in the monitoring and review.</li> <li>A further locum GP had been appointed as the safeguarding lead since our last inspection, however some non-clinical staff were not fully aware of who this was and had not been officially notified of the change.</li> <li>We reviewed a patient record where we previously identified a safeguarding concern and found that no action had been taken to review this further.</li> <li>We requested evidence that all staff had completed adult and child safeguarding. The provider sent us evidence that three non clinical staff were up to date with safeguarding training and two newly appointed staff members had commenced online training relevant to their role. We were only able to evidence that one out of three GP locums had been trained to level 3 safeguarding and were unable to evidence safeguarding training for a locum nurse. The practice told us they would send this information; however this was not provided.</li> <li>We found that there were up to date registers in place for adult and children safeguarding and patients who were housebound.</li> <li>We saw evidence that safeguarding was a standing agenda item in practice meetings that were held monthly. However we reviewed minutes of the last two meetings and found no safeguarding discussions had taken place and were unable to evidence how safeguarding was being actively managed, reviewed and monitored within the practice.</li> <li>We were told that a GP locum attended monthly integrated care meetings with another practice as part of multidisciplinary reviews of patients. We requested evidence of these minutes; however these were not provided.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>During our inspection visit we were unable to review any recruitment files or evidence of staff immunisations. We requested all information was sent to CQC as part of our inspection and received one sample for a non clinical staff member. We carried out a second site visit to review recruitment further and found that non clinical staff files were held in line with safer recruitment, this included staff immunisations. However, we were unable to review any information held for locum clinicians working at the practice.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2019	Not available upon request
There was a fire procedure.	Not available upon request
Date of fire risk assessment: October 2019 Actions from fire risk assessment were identified and completed.	Not available upon request
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The building was managed by NHS property services who carried out health and safety, premise, security checks, fire risk assessments and maintenance of the building every two years. The last review of this was in October 2019. We asked the provider for an updated copy of their health and safety assessments. They informed us they had contacted property services on a number of occasions and were awaiting this information, however this was not provided.</li> <li>There was no recent evidence that a fire drill had been carried out in the last 12 months. Fire extinguishers for the building expired in October 2021. We made the provider aware of this during our inspection.</li> </ul>	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 29 June 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A locum nurse who had been the infection control lead for the practice had left. They had carried out an infection prevention and control (IPC) audit in June 2022 which achieved an overall score of 100%. There was no areas for action following this audit. A replacement for the IPC lead had not been appointed at the time of our inspection.</li> <li>We requested evidence of staff training on IPC and found that non-clinical staff had completed online training. We were unable to evidence that clinical staff had completed IPC training.</li> </ul>	

## Risks to patients

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

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

#### Explanation of any answers and additional evidence:

- There was a system in place to manage staff absences to ensure that cover arrangements were in place for non clinical and clinical staff. However, we found that staffing remained a significant area of concern due to a high staff turnover. For example, all clinicians employed by the practice were locums. During the last 12 months the practice had appointed a clinical lead GP on three separate occasions. One out of two nurse locums had left the practice. The current GP clinical lead had been in post for nearly three months. Three out of six reception/admin staff had left the practice since our last inspection in December 2021 and three staff had recently been appointed, including a further apprentice. At the time of our inspection, the practice manager and a newly appointed receptionist were due to leave the practice at the end of July 2022. Feedback from staff reported concerns around the staffing levels at the practice.
- The insufficient staffing and lack of consistency at the time of our inspection did not assure us around the continuity and safe management of patients registered.
- At the time of our inspection there were plans to address these shortfalls and a new provider had been sought to take over the practice and address areas of concerns found.
- Non-clinical members of staff had completed online basic life support and sepsis training and understood the procedures to take when encountering deteriorating or unwell patients. We were only able to evidence that two out of three clinicians were appropriately trained in basic life support and sepsis at the time of our inspection.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in December 2021 we found issues with record keeping, inaccurate coding, gaps and inconsistencies in patient records and review, a lack of timely response and referrals to specialists and a lack of clinical oversight for the nursing team.</p> <p>At this inspection:</p> <ul style="list-style-type: none"> <li>• There still continued to be gaps in the clinical system. A review of patient records in relation to the clinical searches identified that care records were not managed in line with current guidance. For example, history, examination, management plans, safety netting and follow up were not adequately documented.</li> <li>• We identified on a number of occasions there were issues with clinical coding and recalling of patients at the practice. The gaps in clinical coding did not enable the appropriate support and review of patients' needs.</li> <li>• We found there was a system in place to monitor test results and action urgent referrals. A long-term locum GP worked remotely each day and would review and action test results as part of their role. However, we found examples where blood tests results for patients had been reviewed and action had not been taken where this was needed. We reviewed this further with the provider during our inspection who confirmed action had been taken to review this further.</li> <li>• A further clinical GP lead had been appointed at the practice, however there remained no formal clinical arrangements for oversight in place. We were told that if a locum nurse had any issues they would task or speak with a GP on-site, however at times this caused delays if the GP was working remotely or not on-site.</li> <li>• There was some systems for managing information coming into the practice. Staff were allocated workflow tasks to complete and the practice manager had oversight of this work to ensure appropriate levels of competence was maintained.</li> </ul>	

## Appropriate and safe use of medicines

### The practice had some 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) (NHS Business Service Authority - NHSBSA)	0.49	0.81	0.79	Variation (positive)
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)	1.9%	6.2%	8.8%	Significant Variation (positive)
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)	4.49	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	70.5‰	138.1‰	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) (NHSBSA)	0.33	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.5‰	8.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	N

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection we found:</p> <p>There was a lack of systems and procedures for supervision, peer reviews or clinical oversight. The processes for the safe handling of requests for repeat medicines were not always effective. We found examples where records were being coded as a review taking place, however there was no details recorded in the patient records and monitoring was not up to date. We identified gaps and inconsistencies in the management of patients medicines including a lack of structured medication reviews, and monitoring of patients on certain medicines. We found that some patient records did not accurately reflect up to date medicines they were actively prescribed.</p>	
At this inspection:	
<ul style="list-style-type: none"> <li>• National prescribing data showed that the practice prescribing for antibiotics was lower than local and national levels. Other prescribing indicators demonstrated the practice was in line with other practices locally and nationally.</li> <li>• There still however, remained concerns in the overall medicines management of patients prescribed high risk medicines and those that require long term conditions management. Our review of clinical records found that some patients had not received appropriate reviews or monitoring of their medicines and the provider was not always able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required.</li> <li>• We found inconsistencies in the recorded medicine reviews carried out. For example, we found reviews had been conducted without documenting the outcomes from the review and without</li> </ul>	

addressing required monitoring or changes to treatment that should have been identified during a comprehensive review.

- We found 19 patients prescribed Potassium sparing diuretic (a medicine used to treat hypertension, cirrhosis or heart failure) and eight patients who had not required monitoring.
- Five patients were identified as being prescribed amiodarone (a medicine used to treat or prevent heart rhythm disorders) and two patients had not had the required monitoring in the last 12 months.
- We found that 378 patients were prescribed Angiotensin-converting-enzyme inhibitors (ACEI) which are medicines for the treatment of high blood pressure and heart failure. We found that 39 patients had not had the required monitoring in the last 12 months.
- We found that 60 patients were prescribed a Direct-Acting Oral Anticoagulants (DOAC) a medicine used to treat or prevent blood clots. We found that 30 patients had not had the required monitoring and a creatine clearance in the last 12 months.
- We found that 11 patients were identified as being prescribed warfarin (a medicines used to treat blood clots) and two patients were identified as not having the required monitoring in the last 12 months.
- We found that 18 patients had been identified as having been prescribed more than 10 prescriptions for benzodiazepines or Z drugs in the past 12 months (these are medicines prescribed for anxiety, sleeping problems, such as insomnia and other disorders).
- We found that 44 patients were being prescribed gabapentin (a medicines used to treat epilepsy or nerve pain) who had not had a review in last 12 months. We reviewed five of these patients and found that four were at potential risk of harm.
- We found issues with the monitoring of lithium for three patients (a medicine used to treat patients with a mood disorder), and no action had been taken to review a patient who had authorised prescription limits. We found that no action had been taken to follow up a patient identified at our last inspection of non-compliance and found a patient prescribed a combination of Lithium and carbimazole (a medicine used to treat an overactive thyroid) whose blood tests required attention where there had been no action taken.
- We continued to evidence a lack of clinical oversight and identified gaps in the diagnosis of some patients with long term conditions and those patients that required further monitoring or review. We reviewed some patients where blood tests had been received by the practice and found that no action had been taken. We continued to identify a lack of clear record keeping that was not always consistently recorded in line with current guidance and legislation. This included lack of oversight of consultation records and poor alignment of health conditions to medicines to aid patients and other health care professionals.
- The lack of oversight and inconsistencies in the monitoring, coding and recalls of patients identified gaps. For example, we found that the practice had not taken appropriate action of blood results or reviewing prescription limits for patients on certain medicines prescribed.
- Whilst we found that some of the coding issues had been actioned from our last inspection, there was a lack of consistency or structured approach to address medicines management.
- The practice told us that they had recently employed a further nurse locum to support in the recalls and monitoring of patients, however we was unable to establish that a recall system was now in place for the safe monitoring and review of patients. During our inspection we sent details of patients with clinical concerns that required immediate action to the clinical lead who confirmed that this was being addressed.
- Where recommended emergency medicines were not routinely held, the practice had undertaken risk assessments.
- We saw fridge temperatures were routinely monitored and vaccines were stored appropriately.



## 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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: The practice had a significant events policy and procedure in place. We saw evidence that significant events were discussed in practice meetings held monthly. We reviewed minutes of practice meetings and saw that these were reviewed with practice staff.	

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

Event	Specific action taken
The incorrect patient information was given to a staff member to make a two week wait referral.	The staff member realised the error and the correct patient was identified, and the referral made. All clinicians were reminded of the process of checking patients information when making referrals and non-clinical members were reminded to double check the correct patient has been identified.
Patients were complaining that their prescriptions had not been actioned and was not being processed through the electronic prescription service (EPS).	On investigation the practice realised that the prescription ordering service (POD) were sending requests to locum GP's who no longer worked at the practice. The POD service was immediately notified of the correct contact details. All outstanding prescriptions were prioritised by the GP's working at the practice.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: At the previous inspection we found:	

- There was a process in place for managing Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts however this was not always effective. Whilst some safety alerts had been actioned, we found examples of alerts which were not acted on by re-visiting historic alerts.

At this inspection we found:

- The practice had taken action to review patients we identified during our last inspection in line with a safety alert, however the provider was unable to demonstrate that all relevant safety alerts had been responded to. For example, we continued to identify an issue with a patient prescribed a statin and calcium channel blocker had not been appropriately reviewed in line with the safety alert.
- We found that patients with asthma prescribed two or more prescriptions of rescue steroids had not been issued with an emergency steroid card in line with a 2020 NHS England and NHS Improvement National Patient Safety Alert (NPSA)- Steroid Emergency Care to support early recognition and treatment of medical emergencies.
- We found the practice did not have an effective system in place to ensure medicine safety information was incorporated into clinical practice, for example through discussion in regular clinical meetings or through regular audits to confirm that the individual locum doctors and other relevant clinicians had read or acted upon such alerts or new guidance.

## Effective

## Rating: Inadequate

### We rated the practice as inadequate because:

- Patients' needs had not been sufficiently assessed and cared for in line with evidence based guidelines.
- There was a lack of systems to keep clinicians up to date with current guidance.
- There was limited monitoring of outcomes of care and treatment.
- Patients who were vulnerable or had a long term condition had not been proactively monitored.
- Childhood immunisations, cervical cancer and breast cancer screening indicators remained below national averages;
- The practice had failed to use data and information from its clinical record system to drive improvements or monitor care
- Staff did not always have the training and skills to provide care and treatment.

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

### Effective needs assessment, care and treatment

**Patients' needs were 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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.	Partial
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Partial

Explanation of any answers and additional evidence:

At the last inspection in December 2021:

- A search of the practice clinical system showed that patients care, and treatment did not always follow evidence-based practice. We identified that structured annual medicines reviews were not always carried out which impacted on the care provided to the practice population.

At this inspection:

- Whilst we found some areas had been actioned since the last inspection there remained inconsistencies in patient care and monitoring and areas of concern that required actioning. We found that not all patients ongoing needs were fully assessed or reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.
- A random view of clinical records showed clinicians did not always assess patients' needs and deliver care and treatment in line with current guidance. For example, patients prescribed a high-risk medicine were not routinely monitored in line with NICE guidance and patients who are steroid dependent were not always issued a steroid card.
- We were unable to evidence any systems or action plans to help safely manage patients recalls or those with high risk monitoring, long term conditions and additional needs. Our clinical system reviews found not all patients had appropriate follow up, care and treatment. We continued to evidence issues with coding and missed diagnosis. For example, our searches found there were nine patients who had not been diagnosed and recorded as having chronic kidney disease. We found that five patients had not been diagnosed as having diabetes. We reviewed five of these records and found that three patients were identified as being at potential risk of being at harm.

## 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 an 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 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
- Patients with poor mental health, including dementia, were not always referred to appropriate services.
- At the time of our inspection the practice had employed an additional locum nurse to carry out patient reviews and monitoring.

## Management of people with long term conditions

### Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training. However, patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. For example, we found examples of patients on high risk and other medicines who did not have appropriate monitoring in place.
- The practice did not always have clear and accurate information to share with relevant professionals when deciding care delivery for patients with long-term conditions, as individual care records were not always accurate or up to date.
- We found examples of patients with an undiagnosed long-term conditions which had not been identified or recorded in their records, were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.
- Patients with long term conditions were not routinely monitored and reviewed. We found there was not always accurate diagnosis coded in the clinical system and patients were not informed or aware of the diagnosis. For example, we found that's nine patients had not been diagnosed with chronic kidney disease and five patients who had not been diagnosed with diabetes.
- 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. Some patients were not always offered an asthma management plan and overuse of medicines was not adequately monitored and acted on.
- Staff who were responsible for the review of patients with long-term conditions had received specific training.
- GPs did not always follow up patients where blood results needed further action.
- 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 not always offered rescue packs.
- The practice had a recall system in place however clinical searches we undertook continued to identify gaps in the recall system. The practice told us they had employed a further nurse locum to support medicine reviews, however we did not see any action plans on how this was routinely being monitored and reviewed to address this further.

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)	44	50	88.0%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	60	66	90.9%	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)	59	66	89.4%	Below 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)	62	66	93.9%	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)	59	63	93.7%	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>

### Any additional evidence or comments

- The practice has not met the minimum 90% for two out of five childhood immunisation uptake indicators. The practice was using locum nurses at the time of the inspection. The practice contacted the parents or guardians of children due to have childhood immunisations and had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice told us they had employed a further locum nurse two days per week to catch up on long term condition management, immunisations and cervical screening.

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)	63.7%	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)	5.2%	55.7%	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)	50.9%	57.0%	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)	56.5%	50.3%	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
The practice uptake for cervical screening and breast cancer screening continued to be significantly below target. The practice were using long term locum nurses to carry out cervical screening for patients and continued to follow up non-attendance, screen patients opportunistically and provide advice and information. The practice told us they had employed a further locum nurse two days per week to catch up on long term condition management, immunisations and cervical screening.

## Monitoring care and treatment

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

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

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

- There was little evidence to show that action plans had been implemented and had led to quality improvements. Clinical supervision or clinical meetings was not routinely carried out. The practice shared with us an audit that had been done by a pharmacist employed by the CCG which related to CCG management activities.

## Effective staffing

**The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Since our last inspection in December 2021 three non-clinical staff members had left the practice. The practice had successfully recruited three non clinical staff to replace them. The newly appointed staff were working through an induction with buddying arrangements in place.</li> </ul>	



We were unable to review an induction plan as this was not available at the time of our inspection.

- Training required by the provider was completed via an electronic training system in areas such as basic life support, fire safety, safeguarding, chaperoning, infection control, equality and diversity and information governance. We were provided with limited evidence that training for locum clinicians and unable to establish how this was maintained on an ongoing basis.
- We were unable to evidence that staff appraisals or one to one's had been completed for staff working at the practice since our last inspection. All five non-clinical staff members had worked for the practice for less than 12 months and all clinicians employed were locums.
- There was no evidence to demonstrate that the practice had assured themselves of the competencies of locum clinical staff working in the practice. Clinical staff were employed locums and were working autonomously and making clinical assessments. We were unable to confirm that there was a system in place to audit the ongoing safety of their clinical decision making or there were regular discussions through clinical meetings
- Non-clinical staff told us that they received support on an ongoing basis from the practice manager with an open door policy.

### Coordinating care and treatment

**Staff did not always work 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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice did not hold clinical meetings to discuss their most vulnerable patients. We were told that a locum GP attended integrated care meetings with another local practice monthly, however we were not provided with any evidence of this.</li> <li>• The practice had opted out of being in a primary care network (PCN), however PCN initiatives were available to practice patients.</li> </ul>	

### Helping patients to live healthier lives

**Staff were not always 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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial

The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Patients did not always receive the required monitoring of their health. Systems and processes had not always been effective, which meant that some patients had not had a structured and comprehensive medication review for the monitoring of high-risk medicines and long term conditions. We identified patients who had a missed diagnosis or had not been followed up further for review. We also identified where no action had been taken following the review of blood results.</li> <li>The practice was not part of a wider primary care network (PCN), however they had access to services offered within the PCN. We spoke with staff about initiatives to refer patients for extra support, however some staff were not aware of some of the services to signpost patients.</li> </ul>	

### Consent to care and treatment

**We were unable to evidence that the provider always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We were unable to evidence that staff had completed training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.</li> <li>We reviewed DNACPR as part of our inspection, however we were told that the practice had no patients with a DNACPR in place at the time of or inspection.</li> </ul>	

## Caring

## Rating: Requires Improvement

We rated the practice as requires improvement for caring because:

- Patients gave us negative feedback about staff attitudes.
- Results from patient survey results were lower than local and national averages and there was no action plan to address this further.

### Kindness, respect and compassion

**Staff did not always treat patients with kindness, respect and compassion.**

**Feedback from patients was mostly negative about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Although some reception staff had received customer service training in the last year, evidence from complaints sent to CQC and online patient feedback showed patients were negative about the way staff treated people.</li></ul>	

Patient feedback	
Source	Feedback
CQC feedback	Feedback told us that some staff were rude, aggressive and lacked knowledge on providing them with the information they needed. Other feedback included concerns of raising a complaint with the practice.
NHS Reviews	There was largely negative comments from patients in relation to the poor attitude of staff who reported staff were unhelpful and rude.

## 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)	70.4%	78.9%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	66.9%	76.9%	83.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	82.8%	89.4%	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)	56.2%	62.2%	72.4%	No statistical variation

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

Any additional evidence
The practice were below local and national outcomes for caring from the national patient survey results. There was no evidence of action plans made to improve this further.

## Involvement in decisions about care and treatment

### Staff did not always help patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Resources were available such as language line, however a hearing loop was not available in the practice.</li> <li>We found in several cases, patients were not provided with information to understand their care and treatment.</li> </ul>	

Source	Feedback
NHS UK	Feedback about the practice were negative about staff mannerism and responding to complaints.
Google Reviews	The ratings scores were 1.7 and 1.4 out of 5 stars based on 31 reviews, posted in the last 12 months. All comments were largely negative and included concerns about poor communications, lack of referral to community services, poor management and running of the practice, poor staff mannerism, careless practice, complaints not being managed and staff not helpful. However, there was a positive review about the GP being caring.

## 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)	81.5%	85.1%	89.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 12 carers which represented 0.3% of its practice population.
How the practice supported carers (including young carers).	Literature was available to support patients who were carers. Information was available on the practice website. All carers were eligible for a flu vaccination.
How the practice supported recently bereaved patients.	The practice would contact patients if appropriate. Literature and information were available for patients on bereavement services available locally.

### Privacy and dignity

#### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Requires Improvement

We rated the practice as requires improvement for responsive because the service did not always meet patient's needs, patients experienced difficulty accessing care in a timely way.

Responding to and meeting people's needs

**Services did not always meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw that the provider was aware of the needs of its population, however feedback from patients reported difficulties in obtaining appointments at the practice.</li> <li>The importance of flexibility, informed choice and continuity of care was not reflected in the services provided. We found that there had been a high turnover of staff working at the practice and found not all patients could not access flexible appointments to meet their needs.</li> <li>Although we found the practice made some reasonable adjustments when patients found it hard to access the service; we found there were areas where they were not providing reasonable adjustments. For example, we did not find a hearing loop used for patients with a hearing impairment on inspection.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am until 12pm and 3pm until 6pm
Tuesday	8am until 12pm and 3pm until 6pm
Wednesday	8am until 12pm and 3pm until 6pm
Thursday	8am until 12pm and 3pm until 6pm
Friday	8am until 12pm and 3pm until 6pm
	** appointment times varied amongst locum clinicians **

### 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 offered home visits and urgent those with enhanced needs and complex medical issues.
- The practice did not always liaise 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 not able to access same day appointments when necessary.
- The practice held a register of patients living in vulnerable circumstances and those 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	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Partial
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment	Partial
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: <ul style="list-style-type: none"> <li>• Patients reported difficulties in relation to poor access to appointments to meet their needs. We reviewed the appointment system and saw the next routine appointments with a GP was available with an average wait of two weeks.</li> <li>• Online appointments were not available through the practice website.</li> <li>• Interpreter services were available for patients who did not have English as their first language, however no hearing loop was available.</li> </ul>	



## 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)	61.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	47.0%	46.1%	56.2%	No statistical variation
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)	52.7%	48.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	58.6%	64.8%	71.9%	No statistical variation

### Any additional evidence or comments

- Results from the latest GP national patient survey published in July 2022 were mostly in line with other practices locally and nationally in the responses received to questions relating to patient experience, however other feedback reported concerns in relation to access to the practice.

Source	Feedback
CQC feedback	<ul style="list-style-type: none"> <li>A patient raised concerns in difficulties obtaining an appointment for ongoing care and treatment, resulting in them attending other services locally.</li> <li>Other patients had raised concerns in obtaining appointments to manage routine procedures and follow up's.</li> <li>Patient complaint around difficulties in obtaining a medicines review, resulting in them registering at another practice.</li> </ul>
Google Reviews	<ul style="list-style-type: none"> <li>Feedback from reviews reported difficulties in getting through on the telephone and delays in obtaining appointments.</li> </ul>

## Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: We saw evidence that complaints were reviewed each month in practice meetings to address areas of quality improvement in the practice.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complaint about the incorrect dose of medication being issued and staff attitude.	An apology was given to the patient. The complaint was investigated with secondary services who requested the dose the practice issued. The practice liaised with the prescription ordering direct service (POD) to ensure the correct dose was now issued. Staff attitudes was discussed at a practice meeting.
Patient complaint about dismissal of medical symptoms.	An apology was given, and a review was undertaken of the patients medical records and blood results resulting in patient treatment. The patient was contacted regarding the outcome and clinical coding protocols in place at the practice.

## Well-led

## Rating: Inadequate

### The practice is rated inadequate for well-led service because:

- We continued to identify concerns in the governance issues found at the previous inspection.
- Staff turnover was high, and moral was low.
- We found patients at risk of harm due to lack of monitoring and clinical governance or oversight.
- There was a lack of oversight and supervision of staff.
- There was no evidence the practice's performance was being discussed between staff and management.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
At the last inspection: <ul style="list-style-type: none"><li>• The practice was unable to demonstrate effective leadership and there remained inconsistencies in the management of patients care and treatment. The leadership team could not demonstrate they had the capacity to effectively manage the practice and oversee all areas of the practice adequately. We were unable to establish whether the practice had developed a succession plan for the protection of the practice, the patients and staff and we were not assured that there were long term arrangements in place to safely manage the service effectively.</li></ul>	
At this inspection: <ul style="list-style-type: none"><li>• We found concerns were still present and had not been fully resolved affecting the delivery, safety and quality of the service. Clinical meetings were not held, and management meetings did not address or support ongoing good quality patient care. We found a lack of systems and processes would support good governance.</li><li>• At the time of our inspection the lead GP had applied to cancel their registration with CQC. The practice manager had resigned, and a new provider had been sought to take over the running of the practice. CQC had received an application for a new GP partnership as part of the long term succession planning.</li></ul>	

## 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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff were clear that their roles involved meeting patients' needs. They aspired to deliver quality care, but the lack of adequate management and clinical leadership had resulted in ineffective and unsustainable systems to deliver and monitor it.</li><li>• The practice had not developed a business plan for the future of the service; however arrangements were in place for a new partnership to take over the running of the practice.</li><li>• Staff had recently been made aware of the provider changes and discussions were underway with staff on the future of the service. Although succession planning was underway and plans to manage the future sustainability and quality in patient care this was in the early stages of development.</li></ul>	

## 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.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the time of our inspection there remained instability within the service. Staff turnover remained high and staff told us there was insufficient staffing level to provide a safe and effective service. All non-clinical staff had worked for the provider for less than 12 months and all clinicians were locums. The practice manager and another member of staff had handed in their notice and a new provider had been sought and arrangements were currently underway to take over the practice. We spoke with the new provider who told us there were plans to address the challenges needed to strengthen resources and provide a safe service.</li> <li>We found that the culture of the practice was not always open and transparent. For example, staff had recently been made aware of the provider changes and no discussion had been held on the impact these changes may have.</li> <li>Staff meetings were being held on a monthly basis with standing agenda items such as complaints, significant events and safeguarding.</li> <li>The practice manager was the appointed freedom to speak up guardian, however, were due to leave the practice.</li> <li>We found that the complaints process had been reviewed and was being strengthened to capture complaints and investigate them and share learning to drive improvements, however patients continued to share dissatisfaction in the running of the practice.</li> <li>We saw evidence that some non clinical staff had undertaken equality and diversity training.</li> </ul>	

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

Source	Feedback
Staff feedback	<ul style="list-style-type: none"> <li>More staff are needed to reduce the pressure on staff who have taken on more of the workload.</li> <li>All staff work well and get along.</li> <li>Able to raise concerns with management.</li> <li>Staff reported being under immense pressure.</li> <li>Low morale and some staff unsure of the future of the service.</li> </ul>

## Governance arrangements

**The overall governance arrangements were not adequately effective in supporting good governance and management across the service.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection:</p> <ul style="list-style-type: none"> <li>We found there was no effective clinical oversight or systems in place. There was a lack of effective leadership oversight and no formal system in place to assess and monitor governance arrangements. We were not assured that there was a consistent approach to monitoring the quality and safety of the services provided and governance structures and systems did not always keep patients safe.</li> </ul> <p>At this inspection:</p> <ul style="list-style-type: none"> <li>We continued to identify areas of concern in systems and processes and found they did not always function effectively to enable safe, effective or responsive care.</li> <li>The provider had policies and procedures in place, however some of these had not been reviewed or were not available at the time of our inspection. We found that where policies and procedures did exist, they were not always followed to improve the care provided to patients.</li> <li>The provider did not provide suitable leadership for all staff working at the practice. For example a system to ensure clinical oversight or clinical meetings was not in place, nor could the provider evidence a regular review of the prescribing practice of locums.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence:	

At the last inspection we found there were ineffective systems to identify, understand, monitor and address current and future risks including risks to patient safety and there were gaps and inconsistencies in patients care and treatment

At this inspection:

- We continued to identify gaps and inconsistencies in patients care and treatment which did not always follow best practice guidance and these risks had not been effectively managed by the practice's own quality assurance system.
- The provider did not have a functioning system or forum for review which would enable the evaluation of services and give assurance of their suitability and effectiveness in meeting the needs of their patient population.
- We found a lack of appropriate communication, oversight and support which would enable the team to carry out their duties safely.
- We saw that there were previous risk assessments in place in relation to health and safety and the premises, however these had lapsed and there had been no appropriate follow up.
- There was little evidence of quality improvement taking place. Audits seen had not been instigated by the practice and improvement was needed. Although the practice had appointed an additional locum nurse to support with long term condition reviews, there was no clear action plan to address areas of medicine management and effective patient recalls.
- We followed up on areas that had been identified in the previous inspection and found that not all areas had not been effectively addressed. We sent clinical areas of concern to the GP clinical lead for follow up, who confirmed this was being actioned at the time of our inspection.
- There were no processes in place to manage performance. This was in relation to monitoring the care provided by locum GPs and ensuring the referrals they made to secondary care were carried out and followed up.

### 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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Partial
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	N
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Partial

Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Patients who were digitally excluded were able to book appointments via telephone or in person and could choose between face to face or telephone consultations.</li> <li>• Staff had access to personal protective equipment and the waiting room had been arranged to support social distancing. However, there was no appointed infection control lead at the time of our inspection.</li> <li>• The practice did not have any specific plans in place for the recovery of services due to COVID-19. However, they told us that they had recently employed a nurse locum to address backlogs relating to long term condition reviews, child immunisations and cervical screening.</li> </ul>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The systems in place to monitor performance were not always effective as we identified gaps and inconsistencies in patient care and treatment from our clinical searches and these were not identified by the practices use of data or were not analysed to identify areas for improvement.</li> <li>• There was no evidence to show how performance information would be used to hold staff to account.</li> </ul>	

### Governance and oversight of remote services

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



Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>At the time of our inspection face to face and telephone appointments were available for patients.</li> </ul>	

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

**The practice involved 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
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice received feedback from patients through the GP National Patient Survey and complaints. The majority of online reviews made within the last 12 months were negative with issues raised such as access, the running of the practice and attitude of staff.</li> <li>The practice was reviewing complaints with staff to improve services and the culture within the practice, however there was no active patient participation group in place.</li> <li>At the time of our inspection staff had recently been made aware of a new provider taking over the practice, however there had been no further discussions with staff.</li> <li>The practice was not part of any primary care network (PCN), a group of GP practices that work together to address local priorities in patient care.</li> </ul>	

### 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.	Partial
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>There was limited evidence of learning, improvement and innovation. Clinical audits were instigated by the CCG and evidence of actions taken in response were not clearly evident.</li> <li>Not all staff had received appraisals or one to one's in the last 12 months with which to discuss learning and development. Where issues had been identified these were not always effectively addressed and acted upon for example, health and safety, governance and medicines management.</li> </ul>	

- There was limited evidence of learning being shared effectively and used to make improvements. This was in relation to medicines management and patient safety alerts. Nursing staff were not involved in meetings.

#### 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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

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

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