

Inspection Evidence Table

Dr Isam Saleh

(1-495351031)

Inspection Date: 01 June 2023

Date of data download: 16/05/2023

Overall rating: Inadequate

At our last inspection in December 2016, we rated the practice as good overall and for each key question.

At this inspection we rated the practice as inadequate overall because:

- The practice failed to demonstrate they delivered safe and effective care to all their patients.
- The practice systems and processes in place did not ensure good governance to protect patients from the risk of harm.
- We found there was a lack of leadership and oversight from the provider to ensure services were delivered in a safe and effective way to patients.

Safe

Rating: Inadequate

At our previous inspection in December 2016, the practice was rated as good for providing safe services.

At this inspection, the practice is rated as inadequate for providing safe service because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were not met.
- There were significant gaps in systems to assess, monitor and manage risks to patient safety.
- Staff did not have the information they needed to deliver safe care and treatment.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.
- The practice did not have a system to learn and make improvements when things went wrong.

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.	N ¹
Partners and staff were trained to appropriate levels for their role.	N ²
There was active and appropriate engagement in local safeguarding processes.	N ³
The Out of Hours service was informed of relevant safeguarding information.	N ⁴
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	P ⁵
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 ⁶
<p>1,2,3,4,6 We found there was no system in place to safeguard patients who were vulnerable and at risk of harm. The safeguarding lead was unable to demonstrate full compliance with training requirements and was unaware of the appropriate referral processes. In addition, a member of nursing staff was only trained to Safeguarding Children Level 2, which was not in line with national guidance and the practice's policy, which stated level 3 was required. There was no evidence to demonstrate how information was reviewed and updated on an ongoing basis. There were no formal arrangements to share information with the multi-disciplinary team. Following the inspection, we saw evidence of a future booking onto a safeguarding training course for the safeguarding lead, yet there was no evidence that the risk resulting from the current lack of knowledge had been mitigated in any way. Additionally, there was no evidence to show the other parts of the training had been considered. Therefore, service users remained at risk of abuse not being identified, prevented, or reported as effective systems were not in place to safeguard children or vulnerable adults from potential abuse.</p> <p>5 We found that not all staff employed by the practice had a DBS certificate, for example, of the 5 staff files we reviewed, there was no record of a DBS certificate for one of the nursing staff. The practice did not have any awareness or oversight of this.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	P ²
Explanation of any answers and additional evidence:	

1. We found that staff recruitment files were incomplete, for example not all files had references or signed contracts. We reviewed 5 files and found issues in all of them. The practice had no oversight of any recruitment checks carried out for a new member of staff employed through a locum agency.
2. Whilst the practice had oversight of the vaccination status for some staff members, we found no information for the newly recruited member of staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N ¹
Date of last assessment:	09/01/2023
There was a fire procedure.	N
Date of fire risk assessment:	P ² June 2022
Actions from fire risk assessment were identified and completed.	N ³
<p>Explanation of any answers and additional evidence:</p> <p>1. The health and safety risk assessment completed on 9 January 2023 identified hazards relating to cabling in multiple areas of the practice. This had not been corrected by the time of this inspection. Following the inspection, we were told that the provider was planning to have an electrician remedy this, but there was no confirmed date for this work.</p> <p>We found that in 2 clinical rooms, the equivalent of a couch used for the examination and treatment of patients was not fit for purpose. They were not height adjustable, did not have a safe working load displayed and were only accessible by an open two-level step with no handrail. We saw that one of these was damaged and repaired with clear tape and another had a missing cupboard door. This equipment was not appropriately located for the purpose they are being used in that access to patients for the purposes of examination and treatment is severely limited. The use of this equipment had not been identified or evaluated within the health and safety risk assessment. There was a significant risk of injury or harm to patients and staff due to height, lack of adjustability, load bearing capability and accessibility.</p> <p>We saw that a Legionella Investigation Report had been completed by the practice manager on 22 September 2022. It was unclear if the practice manager was competent to carry this out. However, after the inspection the provider shared with us a certificate dated 25 May 2023 that confirmed no legionella bacteria had been detected.</p> <p>2,3 On the day of inspection the practice did not provide evidence that a fire risk assessment had been carried out however, after the inspection the provider sent details of an assessment carried out June 2022. During the inspection, we saw that 2 fire extinguishers were in a locked cabinet in the waiting area. The key was missing, and the extinguishers were therefore not accessible. Following the inspection, we were sent evidence to show that the extinguishers were now accessible following a contractor breaking into the cupboard. Further work was still required to secure these appropriately. We saw evidence of a visit by a fire company in 2020 where a required action was to remove boxes from underneath the electrical fuse panel in a store</p>	

cupboard due to the risk of fire. On the day of this inspection, this had not been carried out and the fire risk remained. The practice did evidence that the fire extinguishers had been serviced in December 2022 and the fire alarms in March 2023. The emergency lights had also been serviced in March 2023 which identified that 2 out of 8 lights were not working. We were not shown evidence that this had been rectified. Following the inspection the provider submitted evidence that all 8 emergency lights were working.

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.	P ¹
Infection prevention and control audits were carried out.	P ²
Date of last infection prevention and control audit:	06/06/2022
The practice had acted on any issues identified in infection prevention and control audits.	N ³
The arrangements for managing waste and clinical specimens kept people safe.	N ⁴
<p>Explanation of any answers and additional evidence:</p> <p>1. Whilst we were told that some staff members had completed training on infection prevention and control (IPC), this had not been completed by all relevant staff. According to the practice's oversight of staff training one of the practice nurses had not completed any IPC training. Following the inspection, we saw evidence that the nurse had completed training, but the practice had not had oversight of this until the inspection team highlighted the issue.</p> <p>2,3. We saw that an IPC audit had been started in April 2022 and was completed in June 2022 by the practice manager. This was not wholly effective as we saw that it was contradictory, for example, there was a statement that walls were clean when they were not and another stated that items were in date when they were not. In addition, the audit stated 'yes' to 'are the toilets clean?' but also stated there was dust and dirt on one of the toilets. Actions had not been completed. During the inspection we found that the practice was visibly dirty. We saw a dirty, used instrument on the floor in a clinical room which had not been correctly disposed of. We saw some areas in the practice where cleaning checklists had not been completed or were dated in the past for example the cleaning schedule on the wall of reception was dated 'Week commencing 27/01/2017'. There were no cleaning checklists for the staff or patient toilet areas. The cleaner had a checklist of areas to complete but there was no method to record completion, so no audit trail existed. We also saw that food and eating utensils were stored in a clinical room which was used for some patient activity and also as a staff rest room.</p> <p>During the inspection, we saw significantly out of date medicines including 2 tubes of lubricating gel which expired in September 2019 and April 2021. There were multiple blood glucose monitoring sets available in the practice which expired in January 2012 and July</p>	

2021, as well as multiple expired vials for blood collection. Therefore, we had no assurance that IPC risks were being assessed or managed safely. Following the inspection, we were told that the food had been removed, the dirty instrument had been removed, and a cleaning checklist had been made yet there was no assurance that all risks had been addressed. We were also told that a checklist will be used to demonstrate the future management of equipment and medication, yet it did not include a comprehensive list of specific medication or equipment to be checked and therefore we did not have assurance of oversight of all items.

4 During the inspection, we saw that bags of clinical waste were being stored on racks in the staff toilet antechamber. These bags were extremely foul smelling and staff had to pass through this room to access toilet facilities. Following the inspection, the provider informed us that a bin had been delivered for the storage of clinical waste bags awaiting collection although it was unclear where this bin would be stored.

Risks to patients

There were significant 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.	N ¹
There was an effective induction system for temporary staff tailored to their role.	N ²
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y 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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	N ⁴
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1, 4 We were told by staff that they had previously had to cancel booked annual leave due to staffing shortages. The provider told us they needed to carry out further recruitment as there were areas where staffing levels were insufficient. 2 We saw that there was no induction system for new staff members. We saw that a member of staff who had been newly recruited had no evidence of an induction. 3 Staff had recently attended resuscitation training provided by the Integrated Care Board (ICB). The practice had recently updated and amended their emergency equipment and medicines following advice given during an ICB quality visit. 	

Information to deliver safe care and treatment

Staff did not 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.	N ¹
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.	P ²
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	P ³
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. During our inspection we reviewed some patient records and we found inconsistencies in the quality of the record keeping. For example, not all medicines reviews contained sufficient detail to be assured that all medicines had been considered yet had been coded as medicine review completed. This posed a risk to patients and for other health professionals not having access to accurate information they may require to make safe decisions. 2. We saw minutes of meetings which were attended by the practice and other agencies. However, there were no regular meetings for staff in the practice. 3. We were told that the practice kept a log of all referrals. However, we saw an example of a letter being received from the practice in November 2022 which contained advised changes to a patient's medicine and by the time of our inspection, it had not been actioned by the practice. Therefore, we did not have assurance that the referral process into and out of the service was safe or effective. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.70	0.86	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of	3.9%	8.2%	8.1%	Variation (positive)

prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)				
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 (01/07/2022 to 31/12/2022) (NHSBSA)	5.92	5.46	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	102.2‰	102.6‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	3.28	0.68	0.56	Significant variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	7.7‰	6.9‰	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.	N ¹
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Not inspected ²
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/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P ³
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.	N ⁴
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.	N ⁵
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage,	N/A

administration, balance checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	P ⁶
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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 ⁷
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.	P ⁸
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> 1. We found that prescriptions were not kept securely, and their use was not being monitored in line with national guidance. Multiple prescriptions were stored in easily accessible, insecure locations with no logs kept with prescription numbers to enable the practice to monitor and log their usage. Following the inspection, we were told that changes had been made to the system for recording prescriptions but the evidence submitted did not provide full assurance. 2. Evidence relating to patient group directions and patient specific directions was not requested as part of this inspection. 3. As part of our inspection and with the consent of the practice, we used a suite of clinical searches on the practice system. Following these searches, we reviewed a sample of patient records. We saw that there was an inconsistent approach to the recording of medicines reviews completed by different clinicians. Some medicines reviews had been coded as completed but contained no details in the patient records. This posed a risk to patients and for other health professionals not having access to accurate information they may require to make safe decisions. 4. During the inspection, we saw a request from a hospital to decrease and potentially stop a patient's medicine in November 2022. This had not been carried out by the practice and the medicine was issued repeatedly. When we highlighted this significant concern to the practice, they told us that they would contact the patient and follow this up. 5. We reviewed the clinical records of patients prescribed medicines that required monitoring and found that not all patients had received all of the required monitoring. For example, we identified 4 patients who were prescribed a medicine which is used to treat auto-immune conditions, and 3 of these patients had not had the correct level of monitoring. Additionally, for 1 of these patients, the directions regarding how to take the medicine were unclear. 	

We identified 272 patients who were prescribed medicines used to treat high blood pressure and require blood monitoring. Our search showed 59 of these might not have had the required monitoring. We looked at 5 of these patients and found that 4 of the 5 patients were overdue blood monitoring. This included patients whose annual monitoring was overdue by between 2 and 5 years.

We identified 65 patients who had been prescribed more than 10 prescriptions of a class of medicines primarily used as a sedative but that have a high risk of addiction or dependency. We looked at 5 of these patient records and found that the records included advice regarding reducing the medicine in only 3 out of 5, and that 4 out of 5 patients had been informed about the risk of addiction.

6. We were shown evidence of a limited audit regarding antimicrobial prescribing which was undated. This showed that 5 out of 10 patients were prescribed antibiotics which did not follow national guidance. The actions in the audit did not include any learning or advice to adhere to current guidelines.
7. We saw that the practice held appropriate emergency equipment and drugs. This had recently been updated and amended following advice given during an ICB quality visit.
8. During the inspection, we found 2 clinical fridges which contained vaccines, both of which were unlocked hence medicines were not securely stored. One of these fridges remained unlocked despite us informing staff and we were subsequently told that the lock was damaged and so it was not possible for it to be locked. After the inspection, the practice told us that the lock will be repaired or replaced but we were given no timescale for this to be carried out.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	P ¹
There was a system for recording and acting on significant events.	N ²
Staff understood how to raise concerns and report incidents both internally and externally.	N ³
There was evidence of learning and dissemination of information.	N ⁴
Number of events recorded in last 12 months:	0
Number of events that required action:	Unclear ⁵

Explanation of any answers and additional evidence:

1. Staff told us that they would report any safety incidents to the practice manager, however as we were told there had been no significant events in the practice in the last year, it was unclear if concerns had been appropriately followed up and documented.
2. Whilst on site 2 events were shared with us. One relating to a telephone issues, changes to the messaging were made to ensure patients and callers were clear about where to call and whom to speak with. The second event related to a difference of opinion between clinicians and the system and process to manage repeat medicines. The outcome did not give assurance that there were clear governance processes in place to ensure all medicines were prescribed safely. In addition, we were told that a contractor had fallen through the ceiling in November or December 2022, from the loft into a storage room. We were told that the provider felt this did not constitute a significant event and hence it had not been written up as such.
3. We did not see evidence that staff were aware of how to report incidents externally.
4. We were told that there were no regular practice meetings and hence we saw no evidence of learning and dissemination of information.
5. It was unclear which event required action because these were not recorded.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N ¹
Staff understood how to deal with alerts.	P ²

Explanation of any answers and additional evidence:

1,2 The practice told us that they reviewed any safety alerts which they received by email. We were told that after recent advice from the ICB, these were now being stored in a folder on the computer. It was unclear how this information was disseminated to staff as no staff meetings were held and any casual discussions were not documented.

As part of our clinical searches, we reviewed the practice’s management of safety alerts. One alert we looked at related to patients taking a certain medicine used to treat diabetes where there is a rare but potentially serious risk of Fournier’s gangrene. The search identified 35 patients taking the medicine and we looked at the clinical records of 5 of these patients. Two patients were potentially at risk as they had not been given the appropriate warnings.

Effective

Rating: Inadequate

At our previous inspection in December 2016, the practice was rated as good for providing effective services.
 At this inspection, the practice is rated as inadequate for providing effective services because:

- 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.
- Patients with long term conditions were not always correctly monitored and treated.
- There was very limited monitoring of the outcomes of care and treatment.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- Staff did not always work with other organisations to deliver effective 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 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.	N ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N ²
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N ³
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P ⁴
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice told us they provided clinical staff with up-to-date guidelines and information via their NHS email accounts. However, the practice failed to demonstrate the systems and processes in place that monitored their performance to ensure clinicians used the most up to date information and worked in line with current evidence-based practice were effective. For example, patients on medicines that required monitoring were not being appropriately managed. 	

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

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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group when a nurse was available to carry this out, which was not on a regular basis or with a GP.
- The practice was unable to give us any data regarding the number of NHS health checks for patients aged 40-74.
- All patients with a learning disability were offered an annual health check. We were told that 14 patients were on the learning disability register in the practice and of these, 11 health checks had been carried out in the last year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- As part of this inspection, we used a suite of clinical searches. We looked at patients with asthma who had been prescribed 2 or more courses of steroids in last 12 months for an exacerbation of asthma. There were 254 patients on the asthma register. We saw that 7 patients had 2 or more steroid courses prescribed in the previous 12 months. We reviewed 5 of these patients and found that the guidelines were not followed to review these patients after 48 hours in all 5 cases. Additionally, these patients were not being given steroid cards where appropriate, and the provider told us they had no awareness of these cards which are commonly used.
- We identified 22 patients who had a potential missed diagnosis of Chronic Kidney Disease (CKD) stage 3, 4 or 5. We looked at 5 of these records and found that all 5 records had not been appropriately coded as the patient having CKD 3,4 or 5.
- There were 59 patients diagnosed with hypothyroidism. Of these, 8 (13.6%) showed as potentially not having had appropriate blood monitoring in the previous 18 months. We reviewed 4 of these patients and found blood monitoring tests were not up to date.

One of these patients' last blood test was in 2018 and was an abnormal result, yet the patient was had not reviewed the patient's medication or dosage.

- We identified 2 patients with CKD stage 4 or 5 who did not have a record of blood test monitoring in their patient record in the previous 9 months. We saw from hospital correspondence that they had received blood test monitoring at the hospital.
- We identified 32 patients with diabetic retinopathy who's latest HbA1c (average blood glucose level) was above 74. We reviewed the records of 2 of these patients and found that they had been appropriately monitored and followed up.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	38	39	97.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	33	38	86.8%	Below 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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	33	38	86.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	34	38	89.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	52	90.4%	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

We saw that the practice is below the WHO target for 3 of the childhood immunisations. Although the practice did not have dedicated immunisation clinics as there was limited nurse time in which these could be carried out, they were flexible with appointments for patients. GPs would also administer immunisations if required.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	49.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	50%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	50.7%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	50.0%	57.0%	54.9%	No statistical variation

Any additional evidence or comments

We saw that the percentage of persons eligible for cervical cancer screening who were screened adequately within a specified time period was significantly lower than the 80% target in England. At the time of the inspection, the practice told us that no cervical screening clinics were available for patients to book. We were told that clinics in the past were irregular due to short hours of nursing availability (6 hours a week total nursing hours). After the inspection the practice told us that they had been improving on their cervical screening performance and had dedicated nursing time to achieve this. They also told us they had reflected that they served a population of patients who were living in the area temporarily, and the screening programme was more challenging to deliver to them.

Monitoring care and treatment

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

Y/N/Partial

Clinicians took part in national and local quality improvement initiatives.	N ¹
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N ²
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Not inspected
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>1,2. We were shown 4 clinical audits which had been completed by the practice in 2022 and 2023. We saw very limited evidence of learning, or any changes implemented as a result of the findings. Additionally, some of the audits were undated and hence it was not possible to determine if a re-audit should have been completed.</p> <p>We did not ask the practice about their review of unplanned admissions and readmissions.</p>	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	P ¹
The practice had a programme of learning and development.	P ²
Staff had protected time for learning and development.	Not inspected
There was an induction programme for new staff.	N 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.	P ⁴
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 ⁵
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Not inspected
<p>Explanation of any answers and additional evidence:</p> <p>1,2 We saw that some staff members were overdue mandatory training, for example there was no evidence of any training in the Mental Capacity Act (MCA) for 2 clinical staff and MCA training was not on the list of required training held by the practice.</p> <p>3. The practice told us they had an induction process for new staff members, we did not see an example of a completed induction programme to support a new staff member.</p> <p>4,5 We saw that some staff members had completed annual appraisals. However, there was no clinical supervision in the practice and therefore competency of staff could not be demonstrated by the provider.</p>	

We did not ask staff about protected time for learning and development. We did not ask managers about the process for managing and supporting staff when their performance was poor or variable.

Coordinating care and treatment

Staff did not always work with other organisations to deliver effective care and treatment.

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N ¹
Patients received consistent, coordinated, person-centred care when they moved between services.	P ²
Explanation of any answers and additional evidence: 1&2: Multidisciplinary working was not consistently coordinated by the practice. For example, they did not have arrangements in place for meetings with external professionals such as social workers, health visitors and palliative care specialists. There were no formal safeguarding or palliative care meetings. Following the inspection, the practice told us that they would arrange to have specific meetings for safeguarding.	

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Not inspected
Patients had access to appropriate health assessments and checks.	P ¹
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	

1. The practice was unable to give us any data regarding the number of NHS health checks for patients aged 40-74. Therefore, we did not have assurance that these health checks were being offered to patients appropriately.
2. We did not ask staff about how they supported patients to be involved in monitoring and managing their own health.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Responsive

Rating: Requires Improvement

At our previous inspection in December 2016, the practice was rated as good for providing responsive services. At this inspection the practice is rated as requires improvement for providing responsive services because:

- Patients were not always able to access appointments in a timely way.
- The practice organised and delivered some services to meet some patients' needs yet the facilities were not being managed appropriately.
- Complaints were not used to improve the quality of care.

Responding to and meeting people's needs

The practice organised and delivered some services to meet some patients' needs yet the facilities were not being managed appropriately.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	P ¹
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	P ²
The facilities and premises were appropriate for the services being delivered.	N ³

The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice was responsive to the needs of most patients, however they had not provided sufficient clinics to ensure that patients who needed an appointment, for example, a cervical screening appointment were adequately cared for. There were insufficient nursing appointments to meet the needs of patients requiring cervical screening. 2. On the day of inspection, we saw that patients were waiting for significant lengths of time and a staff member absence meant that a whole clinic had been cancelled. 3. The facilities and premises were not appropriate for the services being delivered due to a lack of cleanliness and poor risk assessment processes. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 1pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • Patients had a named GP who supported them in whatever setting they lived. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

Access to the service

People were unable to access care and treatment in a timely way.

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

Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	P1
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> Patients could book appointments in person, by phone and online. They could also arrive at the surgery and wait to be seen. However, we saw significant waiting times for patients to be seen in the practice as the clinician was busy and running late. Due to a lack of nursing appointments, patients were not always able to book nursing appointments in a timely manner. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	55.0%	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)	56.1%	45.9%	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)	65.2%	46.0%	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)	71.9%	65.6%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	No reviews had been posted.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Unclear
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	4
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.	N ¹
<ol style="list-style-type: none"> 1. We saw no evidence that complaints were used to drive improvement, and they were not discussed with staff in meetings as regular practice meetings were not held. There was no evidence of any changes or learning as a result of these complaints. 2. Information about complaints, investigations and details of complaint outcomes were minimal. We saw that apologies were offered, however, information on how to escalate concerns to the Parliamentary and Health Service Ombudsman was not included in complaint responses. 	

Well-led

Rating: Inadequate

At our previous inspection in December 2016, the practice was rated as good for providing well-led services.

At this inspection, the practice is rated as inadequate for providing well-led services because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice could not demonstrate a clear vision, and that vision was not supported by a credible strategy to provide high quality sustainable care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not act on appropriate and accurate information.
- The practice did not involve the public, staff and external partners to sustain high quality and sustainable care.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

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.	N ¹
They had identified the actions necessary to address these challenges.	N ²
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N ³
<p>Explanation of any answers and additional evidence:</p> <p>1,2 Information, feedback and evidence gathered during our inspection highlighted systems and processes which had failed to ensure all patients received safe care and treatment. There was a lack of effective oversight in some areas. This included poor performance in the management of medicines, the management of long-term conditions, health and safety, safeguarding, the management of information and infection prevention and control. There was a lack of process to identify learning and improvement.</p> <p>3 The partnership was unclear of the succession plan for the future and there was no leadership development programme in place.</p>	

Vision and strategy

The practice could not demonstrate a clear vision, which 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.	P ¹

Staff knew and understood the vision, values and strategy and their role in achieving them.	P ²
Progress against delivery of the strategy was monitored.	N ³
<p>Explanation of any answers and additional evidence:</p> <p>1,2 Staff told us that whilst they felt the practice had a clear vision for the future, they had not been developed collaboratively.</p> <p>3, There were limited audits completed at the practice and no re-audits to demonstrate improvements.</p>	

Culture

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

	Y/N/Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	N ¹
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	N ²
Staff had undertaken equality and diversity training.	N ³
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. There was a lack of cleanliness of the practice, a lack of awareness of the immunisation status of staff and general lack of oversight of staff which all resulted in a lack of consideration for the safety and well-being of staff. 2. There was no Freedom to Speak up Guardian in the practice and staff were unaware of if there was one available externally. 3. Whilst the practice showed us a spreadsheet which had ticked that 4 staff members had completed Equality and Diversity training, it was incomplete with no dates. We found no evidence that staff had in fact completed this training as no certificates were available. Following the inspection, the practice provided us with the dates that staff had completed their training and certificated evidence. 	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	N ²
There are recovery plans in place to manage backlogs of activity and delays to treatment.	n/a
<p>Explanation of any answers and additional evidence:</p> <p>1. The concerns and risks identified through our inspection did not support that the practice regularly reviewed their governance structures and systems.</p> <p>2. We were told that there were no regular meetings with third parties for example with local social workers.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N ¹
There were processes to manage performance.	N
There was a quality improvement programme in place.	N ²
There were effective arrangements for identifying, managing and mitigating risks.	N ³
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.	N ⁴
<p>Explanation of any answers and additional evidence:</p> <p>1,2,3,4 The practice had failed to have clear and effective processes for managing risk, issues and performance. We found shortfalls in the leadership and management oversight leading to concerns in good governance, safe and effective prescribing and the competency of staff to undertake their roles. The practice system for managing complaints needed some improvement.</p>	

Appropriate and accurate information

The practice did not act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	N ¹
Performance information was used to hold staff and management to account.	N ²
Staff whose responsibilities included making statutory notifications understood what this entailed.	N ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1 During our inspection we saw some audits which had been completed at the practice. These audits were of poor quality; we were shown one audit on antibiotic prescribing which had very limited information – it was unclear what evidence standards were being used for comparison, there was no method, no conclusions or evaluation of the evidence. No learning was demonstrated from this audit and no repeat date was considered to ensure improvements had been made and sustained. We therefore identified inconsistencies and a lack of quality and improvement systems such as appropriate clinical audit. 2. These shortcomings did not equip the practice with accurate information on which to encourage improvement and hold staff to account. There was little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes. 3. Staff who were responsible for making statutory notifications did not demonstrate awareness of this process. For example, the partnership status of the practice had changed, yet the practice was unaware of the required notification to ensure correct registration with CQC. 	

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.	N ¹
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y

Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<p>1. During the inspection, we found multiple documents containing patient identifiable data which was stored insecurely. This included test results, consultation notes, referral requests, detailed records of safeguarding cases and meeting minutes. The oldest of these records was dated 2009 and were found in a kitchen cupboard. Following the inspection, the practice told us that these records had been secured in a locked cupboard.</p>	

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.	N ¹
The practice had an active Patient Participation Group.	N ²
Staff views were reflected in the planning and delivery of services.	N ³
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N ⁴
Explanation of any answers and additional evidence:	
<p>1,3 The practice told us that they had completed staff and patient surveys in the past but had not completed any patient and staff surveys in the last year.</p> <p>2 The practice told us that Patient Participation Group (PPG) meetings had not yet been resumed after the COVID-19 pandemic. We saw that invitations had been sent to patients asking if they wished to be involved in the group and there had been 11 patients who had expressed an interest. At the time of inspection, no meetings had been arranged.</p> <p>4 The practice did not evidence they had worked with stakeholders to identify and mitigate the risks and the negative impact of the challenges they had faced.</p>	

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.	N ¹
Learning was shared effectively and used to make improvements.	N ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. There was no evidence of innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement was not a priority among staff and leaders. 2. There was minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care was not understood. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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