

Care Quality Commission

Inspection Evidence Table

The Ecclesbourne Practice (1-537836336)

Inspection date: 9 November 2022

Date of data download: 08 November 2022

Overall rating: Inadequate

Safe

Rating: Inadequate

We rated the practice as Inadequate for providing safe services because:

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

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.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Not assessed
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

Safeguarding	Y/N/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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Although we saw evidence of some safeguarding systems and processes in the practice, we were not assured these were operating effectively to ensure patient safety. For example, when we discussed how safeguarding concerns were managed within the practice, we saw examples where the practice acted swiftly to raise safeguarding referrals for at risk patients with the multidisciplinary team. However, we were not assured that all safeguarding systems and processes were communicated to all staff. Non-clinical staff we spoke with were not aware of any safeguarding referrals and we were not provided with any meeting minutes where safeguarding was discussed in the practice to demonstrate communication with staff. The practice told us they did not hold any specific safeguarding meetings but patients were discussed opportunistically. We were provided with a list of children with safeguarding concerns and an adult safeguarding concern household list. The adult safeguarding list did not appear up to date as it listed only 12 patients, which was inconsistent with the practice list size of 10,008 patients. The practice told us these patients were reviewed by the GP safeguarding lead and discussed at clinical meetings; however, both these lists did not provide any information on the reason for safeguarding concern and how often these patients would be reviewed. There was no evidence from any minutes provided to show where these were discussed. The practice told us staff were up to date with their safeguarding training; however, this was inconsistent with our findings. When we requested training records, the practice informed us of an ongoing issue with their training platform for several months; therefore, they could not demonstrate all staff were up to date with their safeguarding training. Following the inspection, they provided us with training records and we found the safeguarding lead had completed their safeguarding children and adults training three weeks after the inspection and there were no prior training records provided for them. We also found three agency clinical staff did not have up to date safeguarding training records and other staff had either not completed the training or had last completed their safeguarding training in 2017 or 2018. This was consistent with staff interviews where they told us they had not undertaken any safeguarding training in the last 18 months. We were provided with both child and adult safeguarding policies but they did not contain the relevant local safeguarding contact detail and the child safeguarding policy did not provide the relevant read codes required. We saw evidence of joint working with the social workers and midwives. We saw other appropriate engagement with the local safeguarding perinatal mental health team and health visitor; however, we did not see evidence of how the practice engaged with school nurses. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were gaps in recruitment processes. We viewed two recruitment records for non-clinical staff and found one did not contain any completed references and both records did not include an interview summary. We also found there were unexplained gaps in employment in both records. When we reviewed the recruitment records for one new clinical staff, we found the practice had not clarified inconsistencies contained within references they obtained. For example, one nursing staff had been referred to as a salaried GP in the references they had sought from their previous employment; however, at the time of inspection this was not rectified or raised as an inconsistency. There was no job description, CV, application form or qualifications on file for this staff member. There were gaps in staff immunisations. There was no evidence any of the lead GPs had received immunisations including hepatitis B and polio and there was no evidence that a risk assessment had been carried out where staff had declined immunisations. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 November 2022	N
There was a fire procedure.	Y
Date of fire risk assessment: 14 November 2022 Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the time of inspection, health and safety risk assessments had not been carried out at both sites by the practice. This included disability, fire safety, health and safety and legionella risk assessments. Following the inspection on 5 December 2022, the practice provided evidence to show all these risk assessments had now been carried out. For example, the legionella risk assessment carried out after the inspection at the Ecclesbourne main site assessed the risk in 17 areas as medium and high; for example, in relation to legionella training and carrying out the recommended water temperature checks and high for gas boiler inspections which had not been carried out. The legionella risk assessment carried out at the Roding Valley branch site determined 11 areas as medium and high risk. The disability access risk assessment carried out on 14 November 2022 at the Ecclesbourne main site showed seven areas of medium and high risk; for example, the lack of an emergency alarm pull cord and ensuring the threshold allowed reasonable access for wheelchair users within the practice. The risk assessment carried out at the Roding Valley branch site showed eight areas determined as medium and high risk; for example, the lack of tactile signage throughout the practice and ensuring a public address system was installed. 	

- The health and safety risk assessment carried out on 14 November 2022 at The Ecclesbourne practice main site determined 17 areas of medium and high risk; for example, the risk was determined as medium due to the absence of an asbestos assessment and register and the lack of display screen equipment risk assessments carried out in the last 12 months. The health and safety risk assessment carried out on 14 November 2022 at the Roding Valley branch site determined six areas of medium and high risk which also found a lack of display screen equipment risk assessments completed in the last 12 months.
- Regular fire drills and weekly smoke and fire alarm checks were not taking place at the practice. We were provided with one fire drill record dated August 2022 for both the main site and the branch surgery.
- The fire risk assessment carried out on 14 November 2022 at the Ecclesbourne main site determined several areas as medium and high risk. For example, the fire risk was determined to be high due to fire alarm systems not installed in the practice and the absence of fire resisting doors, as well as a lack of regular fire drills. The escape routes were observed to be obstructed with storage and fire extinguishers were not suitably stored.
- The fire risk assessment carried out on 14 November 2022 at the Roding Valley branch surgery determined several areas as medium and high risk. This included the use of portable heaters in the practice that posed a fire risk and other areas of high risk included fire doors being wedged open. Areas determined as high risk of fire included the testing of smoke detectors and fire alarms, as well as carrying out regular fire drills and appropriate training of fire marshals within the practice.
- There were no completed action plans provided with these risk assessments to show what steps the practice had taken to rectify the areas that were determined as high risk and required immediate action. However, as these risk assessments had only been carried out following the inspection, action taken on the areas determined as low risk will be assessed at the next inspection.
- Portable appliance testing (PAT) and calibration was up to date. We saw evidence where the practice disposed of a fax machine where it failed the PAT test.

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.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Not known	N
The practice had acted on any issues identified in infection prevention and control audits.	n/a
The arrangements for managing waste and clinical specimens kept people safe.	N
Explanation of any answers and additional evidence:	

- There were inadequate infection control processes at the practice. They could not demonstrate all staff had received effective infection control training. Staff we spoke with could not recall when they last received this training and this was consistent with training records we viewed that showed some staff had last received this training five years ago, whilst others had completed the training after the inspection; however, at least nine training records showed this training had not been carried out.
- We were not assured of adequate systems in place for infection prevention and control. We received inconsistent information regarding who the designated infection control lead was. We were also told an infection control audit was carried out but none was provided when requested during and after the inspection. As a result of being unable to view the requested infection control audit, we were unable to assess whether any areas were identified for improvement and what action was taken.
- We were not assured the arrangements for managing waste kept people safe. On inspection we observed no sanitary bins available in the staff toilets.
- The practice told us clinical equipment was cleaned but no records were maintained for this.
- When we viewed a cleaning schedule document in the practice, it was not clear which room it related to, there were no signatures to confirm cleaning had taken place and the dates recorded on the document to show cleaning had taken place also showed future dates after the inspection.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Explanation of any answers and additional evidence:

- The practice told us there was a system in place for induction, which included buddy support. However, we were not assured of an effective induction system in place as we were not provided with induction records for temporary staff on request.
- The staff were not adequately equipped to respond to medical emergencies as there was no defibrillator available at the Ecclesbourne main site and there was no risk assessment in place.

- Staff were aware of actions to take if they encountered a deteriorating patient and they were able to demonstrate this; however, we were not assured staff were suitably trained in emergency procedures. The practice told us staff had received sepsis training; however, we did not find evidence of any sepsis training for nearly all the staff and we were not assured reception staff had been given guidance on identifying such patients, as not all staff were able to recognise the sepsis red-flag symptoms. We also found staff were not up to date with basic life support and anaphylaxis training where it was relevant for their role. Training records provided by the practice showed at least 12 staff had last received basic life support training between 2017 and 2020. The practice told us basic life support training was scheduled for January 2023.

Information to deliver safe care and treatment

Staff had 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. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
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.	N

Explanation of any answers and additional evidence:

- The practice had a system for referrals but it required monitoring. Whilst we saw evidence of how two-week wait referrals were processed, monitoring was required to ensure the overall referral system was operating effectively. When we reviewed their electronic hospital referral system, we found there were 13 outstanding and nine incomplete referrals which were at risk of not being processed by the hospital and the patient not receiving their appointment. It was not clear what action had been taken to ensure these referrals were successfully received by the hospital and the referral policy in place did not contain any information in relation to resolving outstanding and incomplete referrals.
- The practice had systems in place for clinical oversight of test results; however, monitoring was required to ensure there were no gaps in all test results being followed up. On the day of inspection we found 14 unactioned test results from October 2022 and 78 unactioned results from the first week of November 2022. Two unactioned results from June 2022 had been actioned already; however, a system issue had prevented them from being filed. When we reviewed two of the outstanding records, we found they related to an abnormal x-ray result and a result relating to antibiotic resistance. We also found it was not clear whether the doctor who

subsequently saw the patient with the abnormal x-ray result was aware of this when they attended the practice for a different condition. These findings were discussed with the practice who advised there was no risk of harm to the patients, including the one with the abnormal x-ray results, as the unactioned results were cleared by the relevant GPs immediately following the inspection.

Appropriate and safe use of medicines

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

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority – NHSBSA)	0.62	0.62	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	11.3%	9.3%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	6.11	5.76	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	102.1‰	64.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.72	0.46	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.3‰	5.4‰	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 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
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	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.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N
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 patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
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: <ul style="list-style-type: none"> The practice could demonstrate the prescribing competence of non-medical prescribers. They told us non-medical prescribers could request support when required but there was no evidence of formal reviews of their prescribing practice supported by clinical supervision or peer review. There was a process for the safe handling of requests for repeat medicines but the system in place for the management of medicines reviews was not operating effectively as we were not 	

Medicines management	Y/N/Partial
<p>assured structured medication reviews for patients on repeat medicines were taking place. We reviewed 20 patient records before observing a structured medication review and we found examples where a medication review was coded in the patient's records but on further review, we found not all the medicines were actually reviewed but rather one or two medicines. Therefore, it was unclear how the practice would be prompted to review the remaining medicines. When this was raised with the practice, they told us this was due to an IT issue where a medication review code was automatically generated whenever a prescriber issued a medicine from the repeat template. They told us they would contact their system provider to rectify the issue but we were not provided with evidence of how this issue would be rectified.</p> <ul style="list-style-type: none"> • When we reviewed the processes in place for monitoring high risk medicines, we found patients prescribed high risk medicines such as methotrexate (an immunosuppressant) and azathioprine (an immunosuppressant) had received the required monitoring and where any patients prescribed these medicines were overdue monitoring, we found the practice had made reasonable attempts to contact the patients. However, we found gaps in monitoring for other high risk medicines such as ace inhibitors (used to treat high blood pressure). We found 110 of 857 patients prescribed this medicine had not received the required monitoring and in two of these cases, monitoring was eight months overdue. In one of these patients we found their medical records recorded a future medicine authorisation date of 22 November 2022 and this was against guidelines to authorise medicines far in advance, with no recent blood test. This was raised with the practice but it was not clear why this prescription had been authorised. • When we reviewed the processes in place for controlled drugs, the practice told us patients were managed individually for controlled drug prescribing. When we carried out a review of this process, we were not assured of consistent and effective monitoring of prescribing of controlled drugs. For example, on inspection we found a patient was issued diazepam (a depressant) 11 times in the last year and they were also issued an unusually large supply of this medicine. The practice had not reinforced the risks of continued use or invited the patient for regular monitoring and documentation was not clear with regards to attempting to wean the patient off this medicine. • There was no documented protocol, or documented evidence of arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. • The practice did not store any controlled drugs on the premises. • The practice did not hold all the appropriate emergency medicines at both sites; for example, there was no cyclizine (used to treat nausea), dexamethasone (used to treat croup in children), diclofenac (used to treat pain), midazolam (used to treat seizures), naloxone (used to treat overdose) and opiates (used to treat severe pain). There were no risk assessments to determine the range of medicines held. • The practice told us there was a system in place to monitor stock levels and expiry dates and there was a designated staff member in place to undertake this task. However, we were unable to access this checklist on inspection as we were advised it was locked away. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> There was medical oxygen at both sites; however, we also found two empty oxygen cylinders at both sites. There was no defibrillator in place at the Ecclesbourne main site and there was no risk assessment carried out. This was reported in their health and safety risk assessment carried out on 14 November 2022. 	

Track record on safety and lessons learned and improvements made

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

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

Explanation of any answers and additional evidence:

- The process in place for significant events was inadequate. Whilst we observed a system to record and act on significant events, we were not assured staff knew how to identify safety incidents, or that these were shared with them. Non clinical staff we spoke with were aware of an incident book but were not aware of a significant policy in place, nor were they aware of any significant events being discussed in meetings. When we reviewed the incident policy provided, it was vague and did not provide specific information for staff on what constituted a significant event.
- Senior staff told us of one significant event relating to a major incident at the practice but were unsure of any others. However, we found at least four other incidents should have been classed as significant events. When we spoke to reception staff, we were told of four incidents that took place in the past year but not identified as significant events; for example, one relating to an aggressive patient in reception and other relating to medical emergencies where staff sought immediate GP assistance.
- There was no evidence of any significant events discussed in any of the clinical or partnership meeting minutes provided by the practice.

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

Event	Specific action taken
Burglary at the practice	The GP partners were informed and immediately informed the relevant authorities. There was damage to premises but no theft as no items were left accessible overnight. Significant event form was completed and incident was discussed with staff. Ongoing criminal case with the relevant authorities.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Although there was a system for receiving and acting on alerts; there was no system in place to ensure all the relevant staff had read, acknowledged and actioned the alerts. For example, we saw examples of action taken on recent alerts; for example, sodium valproate (an anti-epileptic) and carbimazole (used to treat hyperthyroidism) and relevant searches were carried out in relation to these alerts. We also saw these alerts were circulated to the clinical team and discussed at clinical meetings; however, there was no evidence of a system to ensure all relevant staff had read and actioned them. In some cases, we it was not clear whether alternative treatment was discussed with patients in response to patient safety alerts. For example, we saw that patients remained on combinations of medicines that increased their risk of heart problems and the practice provided spreadsheet evidence stating patients had been informed of the risk; however, there was no indication that alternative treatments had been considered. For example, evidence provided by the practice showed 11 patients continued to be prescribed 40mg simvastatin (used to treat high cholesterol) in combination with amlodipine (used to treat high blood pressure) which increases the concentration of simvastatin, instead of 20mg. An MHRA drug safety update in December 2014 advised that if patients were given a high dose of both simvastatin and amlodipine, there was an increased risk of muscle damage and they should not be prescribed this. The alert advised that alternative statins should be prescribed but if simvastatin was the only option, the maximum dose was to be 20mg if prescribed with amlodipine. There was no record to show what alternative statins had been considered for these patients. 	

Effective

Rating: Requires Improvement

The practice is rated requires improvement for providing Effective services because:

- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools; however, further improvement was required.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

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

Effective needs assessment, care and treatment

Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools; however, further improvement was required.

	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. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
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.	Y

Explanation of any answers and additional evidence:

- We saw the practice had systems in place to ensure they were up to date with current guidelines. For example, the practice provided seven clinical meeting minutes where the latest guidelines were being discussed; however, it was not clear whether these guidelines were

shared with all relevant clinicians, as the minutes did not document who was in attendance but rather only recorded who was presenting the meeting.

- We saw evidence of systems in place to ensure patients' immediate and ongoing needs were fully assessed; for example, we saw evidence where the practice continuously monitored a patient where they had made several attempts to reduce the dose and the number of medications they were taking without much success. Their approach was now focused on harm reduction whilst providing ongoing support for them. However, further monitoring was required to ensure this was consistently taking place in the practice. For example, when we reviewed the learning disability register in place, we found one patient diagnosed with learning disability had not received a review in the past year, neither had there been a discussion in relation to their health. We also received a patient complaint in relation to a lack of ongoing pain and diabetes reviews and they stated this resulted in episodes of both low and high blood sugar levels leading to hospitalisation.
- Whilst we saw that patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way and this included abnormal blood test results, further monitoring was required to ensure a consistent system of timely follow up. For example, we saw three examples where the practice made several attempts to follow up patients with abnormal average blood sugar levels. We also reviewed three patient records where patients diagnosed with asthma had required prednisolone (a steroid) due to exacerbation and were followed up within one week as per guidelines, we found one patient had received a follow up as per guidelines. However, two patients had not received the recommended one week review as per guidelines.
- The system in place to ensure recalls were taking place for long-term condition patient reviews was not operating effectively as gaps were identified. Whilst we saw good practice in relation to restricting the issuing of their repeat prescriptions until they booked their review, this was not consistent with all patients. On inspection we found one patient was overdue an asthma review since March 2021 and another patient was overdue a review since 2020. Following the inspection, the practice took action to contact these patients and arrange for their reviews.
- The practice had a system for referrals but it required monitoring. When we reviewed their electronic hospital referral system, we found there were 13 outstanding and nine incomplete referrals which were at risk of not being processed by the hospital and the patient not receiving their appointment. It was not clear what action had been taken to ensure these referrals were successfully received by the hospital and the referral policy in place did not contain any information in relation to resolving outstanding and incomplete referrals.
- Patients were not consistently told when they needed to seek further help if their condition deteriorated. We found whilst safety netting was in place for some patients, we found some patients were not always notified of the risk of taking particular medicines on a long-term basis. This was in relation to this was not the case for all patients. For example, when we reviewed clinical records, we found the practice had not reinforced the risks of a patient's continued use of diazepam (a depressant) or invited the patient for regular monitoring.

Effective care for the practice population

Findings

- The practice were part of the Integrated Care Management team led by a community matron which provided additional support and care for elderly housebound patients.
- The practice had an arrangement with the local chemist to provide a delivery service for housebound patients.
- Spirometry, ECG monitoring, 24-hour BP monitoring and pulse oximetry were offered in house.
- The practice held an annual walk-in flu clinic day with opportunistic health checks for all patients with chronic disease.
- They held dedicated chronic disease management clinics for poorly controlled diabetes patients with insulin initiation.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- 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 demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were assessed at the practice and referred to appropriate services.

Management of people with long term conditions

Findings

- When we carried out the inspection, we reviewed 50 patient records and found some examples of good practice where patient care was reviewed and action taken to ensure recalls were taking place. Whilst these systems were in place, they did not always operate effectively and therefore we found gaps in care as not all patients were being monitored or followed up to ensure their treatment was in line with national guidance. For example, we found one patient diagnosed with hypothyroidism was overdue monitoring by nearly two years and there had been no attempt to contact the patient to book their review. We found their last monitoring took place in January 2020 and showed elevated thyroid levels. Following the inspection, the practice made attempts to contact the patient and take action to restrict their medicine until they were reviewed.
- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, there were gaps in these systems as on inspection we found one patient was overdue an asthma

review, which included an asthma review plan since March 2021 and another patient was overdue a review since 2020.

- The practice could refer patients to the rapid response team who would carry out home visits within an hour to assess patients, carry out test samples and following up acutely ill patients recently admitted into hospital.
- We were not assured staff responsible for reviews of patients with long-term conditions, such as nurses had received specific training, as we were not provided with the appropriate training records to demonstrate this.
- The practice shared 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, chronic kidney disease.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice carried out six to eight week baby and postnatal checks.

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)	99	115	86.1%	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)	87	107	81.3%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	88	107	82.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles,	86	107	80.4%	Below 90% minimum

mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	97	124	78.2%	Below 80% uptake

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 told us there was a recall system in place for childhood immunisations. Immunisations were also advertised on the practice website.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	71.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	46.0%	54.8%	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)	61.0%	58.1%	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)	69.2%	53.2%	55.4%	No statistical variation

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.

Any additional evidence or comments

The practice told us there was a recall system in place for cervical smears organised through the admin team. There was no other information provided as to what action the practice was taking to improve uptake.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

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

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

The practice carried out a quality improvement audit in relation to completing palliative care drug charts. They found when completing these charts, they were not pre-populated and all sections had to be completed manually. They identified this as time-consuming and at risk of mistakes. They worked to develop a form embedded into the computer system that was pre-populated and editable as needed. The practice found this significantly reduced the time taken to complete these palliative care drug charts, so they could be promptly given to the district nurses to administer medicines for palliative patients.

Any additional evidence or comments

We also found other audit activity in relation to prescribing antibiotics and steroid inhalers carried out by the pharmacist.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Whilst we saw evidence that some staff had the skills and knowledge to deliver effective care and treatment, we were not assured that all staff were able to demonstrate they had the skills and knowledge to deliver effective care and support. For example, we were not provided with any continuing professional development training for the nursing staff and there was no evidence provided to show the healthcare assistant had received their care certificate training. We also found gaps in mandatory staff training and the knowledge of sepsis and we found not all staff were aware of the safety processes such as safeguarding and their responsibilities in ensuring policies were up to date. The practice's programme of learning and development was inadequate. On inspection, the practice was unable to provide any bluestream training records as they told us this system had been offline until just before the inspection. Staff we spoke to could not recall having undertaken training in the last 18 months. When training records were provided following the inspection, we found significant gaps in mandatory training, such as basic life support, infection control training, fire safety and information governance for most of the staff. We saw a comprehensive template for the induction programme for new staff that covered a wide range of areas. However, we were not provided with evidence of completed induction records for new staff. The two new staff recruitment records we were provided with did not contain any induction records. The practice told us appraisals took place and they had completed half of the appraisals for this year; however, the evidence provided to demonstrate this was incomplete. This evidence consisted of a staff list of appraisal dates but there was no other information provided in relation to the appraiser and what the appraisal consisted of and feedback provided and this included clinical staff. There was no evidence provided to show how the practice supported clinicians to meet the requirements of revalidation; for example, nurses. The practice described how they assured the competence of staff employed in advanced clinical practice, for example, nurses and pharmacists. However, there was no formal documentation to demonstrate clinical supervision or any formal system to audit their consultations. For one clinician who was undertaking insulin initiation, there was no evidence of training or supervision records provided to demonstrate their competencies in this area. We found there was no sufficient clinical oversight to ensure one clinician who was responsible for supervising two other clinicians recruited by an external agency was being formerly monitored by the practice. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Partial
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

Consent to care and treatment

The practice was unable to demonstrate that it 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	N
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	N
Explanation of any answers and additional evidence:	

- The practice carried out weekly minor surgery and when we reviewed the process of recording consent, the practice told us patients signed consent forms; however, there was a backlog in scanning. We found only the consent record templates saved to the patient records and not a signed form. When we also reviewed the records of minor surgery patients for the previous four weeks, we did not find any signed consent forms in any of their records.
- Clinicians told us they supported patients to make consent decisions; however, there were no specific documented examples noted on review.
- We were not assured they appropriately assessed and recorded a patient's mental capacity to make a decision. For example, we received a complaint from a patient regarding significant difficulty their relative was experiencing with trying to access the practice for their review. We were advised the patient did not have capacity to make a decision due to cognitive issues; however, we found the practice had not taken this into account when they contacted the patient and a decision was made, without an assessment of their mental capacity.
- Our clinical review of notes where a DNACPR decision had been recorded identified one patient who DNACPR dated July 2017. However, we found that this form had not been scanned into the patient's records and the record of the discussion with the patient was very brief. There was also no alert on the patient's records and although coded this was not easily visible. This record had not been reviewed since 2017 and there was no evidence this had been shared with relevant agencies and there was no evidence of a multidisciplinary approach to decision making.

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
Google reviews	Practice had a rating of 2.8 out of 25 stars. Feedback received in the past year was mixed where some felt the practice staff were polite, helpful and compassionate, other reviews reported issues with attitude to patients from receptionists and some review.

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 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)	81.0%	78.8%	84.7%	No statistical variation
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)	82.0%	76.4%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence	91.9%	89.2%	93.1%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)				
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)	67.9%	65.7%	72.4%	No statistical variation

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

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	We did not speak to patients as part of this inspection.

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 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)	90.7%	84.6%	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:	
<ul style="list-style-type: none"> The practice had a google translate language option on their website with access to over 120 languages. 	

Carers	Narrative
Percentage and number of carers identified.	253 (2.5% of practice population)
How the practice supported carers (including young carers).	<p>Carers were offered on the day appointments and support posters were displayed in the practice and on their website.</p> <p>Young carers were added to the safeguarding register and received high priority care in the practice.</p>
How the practice supported recently bereaved patients.	Patients were offered bereavement counselling arranged by the social prescriber available at the practice. Practice staff had links to the local bereavement centre and forwarded a list of patients requiring bereavement counselling

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires Improvement

The practice is rated as requires improvement for providing responsive services because:

- Services did not always meet patients' needs.
- People were not always able to access care and treatment in a timely way.
- Complaints were not used to improve the quality of care.

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.	Y
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.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Explanation of any answers and additional evidence:

- We were not always assured that flexibility and continuity of care was reflected in the services provided. Patient complaints received by CQC highlighted issues with ongoing monitoring of long-term conditions and this was consistent with findings on the day of inspection where we found some patients were overdue monitoring for their long-term conditions and some medicines.
- There was a hearing loop available at the practice.
- The practice had an operational passenger lift at the branch site and disabled access, including disabled toilets to both sites.

Practice Opening Times	
Day	Time
Ecclesbourne Surgery	
Opening times:	
Monday	08.00 – 6.30pm
Tuesday	08.00 – 6.30pm
Wednesday	08.00 – 6.30pm
Thursday	08.00 – 6.30pm
Friday	08.00 – 6.30pm
Roding Valley branch site	
Opening times:	
Monday	08.00 – 6.30pm
Tuesday	08.00 – 6.30pm
Wednesday	08.00 – 6.30pm
Thursday	08.00 – 6.30pm
Friday	08.00 – 6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • The practice offered an in house and home visiting phlebotomy service for elderly patients. • Patients had a named GP who supported them in whatever setting they lived. • We were not always assured the practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. We received a complaint of an elderly patient who had not received regular reviews of their condition and could not access the GP for pain assessment. Action was taken by the practice to offer this patient an appointment following intervention from the inspector, when the patient had reported continued difficulty getting through to the practice for both routine and urgent appointments. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • The practice actively participated in the Integrated Care Management Team led by a community matron which provided additional support and care for elderly housebound patients. • The practice held a register of patients living in vulnerable circumstances including homeless people and they were easily able to register with the practice. • Patients with a learning disability were offered longer appointments and could be offered home visits. • The practice had a designated number of same day appointment slots for children under five and those of school age.

Access to the service

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

	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 (including those who might be digitally excluded)	Y
Patients with most urgent needs had their care and treatment prioritised	Partial
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:

- We saw that the practice had taken action to ensure patients were able to make appointments that met their needs. They told us that prior to April 2022, the telephone service company they had commissioned was providing a poor service and this led to increased patient complaints which they monitored. As a result, they changed their telephone provider in April 2022 and the service provided now included a callback service. They also told us as a result of this new service, patients had access to staggered appointments and patients could access appointments until 10am and patients were guaranteed to speak to a clinician on the day.
- Further improvement was required to ensure this benefited all patients and that patients with the most urgent needs had their care and treatment prioritised, as we were not assured of this. The national GP patient survey results showed patients overall experience of making an appointment up between January and April 2022 was above the local and national averages; however, we were not assured this was consistently applying to all patients. For example, one patient complaint reported that they had not been reviewed for their long-term conditions and the appropriate specialist referrals had not been made. They also reported that in September 2022, they were unable to access any urgent appointments via telephone from both the main site and branch surgery to submit abnormal test readings and were advised there were no appointments left. Although the national GP survey results did not show the practice as outliers for telephone access, it did show their telephone access data was 10% below national average.
- The practice had not carried out a survey since installing the new telephone system, to ensure the new service was operating effectively for patients and access had improved.
- The practice offered a range of appointment types; however, evidence did not support the availability of online appointments. Although they told us they offered online consultations, this

was inconsistent with the message patients were being informed of on their website. The practice website advised patients that due to coronavirus, their online appointment booking service was suspended until further notice. It was not clear why and when this service would resume.

- There were systems in place to support patients who faced communication barriers to access treatment. For example, mental health patients were encouraged to self-refer to external services. However, if language was a barrier for example, the GP would assist them in completing a referral form.

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 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)	42.6%	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)	57.2%	50.6%	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)	60.4%	52.6%	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)	73.3%	65.1%	71.9%	No statistical variation

Source	Feedback
For example, NHS Choices	The practice received three reviews in the past year and whilst one of them praised the clinician for a good experience during their consultation, two of them reported difficulty with the telephone system. They reported long telephone waiting times and phones disconnected and unavailable appointments and a second review reported issues with no call backs from the GPs at the allocated time, affecting working age patients.
Patient complaint sent to CQC	Patient complaint relating to phones not been answered, leaving them without reviews and essential supplies for medical equipment, such as insulin needles. They reported despite complaints to the practice, they were never responded to, acknowledged complaints in writing nor apologised.

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.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0
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

Explanation of any answers and additional evidence:

- We were not assured of the practice systems in place for handling complaints. The practice provided two complaints that had been raised by patients during and after their inspection in November 2022, relating to difficulty accessing the service. One of the two complaints acknowledged the patient's complaint and was passed onto the manager after seven days; however, there is no evidence to show if this patient received a response and if their complaint was resolved. The complaints leaflet provided also advised patients their complaint would be acknowledged within two working days and resolved within 10 days; however this was not the case.
- There were arrangements in place to act on patient complaints when the designated complaints lead was not available.
- Patient complaints raised with CQC reported that the practice had never acknowledged complaints, nor offered any apology.

Example(s) of learning from complaints.

Complaint	Specific action taken
E-consult did not take place at the appointed time. A second appointment for the same patient also did not materialise. Complaint also included inappropriate comments made a reception staff member.	Patient submitted a written complaint and a response was received that their complaint had been passed to the practice manager. There was no evidence of practice response or action taken to resolve their complaint.
Patient was not called back using the call-back system when they reached number one in the queue and when they rung the practice, they were informed all the appointments were no longer available, leaving them to access out of hours care.	Patient submitted a written complaint and a response was received that their complaint had been passed to the practice manager. There was no evidence of practice response or action taken to resolve their complaint.

--	--

Well-led

Rating: Inadequate

The practice is rated as inadequate for providing well-led services because:

- There were gaps in governance structure.
- There was compassionate and leadership; however, effective monitoring was required to ensure this was taking place at all levels.
- The practice had a clear vision but it 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 practice did not have clear and effective processes for managing risks, issues and performance.
- There was evidence of systems and processes for learning, continuous improvement and innovation but improvement was required.
- The practice did not always involve the public and staff to sustain high quality and sustainable care.

Leadership capacity and capability

There was compassionate and leadership; however, effective monitoring was required to ensure this was taking place at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- The partners in the practice understood the challenges to quality and sustainability and they took several lead roles in the practice. For example, they understood challenges such as access and appointments, workforce retention, multiple sites, multi-ethnic transient population and issues relating to secondary and social care. However, we were not assured that effective action and monitoring had taken place to ensure all staff had the capacity and skills to deliver high quality sustainable care.
- We saw evidence some action had been identified and implemented to address these challenges. This included the implementation of a new telephone system with a callback function, online access, inhouse phlebotomy, e-consults, prescribing and expanding their minor surgery services. However, there was insufficient clinical and governance oversight to ensure

all these actions were operating effectively. For example, their practice website showed their online appointment booking system was out of service, patients complained e-consults were not taking place as planned and the callback function did not always work, leaving patients unable to access the service.

- Although staff reported leaders were approachable, on inspection we observed non-clinical staff working downstairs were not always visible to management working upstairs. We were also not provided with meeting minutes to demonstrate how non-clinical staff worked jointly with the leadership team. As a result we found gaps in staff knowledge in relation to the safety systems and processes in place at the practice.

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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a vision to deliver high quality patient centred care and to promote learning. However, we found the lack of adequate oversight had resulted in ineffective and unsustainable systems to deliver and monitor it. • Staff we spoke to were aware of the mission statement in place; however, we were not assured staff were aware of their role in delivering the strategy due to gaps found in safety systems within the practice. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with behavior inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
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.	N
The practice encouraged candour, openness and honesty.	Y

The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Whilst we saw there was a strong emphasis on the safety and wellbeing of staff, this was not always consistent. For example, we saw evidence of where the practice made reasonable adjustments for a staff member. However, we also found the practice had not undertaken the recommended display screen equipment risk assessments for staff in the past 12 months, to ensure there was no risk to their health and safety due to the display screen equipment they used. We were not assured patients were always offered an apology when things went wrong. This was in relation to two patient complaints that had not been responded to in a timely manner, one of which was regarding two appointments made where the consultations did not take place, despite the patient waiting for the clinician. There was no evidence this was followed up with the patient despite the complaints raised, nor that an apology was provided and they were informed of any resulting action to ensure this would not occur again. It was not clear who the designated Freedom to Speak up Guardian for the practice was. There were gaps in equality and diversity training. When we reviewed training records, we found at least eight staff had not undertaken any training including clinical staff, four staff last completed this training between 2017 and 2018 and we also found seven other staff completed this training after the inspection in December 2022. 	

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

Source	Feedback
Clinical and non-clinical staff	<p>Staff felt they had a good professional, working relationship with the GPs and practice management and felt they could raise concerns.</p> <p>Staff also felt the team was nice and approachable but felt staff recognition could improve in some areas.</p>

Governance arrangements

The overall governance arrangements were inadequate.

	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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	

- We found gaps in governance structures and systems such as, safeguarding, recruitment, clinical supervision and oversight, as well as monitoring of professional registration and training.
- Staff were not always clear about their roles and responsibilities. Although we found staff such as the pharmacists were clear on their roles and responsibilities, this was not consistent within the practice. This was in relation to the unactioned blood test results dating back to October 2022, as well as the inconsistent information we received regarding who the designated infection control lead was in the practice.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	Not assessed

Explanation of any answers and additional evidence:

- There was a business continuity plan in place but it did not contain all the essential contact numbers required in an emergency. Staff we spoke to were aware of who to contact in the event of an emergency but they were not aware of the incident plan in place, or the buddy practice.
- There were no comprehensive assurance systems in place to underpin essential standards to identify, manage and mitigate risk. On inspection, risk assessments could not be evidenced and this included, disability, fire safety, health and safety and legionella risk assessments. There was no process of oversight to ensure staff training, effective induction, identification and handling of significant events and patient safety alerts.
- The practice had not ensured readiness for a medical emergency as there were gaps relating to non-clinical staff receiving sepsis awareness training and gaps relating to the availability of the recommended emergency medicines.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
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"> Whilst data was used to adjust and improve performance; for example, in chronic disease management, we found improvement was still required in areas such as cervical screening and use of the new telephone system and patient satisfaction surveys. 	

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.	Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Not assessed
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Not assessed
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.	N
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: <ul style="list-style-type: none"> Although the practice used digital services securely, we found they were not always operating effectively. For example, the practice website contained out of date information such as bank holiday dates when the practice would be shut in 2021. There was no updated information for 2022 and 2023. 	

- Although the practice told us they offered online consultations, this was inconsistent with the message patients were being informed of on their website. The practice website advised patients that due to coronavirus, their online appointment booking service was suspended until further notice. It was not clear why and when this service would resume.

Engagement with patients, the public, staff and external partners

The practice did not always involve the public and staff 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.	Not assessed
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were not always assured patient views were acted on to improve the services and culture. Whilst we saw action taken to implement a new telephone system, we were not assured patient views were monitored in relation to the concerns they raised about the efficacy of this system and we found complaints were not responded to in a timely manner. The practice told us they used to have a Patient Participation Group but it went dormant during the coronavirus pandemic. They told us they were attempting to revive it and trying to strengthen their communication with the group. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw a strong focus from the practice to learn and make improvements in identified areas. We saw the practice take immediate action to contact patients that were overdue their monitoring when identified on inspection. When the inspection also identified gaps in undertaking health and safety risk assessments, we saw the practice take action to schedule these risk assessments and provide us with the completed reports. The practice was also receptive to constructive feedback provided by the inspection team and although action was taken to rectify some areas of weakness, this will be assessed at the next inspection to ensure action taken was embedded within the practice culture. Although we saw evidence of a strong focus on learning and improvement in areas identified by the inspection team, on inspection we found there was limited evidence of learning being 	

shared effectively and used to make improvements. This was in relation to significant events and patient safety alerts and patient complaints.

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)	≤ -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 SICBL 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 SICBL 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.