

## Inspection Evidence Table

Whitestone Surgery

(1-1338723916)

**Inspection Date: 12 January 2024**

Date of data download: 11/01/2024

## Overall rating: Inadequate

We have rated the practice as Inadequate overall because the provider did not have effective systems and processes in place to minimise risk and keep patients safe. This included issues relating to medicines and the management of long-term conditions, safeguarding, clinical oversight, infection prevention and control, quality improvement and the governance and leadership of the practice.

## Context

Whitestone Surgery is a small family run GP practice with approximately 2,400 patients located in a relatively affluent area. Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is within the eighth decile (on a scale of 1 to 10, with 1 being the most deprived). The practice population is predominantly White with a small proportion of patients from Asian, Black and other minority ethnic backgrounds. The age distribution of the practice population indicates this is a family area with higher proportions of younger adults and children. Published data shows lower than average prevalence of diseases in the area.

The provider is a single-handed GP currently suspended by the General Medical Council. While the provider is involved in the running of the practice the clinical care has been provided by locum doctors, supported by the practice nurse and Healthcare Assistant since the provider's suspension in September 2020.

## Safe

## Rating: Inadequate

We have rated the practice as Inadequate for providing safe services because the practice did not have effective systems and processes to keep patients safe and protected from avoidable harm. We identified concerns with safeguarding systems and processes; patient workflow; availability of clinical equipment; management of infection prevention and control; management of medical emergencies; and risks relating to staffing.

## 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
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	N
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice nurse had the lead role for safeguarding children and vulnerable adults.</li> <li>There was information available to staff to advise them on the local safeguarding processes and who to contact should they have a concern.</li> <li>However, our clinical searches found that alerts were not routinely used on the clinical system to identify the practice's most vulnerable children and adults and other household members. This was particularly important as the practice relied on the use of locum staff to run the service who may be unfamiliar with these patients.</li> <li>The practice was unable to show that they held regular discussions with other health and social care professionals in relation to their most vulnerable patients. The practice nurse advised that they had not had any contact with a health visitor since the pandemic.</li> <li>We saw that permanent staff had safeguarding training to an appropriate level however, we were unable to verify this for locum staff as the information was not available.</li> <li>We asked to see the Disclosure and Barring Service (DBS) checks for three of the clinical staff but only one could be found.</li> <li>We reviewed the practice's child safeguarding register and found 5 out of the 11 patients listed were adults (between the ages of 19 and 32 years). When we asked to see the practice's vulnerable adult register the practice advised that they did not have one. This did not provide assurance that the practice's most vulnerable patients were being kept under review.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Not reviewed

Explanation of any answers and additional evidence:

We did not fully review recruitment systems during the inspection however, when we asked to see specific documents such as DBS checks the practice was unable to find them for 2 out of 3 members of clinical staff.

Staff files were unorganised, the practice shared with us 3 locum staff files, only 1 of these contained full information relating to appropriate recruitment checks.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N/K
Date of last assessment:	N/K
There was a fire procedure.	Y
Date of fire risk assessment:	N/K
Actions from fire risk assessment were identified and completed.	N/K

Explanation of any answers and additional evidence:

We did not fully review safety systems and records during the inspection due to focussing on other serious clinical concerns.

However, we saw that fire procedures were in place and displayed. Fire extinguishers had been serviced within the last 12 months and training records seen for permanent staff showed that they had received fire safety training.

We saw evidence that some items of clinical equipment had undergone portable appliance testing and calibration checks in the last 12 months to ensure they were fit for use. However, we also saw items of clinical equipment that had not undergone these checks for example, a thermometer and nebuliser machines.

**Infection prevention and control**

**The practice was unable to demonstrate effective systems for ensuring appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit:	24/06/2022
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence:	

- The practice was observed to be visibly clean and staff had access to handwashing facilities, personal protective equipment and clinical wipes for cleaning clinical equipment and work areas between patients. However, we saw that there was damage to the doctors room wall, which staff advised had been caused by leaks from a recent storm. We saw from meeting minutes that steps were being taken to address the damage.
- The practice nurse was the infection prevention and control (IPC) lead for the practice.
- Training records seen for permanent members of staff showed that staff had undertaken IPC training. The practice nurse advised that they were due to go on refresher training later this month.
- There had been no recent IPC audit, the last audit was completed in June 2022. The practice nurse advised that they had replaced an examination couch in response to actions from the last audit.
- During the inspection we identified issues such as lack of labelling on sharps boxes, privacy curtains that had not been changed since September 2022 and insufficient clinical equipment for assessment of patients with potential infections such as sepsis. For example, pulse oximeters, thermometers and blood pressure monitors.
- The practice directly employed a cleaner for the service. Cleaning schedules were in place although the completion of these did not match the frequency of cleaning staff had advised. Staff told us that cleaning was undertaken two days each week but the schedules indicated only once per week.
- We saw appropriate arrangements were in place for the removal of clinical waste.

**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.	N
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.	N/K
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was reliant on locum GPs to provide medical cover for the service over a long-term period due to the suspension of the GP provider. The practice advised that they used a pool of 4 regular locums for consistency.</p> <p>During our inspection we were concerned that a member of staff was undertaking clinical duties without the qualifications, competence and skills to do so safely or oversight in the tasks they performed. For example, medicine and long-term condition reviews.</p> <p>The practice had not put in place suitable arrangements when it was closed every Thursday afternoon. This was for the Patient Group to run health and social wellbeing activities which originally took place at the surgery but had moved to other premises due to the increased numbers of patients involved. On a Thursday afternoon</p>	

the practice manager advised that they held the phone if patients needed to contact them and clinical support was needed. However, there were no formal arrangements in place as to which locum they would contact and if the locum would be available to take a call.

At the time of our inspection, the practice had no reception cover or healthcare assistant due to absence. The main GP locum who had been brought in to provide clinical oversight was also absent. The practice manager was providing reception cover at the time. Staff we spoke with told us that workloads were manageable when staff were not absent.

Published data showed A&E attendances for the practice between 1 April 2023 and 30 June 2023 were higher than both local and national averages.

We reviewed the locum pack available to support staff working at the practice on a temporary basis. We found this had not been updated since 2021 and contained information that was out of date.

Training records for permanent staff showed that basic life support training was overdue for most staff. We were unable to verify this training for the locum staff as records were not available.

Training records showed 3 of the 5 permanent staff had undertaken sepsis or sepsis awareness training.

The practice was not well equipped to respond to medical emergencies. The practice held a defibrillator and oxygen for use in an emergency, but no emergency medicines with the exception of an anaphylaxis pack. The nebuliser machines in the practice were not in use having not recently been tested for electrical safety and there were no medicines available for them. We found only one set of basic clinical equipment available on site for the assessment of patients (such as, blood pressure monitor, thermometer, adult pulse oximeter). There was no child pulse oximeter. The practice advised that locum staff brought their own and this was the case with the locum we saw on duty during the inspection.

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Not Reviewed
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
Explanation of any answers and additional evidence:	

As part of our inspection, we undertook clinical searches and reviews of patient records in relation to medicines and management of long-term conditions. We found significant concerns in the management of patient health and care needs. For example, medicine reviews were coded but contained no detail as to what had been reviewed, there was a backlog of workflow which included 237 laboratory reports unmatched or unfiled dating back to 30 December 2020. Of these reports, 51 of these were showing abnormal results and 906 other documents were awaiting processing including out of hours reports and clinical documents.

The practice nurse advised that they reviewed test results and flagged any that needed to be reviewed with one of the doctors. They also supported the locum GPs with their referral letters.

The practice manager undertook the summarising of new patient records. We saw a pile of approximately 30 records which we were told were awaiting summarising, the practice manager advised these went back to October 2023. However, when we looked at a couple of examples the practice manager was not clear as to whether or not they had actually been summarised.

The practice advised that they contacted the district nursing team and palliative care team when needed to share information but did not have any contact with the health visitors.

### Appropriate and safe use of medicines

#### The practice did not have effective 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) (01/10/2022 to 30/09/2023) (NHSBSA)	0.78	0.95	0.91	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). (01/10/2022 to 30/09/2023) (NHSBSA)	7.8%	8.2%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2023 to 30/09/2023) (NHSBSA)	4.81	5.12	5.19	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	60.8‰	125.5‰	130.7‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.42	0.64	0.53	No statistical variation

Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	6.1‰	8.4‰	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 authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
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.	N
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
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Not reviewed
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Not reviewed
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Not reviewed
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.	N
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.	Partial
Explanation of any answers and additional evidence, including from clinical searches.	
Nationally published data showed that practice prescribing was below local and national averages.	

Prescription stationery was kept away from patient areas but was in an unlocked room and had not been securely locked away, there were no records available to monitor their use.

Staff did not always have the appropriate authorisations to administer medicines. We saw Patient Group Directions (PGDs) that were out of date or had not been appropriately signed for the practice nurse to administer vaccinations and no Patient Specific Directions were in place where records showed the Healthcare Assistant had administered medicines.

During our review of clinical records, we found 17 examples of medicines reviews that had been recorded as conducted without documenting the outcomes from the review and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review. We found an example where a hospital had requested the patient start on a diabetic medicine that had not been acted on.

We reviewed a sample of clinical records for patients on medicines that require specific, frequent monitoring due to the risk of significant adverse side effects. The searches identified nine patients were prescribed a disease-modifying antirheumatic drug (DMARDs), 7 patients were prescribed Methotrexate and 2 patients Azathioprine. DMARDs are commonly used to treat inflammatory conditions such as rheumatoid arthritis. We reviewed 4 patient records and found monitoring was not up to date, although we were told up to date results were available on the hospital laboratory system for three patients. There was no evidence monitoring had been checked prior to issuing a prescription for the medicine. Prescriptions did not specify the day of the week to take Methotrexate as advised by the Medicines and Healthcare products Regulatory Agency (MHRA) in a Drug Safety Update published in September 2020 to minimise the risk of overdose.

A search suggested that 38 out of 43 patients prescribed a direct oral anticoagulant (DOACs) had not had the required monitoring. We reviewed a random sample of 5 patient records and identified that 4 patients had never had a calculation made to ensure safe prescribing of the medicine. The provider was therefore not able to demonstrate that it remained safe to prescribe these medicines.

The practice did not hold any emergency medicines (with the exception of medicines for use in anaphylaxis). There were no risk assessments in place to determine the range of medicines held or mitigating action to take if recommended emergency medicines not stocked were needed in a medical emergency.

The practice had a defibrillator and oxygen available. While we saw that defibrillator pads were in date and the oxygen full and in date there were no records to show this was being monitored.

Vaccinations are required to be stored at specific temperatures in line with manufacturers' instructions to maintain their effectiveness. We saw that vaccinations were stored in a medicine fridge that had been checked for electrical safety and calibrated in the last 12 months. There were systems for monitoring the fridge temperature on a daily basis however, there were gaps in the monitoring and no system of back-up such as a data logger or thermometer should the fridge fail to maintain the required temperature range and the safety of the vaccines. The practice had a second medicines fridge which we were advised was not being used for medicines.

#### **Track record on safety and lessons learned and improvements made**

**The practice did not have 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.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	1
Number of events that required action:	1
<p>Explanation of any answers and additional evidence:</p> <p>Findings from the inspection identified a lack of clinical oversight at the practice in which staff were able to identify incidents and learning.</p> <p>Staff we spoke with told us that there were processes for reporting incidents and that learning was discussed at staff meetings. However, there was only one example recorded. This was an area raised for improvement at our previous inspection in November 2018.</p>	

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

Event	Specific action taken
A caller to the practice was incorrectly advised that the practice did not do home visits. The caller's details had not been recorded.	The incident was followed up and no harm was identified to the patient. Staff were reminded to take patients details in full when taking calls.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Systems in place for managing safety alerts were not effective.</p> <p>We saw that the practice manager maintained a log of safety alerts and forwarded those deemed relevant to the GPs working at the practice. We saw examples of searches undertaken to identify patients that may be affected by alerts.</p> <p>However, when we undertook searches in relation to safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) during the inspection we found they had not been appropriately responded to. For example:</p>	

A MHRA alert published in 2014 advised a specific combination of medicines (an antiplatelet and indigestion medicine) should not be prescribed together as one of the medicines reduced the effectiveness of the other, placing the patient at increased risk of a stroke or heart attack. We found 5 patients on this combination of medicines with no evidence that the risk had been identified and discussed with the patient or alternative treatments considered.

A MHRA alert published in 2014 advised against prescribing a particular medicine (used to treat depression) at higher doses in older patients as it can lead to serious disturbance of their heart rhythm, we found 2 patients on this medicine. Neither had been informed of the risk and no appropriate assessment had been completed.

## Effective

## Rating: Inadequate

We have rated the practice as Inadequate for providing effective services because care and treatment was not always delivered in line with standards and evidence-based guidance. This included the management of medicines and long-term conditions. The practice was not able to demonstrate all staff carrying out specific roles in the management of long-term conditions and medicine reviews had appropriate qualifications, competencies and skills to do so. There was little evidence of supervision and oversight of clinical staff and of quality improvement initiatives. Uptake of childhood immunisations and cervical cancer screening was not meeting the national standards for any of the indicators.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
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 during the pandemic.	Not reviewed
The practice prioritised care for their most clinically vulnerable patients.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice nurse advised that they kept up to date with current evidence-based practice through training and journals. They were also part of an online nursing group.</p> <p>Practice staff told us that the locum GPs received clinical oversight of their work from a senior locum GP but we saw no evidence of this or discussions relating to evidence based guidance.</p> <p>Our review of clinical records found significant concerns in relation to the management of medicines, long-term conditions and those at risk of developing a long-term condition. Patients did not always receive appropriate care treatment and follow up in line with evidence-based guidance to keep them safe. For example, the National Institute of Health and Care Excellence recommends that a medicine to protect the stomach is prescribed in conjunction with oral Non-steroidal anti-inflammatory drugs or antiplatelet therapy in older patients to reduce the risk of gastrointestinal bleeding. Our searches found 22 patients out of 47 prescribed a non-steroidal or antiplatelet medicine that were not prescribed this medicine to reduce their risk.</p>	

## Effective care for the practice population

Findings
<p>As part of our inspection, we undertook a range of clinical searches and reviews of records, we identified cases where patients ongoing needs were not fully assessed and appropriately followed up placing them at risk of long-term harm. For example:</p> <p>We found 4 out of 9 patients on disease-modifying antirheumatic drugs (DMARDs) that were not receiving appropriate monitoring in line with guidance.</p> <p>We found 38 out of 43 patients (88%) on a specific high-risk medicine that were not receiving appropriate monitoring in line with national guidance. Of the 5 patients we reviewed, none were receiving an adequate review of their medicine.</p> <p>We found 29 patients who were put at risk from their medicines because advice from patient safety alerts and NICE guidance had not been actioned.</p> <p>The practice told us that annual health reviews for patients with long term conditions were carried out by the Practice Nurse and Healthcare Assistant but they did not undertake NHS Health checks for patients aged 40 to 74 years. NHS Health checks provide an opportunity to identify patient health risks and potentially undiagnosed conditions so that they may be effectively managed at an early opportunity. This was despite published data showing lower prevalence of diseases at the practice than local and national indicators which could potentially be the result of conditions not being identified.</p> <p>The practice advised that all patients with a learning disability had been reviewed in the last 12 months.</p> <p>The practice did not offer flu vaccinations for eligible patients. Patients were instead signposted to other local services available to receive the vaccination.</p>

The practice advised that they did not hold any formal meetings with the palliative care team for patients nearing end of life but was able to contact them when needed.

The practice did not provide a service to support patients who misused substances and staff we spoke with were not aware of any local services to refer these patients to for appropriate support.

## Management of people with long term conditions

### Findings

Practice staff told us that they carried out annual reviews of patients with long term conditions based on the month of their birthday. These reviews were undertaken by the Practice Nurse and Healthcare Assistant.

As part of the inspection, we reviewed the management of people with long-term conditions in a sample of patients: Our findings did not provide assurance that patients were being effectively managed. For example:

Our clinical searches identified patients with a missed diagnosis of diabetes who were not receiving appropriate follow up. For example, 8 patients were identified with a potential missed diagnosis of diabetes based on their blood results. We reviewed a sample of 5 records and found that 4 of the patients had a missed diagnosis of diabetes and had not received recommended screening, monitoring reviews and treatment. This placed them at risk of their condition deteriorating and leading to irreversible complications.

We identified 2 patients that were incorrectly coded for their Chronic Kidney Disease stage, which placed them at risk of not receiving the correct care and treatment for their condition and worsening renal failure.

We identified 9 out of 108 patients on the asthma register who have been prescribed 2 or more courses of rescue steroids to treat an exacerbation of asthma (an indication of poor asthma control). We reviewed a sample of 3 records and found the dosages and quantities prescribed were not in line with national guidance. At the time of prescribing, patients had not received an adequate assessment of their condition or follow up. This placed patients at risk of their asthma condition deteriorating and exacerbations not being properly managed.

We identified 23 out of 132 patients with diabetes whose latest blood test indicated poor diabetic control. We reviewed a sample of 4 records and found patients were not receiving adequate follow up of their diabetes and review their medication when their diabetic control was poor.

The practice could not demonstrate that staff who were responsible for reviews of patients with long-term conditions had the qualifications, training or received appropriate oversight to undertake them.

Patients with suspected hypertension were asked to undertake home blood pressure monitoring. At the time of inspection, the practice nurse did not have basic clinical equipment to undertake any blood pressure checks.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae 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)	25	28	89.3%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	29	34	85.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	29	34	85.3%	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)	29	34	85.3%	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)	34	39	87.2%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice was not meeting the 95% WHO target (the recommended standard for achieving herd immunity) or the 90% minimum target for child immunisation uptake.</li> <li>Trend data showed that the uptake for all 5 childhood immunisation indicators had significantly declined between 2021 and 2022.</li> <li>Staff we spoke with advised that they tried to contact failed attendances on 3 occasions. However, there was no evidence that they engaged with the health visiting team regarding uptake of child immunisations.</li> <li>Patient numbers involved were also relatively small and therefore the impact of 1 or 2 patients not attending could make a difference to the target being achieved.</li> </ul>

Cancer Indicators	Practice	SICBL average	England	England comparison
Bowel cancer screening coverage: aged 60 to 74 years old (01/04/2022 to 31/03/2023) (UKHSA)	72.9%	N/A	72%	N/A

Breast screening coverage: aged 53 to 70 years old (01/04/2022 to 31/03/2023) (UKHSA)	63.8%	N/A	66.6%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	50.0%	56.3%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	66.4%	N/A	80.0%	Below 70% uptake

### Any additional evidence or comments

- The practice was significantly below the national target of 80% for the uptake of cervical cancer screening. There had been little change in the trends in uptake over the past few years.
- Trends in cervical screening uptake were showing a downward trend over the last 5 years. There were no effective plans in place to improve uptake.

### Monitoring care and treatment

**There was a lack of monitoring of the outcomes of care and treatment.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:  Findings from our clinical searches did not demonstrate any clear and targeted quality improvement initiatives were in place. Staff we spoke to were unaware of any clinical audits undertaken.	

### Effective staffing

**The practice was unable to demonstrate that all 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.	Partial

Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Not reviewed
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice Manager shared with us the practice's mandatory training requirements however, it was not clear that there were effective systems for monitoring training to ensure all staff were up to date with these training requirements. We reviewed training records for the 5 permanent staff members and found basic life support training had not been undertaken in the last 12 months, not all staff had completed sepsis or sepsis awareness training and one member of staff had not undertaken recent training in infection prevention and control or had undertaken any information governance training. The practice did not maintain training records for the regular locum staff.</li> <li>Not all staff had access to annual appraisals to discuss their performance and learning and development needs. Of the 4 staff files we reviewed, 2 members of staff had received an appraisal in the last 12 months. For the remaining 2 staff, the last appraisal available was in 2019 and for the other member of staff there was no record of an appraisal.</li> <li>The provider told us that they had put in place a senior locum GP to provide clinical oversight and supervision of clinical staff working at the practice. However, there was no evidence of this being in place.</li> <li>We saw that the Practice Nurse and Healthcare Assistant had received training in relation to some of the role specific duties they undertook for example, immunisation training and cervical screening sample taking. However, they were also involved in long term condition reviews, medicine reviews and patient workflow for which there was no clear oversight from the medical team and limited evidence of specific training, competence or qualifications within the staff files for this role. The Practice Nurse advised that they had undertaken a diploma in cardiology.</li> </ul>	

### Coordinating care and treatment

**There was limited evidence that staff worked 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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial

Explanation of any answers and additional evidence:

The practice did not hold regular multidisciplinary team meetings to discuss the care and treatment of their most vulnerable patients. Staff told us that they did not have contact with the health visiting team but was able to contact other community services such as the district nursing and palliative care teams when needed.

**Helping patients to live healthier lives**

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population’s health, for example, stop smoking campaigns and tackling obesity.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that they referred and signposted patients who needed additional support to a range of services as appropriate for their needs for example, diabetes prevention programmes, flu vaccination services, blood tests, weight management and family planning services.</p> <p>Carers were signposted to the caring café hosted by practice’ Patient Participation Group where they could obtain further support.</p> <p>The practice did not carry out NHS Health checks to support the identification of patients at risk of developing long term conditions so that earlier interventions and lifestyle support may be put in place.</p> <p>Our review of clinical records found that changes to patients care and treatment was not always adequately discussed with them. For example, changes in medication. Long-term condition reviews did not always provide appropriate follow up for example in relation to asthma exacerbations.</p>	



### Consent to care and treatment

**Staff demonstrated and understanding of legislation and guidance when obtaining consent to care and treatment.**

	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.	Not reviewed
Explanation of any answers and additional evidence,  At the time of our inspection the practice was not undertaking procedures for which formal consent was required.  Staff we spoke with demonstrated an understanding of the legal requirements of consent in relation to mental capacity and children. They told us that they recorded verbal consent within patient records.	

## Caring

## Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing caring services because there was mixed feedback from patients relating to their experience. The practice could not demonstrate that it was acting on patient feedback to improve the patient service. The practice did not demonstrate a flexible approach to support carers to access services in a way that met their needs and caring commitments.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. However, feedback from patients was mixed in relation to the patient experience.**

	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.	Partial
Explanation of any answers and additional evidence:  Clinical records seen did not always demonstrate that patients were given timely information and opportunities to discuss their care. For example, in relation to exacerbations of asthma, changes to medicines and delays in workflow.	

<p>Results from the latest GP national patient survey published in July 2023 were lower than local and national averages for patient experience. Online reviews made in the last 12 months mainly raised issues about access.</p> <p>Practice staff told us that they were not formally participating in the Friends and Family test which invites patients of NHS services to provide feedback on their experience but did have their own version where they had texted patients. The practice shared with us results from this which showed 76% of patients were likely or very likely to recommend the service to others based on 21 responses. Comments indicated patients wanted permanent doctors for consistency and inhouse services for blood tests and flu vaccines. However, they were positive about the staff describing them as friendly and helpful.</p> <p>There were no action plans in place in response to patient feedback received in order to improve the patient experience.</p> <p>The practice had a very proactive and successful Patient Participation Group that hosted regular events to support the wellbeing of carers and develop patient skills in using technology to enable them to access online services and information.</p>	
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Patient feedback	
Source	Feedback
NHS Website reviews	There were 2 reviews in total, both were made in 2022 and reported difficulties getting through on the phone.

### 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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	67.8%	85.8%	85.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	69.4%	84.6%	83.8%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	89.8%	92.8%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	48.0%	73.9%	71.3%	Tending towards variation (negative)

### Any additional evidence or comments

The practice had not undertaken any analysis of the latest GP National Patients Survey to identify and take action to improve the patient experience.

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

### Any additional evidence

The practice had undertaken their own version of the Friends and Family test but there was no evidence that the results had been analysed or actions put in place to improve the patient experience. The information was undated so it was not clear what period the information related to.

### 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.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice held a wide range of health information leaflets for patients to take away.</p> <p>Patient records seen did not always demonstrate that patients were helped to understand their care and treatment. For example, changes to a patients long term medicines given by text did not provide the patient with adequate opportunity to ask questions.</p> <p>The patient participation group ran a successful caring café in which patients were able to find out more about support available to them.</p>	

Source	Feedback
Interviews with patients.	We spoke with two members of the practice's patient participation group. They did not raise any concerns relating to involvement in decisions about care and treatment.

### 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 stated that during their last GP appointment they were involved as much as they	85.7%	90.3%	90.3%	No statistical variation

wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)				
<b>Any additional evidence or comments</b>				
The practice scores for the question about involvement in decisions about care and treatment in the GP national patient survey was similar to local and national averages.				
				<b>Y/N/Partial</b>
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:				
Practice staff told us that they were able to access interpretation services but had not needed to.				
Information available in the practice and on the practice website signposted patients to support services available.				

<b>Carers</b>	<b>Narrative</b>
Percentage and number of carers identified.	27 (1.1%) of the practice list size.
How the practice supported carers (including young carers).	Staff advised that patients who were carers were referred to the Caring café hosted by the Patient Participation Group (PPG) that met on a regular basis.  The practice did not provide NHS Health checks for 40 to 74 year olds or inhouse flu vaccinations to support carers. However, staff were able to signpost patients eligible for flu vaccinations to other services who provided them.
How the practice supported recently bereaved patients.	Practice staff told us that they would send a condolence card and signpost to bereavement services.

### Privacy and dignity

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

	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence:	
The reception desk was within close proximity to the patient waiting area. Screens at the reception desk and background music helped minimise risk of conversations being overheard.	

Staff we spoke with told us how they would respect patients' privacy and dignity during examinations.  
 Privacy curtains were available in the clinical rooms.

## Responsive

## Rating: Inadequate

We rated the practice as inadequate for providing responsive services because, results from the latest GP national patient survey were below local and national averages. Feedback from patients raised issues relating to consistency of care, access to appointments and lack of in-house services such as blood tests and flu vaccinations. There was a lack of appropriate arrangements for when the practice closed during core hours. The management of complaints was disorganised and did not demonstrate that they were effectively managed and used to support learning and improvement.

### Responding to and meeting people's needs

**The practice was unable to demonstrate that it organised and delivered services to fully meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N
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.	Partial
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> <p>The practice had a very active and supportive Patient Participation Group (PPG) who had over the years been involved in setting up and hosting various successful social and wellbeing schemes within the local community. Most notable was the caring café which met every 2 weeks and the computer group, set up to support patients use the GP online access. Both groups had been running for approximately 7 years.</p> <p>There was little evidence that the practice fully understood the needs of their population and were developing services in response to those needs. We were not assured that the practice had effective systems for the early identification of long-term conditions and health risks. The practice was not proactive in providing NHS health checks and equipment was not always available to enable staff to identify and monitor health risks and diseases. This may have contributed to the lower prevalence of disease identified in the practice population compared to local and national averages. The practice did not routinely provide services such as blood tests</p>	

or flu vaccinations for the convenience of patients. The practice itself was not part of any Primary Care Network (PCN). PCNs are groups of local practices which work together to address local priorities in patient care.

The service was provided by locum staff, although the practice aimed to use regular locum staff this made it difficult for patients to receive effective continuity of care.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 12.30pm  (the practice told us that a health and wellbeing drop-in clinic took place in the afternoon, this related to services run by the patient participation group and was held at another location)  When the practice was closed, there was an answerphone message which provided an alternative telephone number for urgent calls held by the practice manager.
Friday	8.30am to 6.30pm
Appointments available:	Appointment times varied depending on locum availability, but were typically:
Monday	10.30am to 3pm
Tuesday	10pm to 6pm
Wednesday	9am to 5pm
Thursday	9am to 12.30pm
Friday	9am and up to 6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>Practice staff advised that they did offer home visits but were unable to recall when the last one was.</li> <li>Practice staff advised that they liaised with the community services to discuss and manage the needs of patients with complex medical issues as and when required. Although this did not currently extend to health visiting staff.</li> </ul>

- Patients were able to obtain prescriptions directly from their chosen pharmacy through the electronic prescription service.
- The practice nurse was able to offer appointments outside school hours so that school age children did not need to miss school.
- Staff told us that they would try to accommodate appointments for children but if this was not possible would advise them to attend the local urgent treatment centre.
- Extended access appointments were available at the practice on alternate Saturdays, through arrangements with a local GP alliance.
- Practice staff told us that if someone living in vulnerable circumstances, needed to access healthcare, such as homeless people they would register them as a temporary patient.
- Practice staff told us that if patients need longer appointments this could be offered on request.

**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 minimise 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).	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.	Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Practice staff told us that appointments were mostly booked on the day although patients could book up to 2 weeks in advance if needed. Appointments could be made online, in person or by telephone and were a mixture of telephone and in person appointments.</p> <p>We found information on appointment times on the practice website was not accurate. For example, the practice website stated the practice was available for appointments from 7am on a Tuesday however, this was not the case.</p> <p>The practice did not open on a Thursday afternoon, this was to allow for health and wellbeing activities led by the patient participation group to take place. However, these activities were not held at the practice. We found the practice did not have appropriate arrangements in place to support patients needing support when the practice was closed on a Thursday afternoon. Patients were directed to an urgent telephone number which was held by the practice manager who told us they would contact a locum GP if a doctor was needed. The practice manager could not assure us that they would be able to contact a GP if needed as there were no formal arrangements in place for providing this cover.</p>	

## 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 (01/01/2023 to 30/04/2023)	40.1%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	38.2%	59.1%	54.4%	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 (01/01/2023 to 30/04/2023)	26.6%	56.2%	52.8%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	65.6%	74.2%	72.0%	No statistical variation

### Any additional evidence or comments

Results from the latest GP National Patient Survey published in July 2023 showed questions about access to services scored lower than local and national averages. There were no action plans in place to support improvement in response to the patient survey.

The practice carried out their own inhouse Friends and Family Test, the results shared with us were undated. There were 21 responses comments, most were positive about the practice but there were some patients who expressed difficulties in getting appointments, obtaining basic services and having a consistent doctor.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 2 reviews in total, from 2022, both reported difficulties getting through to the practice on the phone.

### Listening and learning from concerns and complaints

**Complaints were not managed effectively. The practice could not clearly demonstrate how complaints were used to support and improve the quality of care.**

Complaints	
Number of complaints received in the last year.	6



Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	1
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Telephone complaint that patient had been given the wrong bottle.	Patient apologised to and new sample taken.
Patient unhappy that the GP would not prescribe a specific medicine.	The practice was unable to find a response to the patient. However, we did see on the patient record that the medicine was subsequently prescribed.

## Well-led

## Rating: Inadequate

We have rated the practice as Inadequate for providing Well-led services. The leadership team were unable to demonstrate they had implemented effective governance systems and processes to ensure the delivery of safe and effective care.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:  During the inspection, we found that systems and processes were not effective and were putting patients at risk.	

There was a lack of clear and effective leadership at the practice and managerial oversight of risks relating to patients and the service. Our inspection identified concerns of both clinical and administrative nature. Risks and performance were not clearly understood, and actions had not been identified to effectively address risks and challenges in the provision of the service.

The provider had not been in a position to provide any clinical oversight over the preceding 3 years and had brought in locum cover to provide this function on a long-term basis. However, findings from the inspection found there was no formal arrangement or contract in place specifying what this would entail and no evidence of any clinical supervision or oversight being undertaken.

When we attended the practice there were several staff absent, this including the GP locum responsible for oversight. In the absence of any reception staff on duty, the practice manager's duties were diverted to providing this cover. The practice nurse also appeared to be undertaking a range of administrative tasks removing them from clinical duties. A health care assistant was performing tasks outside of their role.

The practice was not part of any Primary Care Network (PCN) but told us that they had recently started to receive pharmacy support through a local GP alliance.

### Vision and strategy

**The practice was unable to demonstrate that they had a clear vision supported by a credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence:	
The provider advised that while they were unable to provide clinical duties, they were involved in the management of the business.	
The practice did not have any formal strategy to provide high quality sustainable care. Their main focus was on the Patient Participation Group who were very proactive in introducing various social wellbeing schemes in the local area.	
The practice had a mission statement to put patients first, and always.	

### Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	N
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	No
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice was a small family run service with the sole GP provider (not currently undertaking any clinical duties), practice manager and cleaner part of the same family. Staff we spoke with told us that the Freedom to Speak Up Guardian was the Practice Manager. This did not provide staff with an independent person to raise any concerns.</p> <p>The practice could not demonstrate how they managed staff performance. For example, not all staff had received appraisals to discuss their performance and learning needs.</p> <p>Staff we spoke with told us that they felt able to raise concerns if they needed to and understood the requirements of duty of candour. However, the practice had reported only one incident in the last year and told us that there had been no incidents in which duty of candour had applied. Our clinical searches indicated a case where duty of candour potentially could have applied.</p> <p>Training records for permanent staff showed that most staff had completed equality and diversity training. We were unable to verify this for locum staff as training records were not routinely held.</p>	

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

Source	Feedback
Staff feedback	Staff told us that they felt supported in their role.

### Governance arrangements

**The overall governance arrangements were ineffective.**

	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.	N
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
<p>Explanation of any answers and additional evidence:</p> <p>Staff were able to tell us who the leads were for specific roles and responsibilities for example, clinical oversight, safeguarding, infection prevention and control, and complaints.</p> <p>However, during the inspection we found the practice was not able to demonstrate effective clinical oversight and governance arrangements to ensure risks to patients were considered, managed and mitigated appropriately. For example, there was no effective systems in place to ensure clinical records contained appropriate information. Medicine reviews seen were not detailed in order to provide clinical staff with information they needed to deliver safe care and treatment. Patients with long-term conditions did not always receive effective follow up to ensure they were kept safe. There was a backlog of patient records which we were told required summarising. This did not provide assurance that records contained up to date information. The safeguarding register was not fit for purpose and did not provide assurance that the practice's most vulnerable patients were being appropriately followed up.</p> <p>Clinical oversight was provided by a long-term locum GP however, the practice had not contractual arrangement for this and what it entailed.</p> <p>We identified other issues in which there was a lack of effective governance for example, in relation to the completeness of recruitment and training information held for staff (including locum staff) and systems for managing infection prevention and control.</p> <p>The practice held regular staff meetings but from the minutes seen these were not attended by the locum GPs who were delivering the service to ensure key messages were shared and meeting minutes lacked detail for staff who were unable to attend or refer back to.</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
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N

Explanation of any answers and additional evidence:

The practice was unable to demonstrate effective processes for identifying and managing risks issues and performance.

We identified significant concerns in relation to the management of medicines and identification of potential long-term conditions. The practice had failed to identify any issues with medicines and in their meeting minutes and practice website had reported that they were the highest performing practice in the locality with regards to effective prescribing and patient safety in the management of medicines. The data presented by the practice showed them as a low prescribing practice. The practice showed little understanding of the data and the context to see if there were any areas for improvement. For example, the practice also had lower than average prevalence of long-term conditions and a lack of systems which they had not considered.

The practice told us that they reviewed quality outcome performance data and took action to call patients in for their annual long-term condition reviews. However, the practice had not taken any specific action or had plans in place to address any specific areas for improvement for example, in relation to child immunisations and cervical cancer screening uptake which were well below national targets or other areas where they may be an outlier.

There were no plans in place to address issues raised through patient feedback such as the GP National Patient Survey.

The practice had a significant backlog of unprocessed and unmatched results and correspondence and no action plans were in place to address this, to ensure important patient had not been missed.

The practice had a business continuity plan in place. However, this was in need of review as some information contained within it was no longer in date.

We identified issues relating to the lack of emergency medicines and clinical equipment and lack of up to date basic life support training to support patients in a medical emergency. At the time of the inspection the practice was also undergoing staffing issues, for which there were no plans in place for example, to ensure the continuity of clinical oversight.

The practice was unable to demonstrate any clear improvement plans in place, there were no examples of clinical audits or quality improvement initiatives available to us.

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
The practice was unable to demonstrate how it used data to improve performance, the practice was unable to provide any evidence of clinical audits, and was not proactive in reviewing information where the practice was	

an outlier for example, child immunisation, cervical cancer screening, patient satisfaction and medicines to identify areas for action and make improvements.

Disease prevalence data had identified the practice as an outlier, but no action had been taken to identify any potential reason for this or actions needed to improve the detection of potentially undiagnosed conditions.

Issues identified during the inspection relating to workflow and summarising backlogs and recording of information in clinical records such as medicine reviews did not provide assurance on the quality and accuracy of information held.

## 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.	Not reviewed
Patient records were held in line with guidance and requirements.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice used NHS approved systems when consulting with patients.</li> <li>• Patients requesting online services were required to provide proof of identification and were given a password to access the systems securely.</li> <li>• Patients were asked to confirm their identity when contacting the service.</li> <li>• There was information about general data protection on the practice website.</li> <li>• Training records seen for permanent staff showed that they had completed information governance training.</li> </ul>	

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

**Engagement with the public, staff and external partners to sustain high quality and sustainable care was very mixed.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a very proactive and supportive Patient Participation Group (PPG) that had delivered a range of successful social prescribing schemes for which they had been nationally recognised.</p> <p>However, feedback from the latest GP National Patient Survey, online reviews and the practices in house friends and family test had raised some areas for improvement. There were no action plans in place to improve the patient experience.</p> <p>As a small practice, staff we spoke with felt involved in the planning and delivery of the services. Regular staff meetings enabled them to participate in discussions about the practice.</p> <p>The practice was not part of any Primary Care Networks, so there was a lack of evidence it worked with other practices to develop services that met the needs of the local population.</p>	

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the practice's Patient Participation Group, they told us that they did not have any major concerns with the practice. The main issues raised by patients related to access and having stability within the medical workforce.

### 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
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence:	

### Examples of continuous learning and improvement

The practice had an innovative patient participation group (PPG) that had a strong history of delivering successful wellbeing schemes.

The practice was unable to demonstrate systems of clinical oversight and regular use of clinical audit to identify and address areas for improvement in clinical care.

Not all staff had access to appraisals with which to identify learning and development needs and training records available to us did not demonstrate that staff always had the qualifications, skills and competences for roles and responsibilities undertaken.

The way in which incidents and complaints were managed did not support learning and development.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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



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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.