

Care Quality Commission

Inspection Evidence Table

Boleyn Road Practice (1-537763824)

Inspection dates: 5 August 2020, 6 August 2020 & 12 August 2020

Date of data download: 23 July 2020

Overall rating: Inadequate

The practice is rated as inadequate for all key questions and population groups. The practice was rated as inadequate at our previous inspection undertaken on 4 December 2019 due to issues related to deficiencies in clinical governance, record keeping, practice policies and procedures, leadership and systems for managing complaints and learning from incidents. As a result of the findings from that previous inspection we issued a notice of decision to cancel the provider's registration. At this inspection we found that the provider had not made sufficient improvement and therefore remains rated as inadequate for all key questions and population groups.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Inadequate

The practice is rated as inadequate for providing services that are safe as there were deficiencies in systems and processes related to safeguarding, significant event management, medicines management, recruitment, infection control and risk management.

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
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	N

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found that not all staff had completed safeguarding training. At this inspection we asked the practice manager if their safeguarding training had been completed since the last inspection. The practice manager said that they had completed safeguarding training but that he was unsure whether this had expired. The reception manager then provided training certificates for both the reception manager and the practice manager which showed that both safeguarding adults and safeguarding children training had been completed within the last three years. However, the child safeguarding training was level 1 and not level 2 in line with current guidelines. The practice manager was not aware that non clinical staff were required to complete level 2 child safeguarding training. The practice provided certificates showing all non clinical staff had completed level 2 adult and child safeguarding training after our inspection.</p> <p>At the last inspection the practice's safeguarding policy did not have the name of the current lead for safeguarding. The policy referred to a GP who was no longer working at the practice. The policy was dated May 2018 but there was no review date document and the policy contained out of date information; including referring to the primary care trust. Additionally the practice manager was unable to locate the policy. At this inspection we were provided with a child safeguarding policy (last updated June 2020) and adult safeguarding policy (dated March 2020). The child safeguarding policy made three references to the primary care trust.</p> <p>We were told that the salaried GP within the practice was the lead for child and adult safeguarding. The salaried GP worked a full day Tuesday and Wednesdays. We were told that the deputy lead for safeguarding was a sessional GP who worked Thursday afternoon but was available throughout the week to deal with any queries that arose. The policies provided confirmed this.</p> <p>We spoke with the practice safeguarding lead who was unable to access the practice's safeguarding registers and told us that the practice's medical secretary dealt with the safeguarding registers and these were password protected. The safeguarding lead said that they had not reviewed these registers since they started working at the practice in July 2020 and was unsure if anyone in the practice did this. The safeguarding lead said that safeguarding cases would be discussed in the practice's multidisciplinary meetings.</p> <p>The practice provided a list of patients with safeguarding concerns who they said were due to be reviewed after the inspection. The list included one patient who had been on a child protection plan since 1999 and therefore, in 2020, would no longer be appropriate to be included on this register.</p>	

Safeguarding	Y/N/Partial
<p>Not all staff we spoke with were able to locate the safeguarding policy on the practice system, but all staff knew who the safeguarding lead was. Not all staff demonstrated an adequate understanding of safeguarding.</p>	
<p>At the last inspection we found that the practice was having external multidisciplinary meetings where safeguarding concerns were referred and discussed with other agencies. However, there was no evidence of internal discussions of patients where safeguarding concerns had been identified. At this inspection we were provided evidence of staff meetings where safeguarding cases were discussed. We reviewed the records of some patients that were discussed in these meetings and were not assured that all patients discussed were being appropriately followed up when requests were made by external agencies. Not all staff said they were involved in discussions around safeguarding.</p>	
<p>At the last inspection we were told that the practice did not share safeguarding concerns with out of hours services. At this inspection the practice manager told us that they historically shared safeguarding cases with out of hours providers but could not provide any evidence of this. The reception manager asked one of the sessional GPs if this was shared. The sessional GP said that the practice placed alerts on their patient records system for any patients where safeguarding had been identified as a concern and that the same systems were used by other providers locally. When asked if the same system was used by the out of hours service, the sessional GP said that they did not know and said that they do not share lists of patients where safeguarding concerns have been identified with the out of hours provider.</p>	
<p>At our last inspection we found that there were no alerts on the record of patients with learning disabilities or dementia. At this inspection we undertook a review of patients with learning disabilities and dementia and found that, of those records reviewed, care plans were in place and alerts were on all records reviewed. However, we reviewed the record of a patient where safeguarding concerns had been raised but there were no alerts on the system to highlight that this patient was a vulnerable adult.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	N
<p>Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.</p>	Y
<p>There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.</p>	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that no induction had been completed and no photo ID obtained for one staff member. At this inspection we reviewed the files of three members of non-clinical staff on the practice's computer system. We found that one staff member had no contract and no induction record on file. Another staff member had no contract on file that was signed (although later the practice manager</p>	

showed us a paper copy of a temporary contract from 2007 for this staff member) and no induction. Another staff member had no file on the system. The practice manager told us that they had some of the staff files at home. The practice manager then said that there had been some data lost when information was transferred over from one system to another.

The practice submitted partially completed induction forms after our inspection. These had been completed after our inspection.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 2 December 2019	Y
There was a record of equipment calibration. Date of last calibration: 31 October 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: February 2020	Y
There was a log of fire drills. Date of last drill: November 2019	Y
There was a record of fire alarm checks. Date of last check: weekly	Y
There was a record of fire training for staff. Date of last training: Various	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: December 2019.	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At the last inspection we found that there was no risk assessment for controlling substances hazardous to human health (COSHH) for certain items stored at the practice including bleach, Dettol and multi surface polish. We asked the practice manager to provide COSHH risk assessments and they asked if we meant the COSHH policy. We clarified that we were looking for the risk assessments for each COSHH item. They then asked the reception manager to provide this. The reception manager then asked another member of staff to find this. We were then provided with a document which showed that assessments had been completed for handwash, hand rub, a medical wash, washing up liquid and Dettol surface cleaner. Some of the assessments were limited in the detail they gave in respect of the hazards to human health. For example, the only hazard for Dettol was "hazardous to ozone layer" and the key	

health effects were noted as “precautions labelled at the back of bottle”. The sixth page of the risk assessment listed several items including bleach and surface polish. The risks were noted as “high” but there was no detail of action taken to mitigate the risk or what the risks were. The document was dated July 2018.

The practice provided COSHH assessments after the inspection. However, there were three items listed as being used at the practice but no assessment had been completed. Additionally, one of the risk assessments completed stated: “No known significant effects or critical hazard” and “No known effects available based on data sheet” However there was information available which detailed these hazards that would necessitate action being taken. The action required was referred to in the risk assessment completed for this item.

At the last inspection we saw that the practice had completed a fire safety drill. There was nothing documented following the drill which showed how long it took to evacuate the building or discussion of any learning from the drill. At this inspection we saw that a fire drill had been completed in November 2019. Again, there were no action points documented. We asked the practice manager about this but did not get a response. We asked one of the two fire marshals if there was any documented learning following this drill. They told us that nothing had been documented following this drill but that it took approximately three to four minutes to evacuate and at the next drill they will aim to reduce this evacuation time. They also told us that the alarm worked during testing. The fire warden outlined the process for evacuating the building including two members of staff checking each of the floors in the practice and said that this should be outlined in the fire policy. The fire policy dated March 2020 stated that:

Emergency and evacuation plans must not depend on the fire and rescue service to evacuate people. However, the practice will consult with the fire and rescue service when planning and determining an appropriate and effective evacuation strategy.

Additionally, the practice will identify the most effective means for checking everyone on the premises is safely evacuated.

There was nothing regarding the requirement for fire marshals to check the premises prior to evacuation or further information about the evacuation process. There was no evidence that the fire service was consulted regarding the evacuation plan.

After the inspection the provider showed they had contacted the fire brigade by email and had drafted a fire evacuation plan. The practice provided a document showing a fire drill had been completed in September 2020 and there was a supporting document which evaluated the drill and detailed action points for how the practice could improve their evacuation procedures.

At the last inspection, the fire policy did not contain the names of the fire marshals. At this inspection we saw that the fire policy had been updated to include the fire marshals and posters were displayed around the practice which said that two of the four staff members listed in the policy acted as the fire marshals. Fire marshals were trained for the role however some staff were not aware of who all the fire marshals were.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	N

Date of last assessment: n/a	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 19 both Health and Safety risk assessment and legionella interim check and water sampling.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had a legionella interim health check completed in December 2019. This expired in July 2020. The practice also had water samples analysed which showed there was no legionella present in the water supply. The practice provided us with three months' worth of temperature checks; April, May and June 2020. The temperature checks for both May and June 2020 showed that the temperature in each room was above 20 degrees Celsius which is the temperature at which legionella bacteria could survive. There was nothing documented to show what action had been taken to address this issue.</p> <p>The practice provided us a document which indicated temperature monitoring had been undertaken in August 2020. This showed that all cold water temperatures were at or under 20 degrees Celsius.</p>	

Infection prevention and control

Not all risks associated with infection control had been addressed or mitigated.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 11 March 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection we were provided an infection control audit which had no date. At this inspection we asked the practice manager for the latest infection control audit. The audit, dated 11 March 2020, was completed by an external consultant and outlined multiple infection control concerns including requirements around cleaning the sink in the reception area and a damaged table with exposed wood in the treatment area. We asked the practice manager if they had a documented action plan to address these concerns and if this had been completed. The practice manager told us that there was nothing documented but that the practice cleaner would have addressed these issues as part of their regular cleaning. We spoke with the practice cleaner and asked if they recalled addressing the areas of concern raised in the audit. The practice cleaner told us that they had no recollection of doing this. The practice manager then said the cleaner would have addressed these concerns as part of their normal cleaning routine. When we asked the practice manager why these issues had been raised in the audit if they would have been covered by the regular cleaning scheduled, the practice manager</p>	

did not provide a response. In respect of the broken desk the practice manager confirmed that the desk was still at the premises because it was only slightly damaged. We reviewed the desk which was cracked and showed exposed wood.

The practice provided an updated copy of the infection control audit which listed the action taken in response to the infection control concerns; including obtaining a plastic sheeting to cover the exposed wood on the desk in the treatment room.

At the last inspection staff were unclear who acted as infection control lead. At this inspection we were provided with the practice's infection control policy. The policy stated that the practice manager took overall responsibility for infection control but that this was shared with three nurses on the days that they worked. Not all staff were aware of the identity of the infection control lead.

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
Comprehensive risk assessments were carried out for patients.	
Risk management plans for patients were developed in line with national guidance.	
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we asked about the arrangements the surgery had in place when staff were absent and there was no policy which dealt with how to manage poor attendance. At this inspection, the practice provided a sickness and capability policy last reviewed in November 2018 which outlined how the poor attendance and capability/disciplinary matters would be dealt with.</p> <p>The practice manager gave an example of a staff member who had asked for time off due to personal circumstances and he had called the staff member in question and told them that they needed to come to work.</p>	

The practice manager said that they did not use agency or locum staff to cover absences in the administrative and reception team as it was difficult to get staff on short notice who could learn the job quickly enough and that agency staff that they hired in the past for these roles were not able to observe the religious and cultural issues of the practice demographic. The practice told us after the inspection that locum administrative staff had been used to cover staff absences related to the pandemic.

The practice manager said that they had found it difficult to undertake their role due to ongoing IT issues. They told us that these issues had been ongoing for years. This had become particularly difficult during the Covid 19 pandemic as these issues had prevented them from being able to access IT systems remotely. When asked who undertook practice management duties on site in their absence, they told us that the reception manager did this job but was able to contact the practice manager at any time for support. The practice manager also said that they had been coming into the practice early in the morning and late in the evening and had been able to access the systems at the practice and ensure that everything that all of the practice management duties were completed. They said they had been working on issues, including those related to CQC enforcement action and the termination of the NHSE contact, during this time.

Information to deliver safe care and treatment

Staff had the information they needed to deliver 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.	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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
At our last inspection the practice was unable to demonstrate how they shared information with other staff and agencies, we asked to view examples of sharing information with external agencies and they	

were unable to provide any. At this inspection we reviewed records which evidenced information sharing with external agencies in relation to the delivery of patient care.

Appropriate and safe use of medicines

The practice had improved some aspects of their medicine's managements. However, we found that processes for medication reviews and monitoring were lacking.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2019 to 31/03/2020) (NHS Business Service Authority - NHSBSA)	0.29	0.71	0.87	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2019 to 31/03/2020) (NHSBSA)	7.5%	9.2%	8.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2019 to 31/03/2020) (NHSBSA)	7.54	5.74	5.46	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2019 to 31/03/2020) (NHSBSA)	0.37	1.36	2.01	Significant Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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 structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that medication reviews lacked sufficient detail and that some patients on high risk medicines were not receiving regular monitoring. At this inspection we reviewed patients prescribed high risk medicines and most patients were being monitored appropriately. Although some patients were slightly overdue monitoring this was considered reasonable in light of the ongoing risks associated with Covid 19 and the advice that had been issued around drug monitoring requirements. However, we did review the record of one patient prescribed a high-risk medicine who was two months overdue monitoring. There was an entry which stated that a medication review had been completed by a staff member who the GP we spoke with was unable to identify. The person who completed the review had not identified that monitoring was overdue. The GP told us that the medication review entry in the patient's record was a mental health review which had been incorrectly coded. This would mean that the patient would not flag as requiring a medication review until it was next due.</p>	

NHSE had undertaken an audit of the GP partner's consultations. This audit identified poor record keeping in 29 of the 30 records that they reviewed. Issue of concern including but were not limited to lack of detail around medication reviews. We raised this as a concern at our last inspection. The practice stated in their response to the notice of proposal to cancel their registration:

As an additional point, we have reflected and accept that no effort had been made to address the deficiencies in the 30 consultations highlighted by NHSE prior to this inspection. Thus, as part of our action plan, we will now work to ensure that this is properly managed. The plan includes dividing the 30 consultations between 3 doctors. (the doctors) have verbally agreed to action this. They will call the patient, admit and explain that there had been poor documentation of the consultation in question. Then, they will reassess the patient in relation to the particular presenting complaint, either face-to-face or over the phone. This will ensure that the presenting complaint is adequately managed. We will also ensure that as patients are seen at the practice, we carry out a brief review of all consultations at the time.

We asked one of the GPs and practice manager if a subsequent record review had been done of these records to determine if any follow was required for these patients. The GP told us that they had reviewed approximately half of the 30 records. They also told us that they had undertaken a review of the partner's consultations before and after the partner had undertaken training to improve their record keeping. This showed that the quality of record keeping had been improved. However other than the dates of the consultations, May and June 2019, there was little information in the audit to enable CQC to review this. The GP told us the audit was based on a random patient sample. Therefore, there were no patient record numbers and no indication of what the consultation involved, if any issues were found and how these were fed back. This was submitted as part of the representations to CQC's notice of decision. The GP confirmed that the partner had not worked at the practice since September 2019 and that there had been no further review of the partner's record keeping.

After our inspection, the practice told us that only half of the records had been reviewed because of pressures associated with Covid 19 which meant that staff did not have sufficient time to review all 30 records.

At the last inspection we found that there were two Patient Group Directions (PGD) that had not been signed by one of the practice nurses. At this inspection we found several PGDs that did not include the name of the practice and some were not signed by one of the nurses. The practice manager told us that this nurse in question had not worked at the practice since March 2020. The other two nurses had signed the PGDs after March 2020. However, the PGDs were dated prior to the dates the nurses signed; some dated as far back as April 2019. It was therefore unclear if signed PGDs were in place prior to the dates the nurses signed them.

The practice told us after the inspection that the PGDs were printed after our last inspection and signed by all staff and they had, after our most recent inspection, updated all PGDs to include the practice name. However, this did not address what documentation was in place for staff administering medicines covered by PGDs in between the last inspection and the date of signing; which in some cases was a period of several months.

Medicines management	Y/N/Partial
<p>The practice was not undertaking any review of their controlled drug prescribing at the last inspection. One of the GPs we spoke with on this inspection told us that this still was not being done.</p>	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found that the practice’s significant event policy was dated February 2018. The deputy lead noted in the policy had left the practice. We were also told that minutes for meetings were drafted without these having occurred and staff could not tell us where to access minutes and there was no evidence or learning documented from significant events or discussed in meetings.</p> <p>The practice told us after the last inspection that they would have regular meetings where significant events would be discussed, and learning would be shared.</p> <p>At this inspection we spoke with the GP and the practice manager about the practice’s significant event process. Both were able to outline learning and action taken in response to recent significant events and we were provided with significant event forms for these incidents and evidence that significant events were being discussed in practice meetings.</p> <p>The practice told us about another significant event involving inaccurate discharge notes from a secondary care provider. One of the GPs at the practice told us that they had discussed this in a practice meeting outlined the action taken but had not formally written this up using the practice’s significant event form.</p> <p>Not all staff we spoke with on inspection could provide an example of a significant event or knew what would amount to a significant event that would need to be reported in line with the practice’s policy.</p>	

We asked one of the GPs about the process for reporting significant events to external organisations. They were unable to provide an example of an external organisation they would report anything to. When asked if they had submitted anything to NRLS they told us that they had not.

The practice provided a policy for reporting incidents to the NLRS which was created and sent to us after the inspection. The practice told us that they were due to discuss this policy at their next practice meeting.

We asked the practice manager for examples of things that would be reportable to CQC. The practice manager said they would report patient deaths but could not provide an example of anything else. The practice manager then said that they had a list of things that they would report in a policy. The practice manager asked the reception manager to find this policy. The reception manager could not find the policy. The practice manager then went to try and find the policy. We were not provided with a policy, but the practice manager provided a list of things that were reportable to CQC. It was unclear where the list came from.

The practice provided a policy after the inspection regarding incidents that were reportable to CQC. The date on the policy indicated that this had been in place since 2016 although this could not be located during our last inspection.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Patient attending surgery with Covid 19 symptoms despite having been asked to confirm if they had symptoms during the telephone triaging process	Appropriate action taken to address immediate Covid related risk by decontaminating the site. Reception staff to ask patients if they have any symptoms and any new symptoms to ensure that they have ample opportunity to relay symptoms before they enter a consultation with healthcare staff.
Patient who needed to be recalled for a test was not notified as text message was sent to a number that was no longer valid.	Patient contacted for follow up. No harm resulted from delay and when patients fail to attend for recalls these were referred to a clinician to decide on the next course of action. Staff were told to confirm the contact information for patient every time they attended the surgery.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found that there was limited evidence of action and discussion taking place in response to patient safety alerts. At this inspection we saw evidence of alerts being cascaded and action points agreed in meetings. However, we reviewed a patient prescribed one medicine which was</p>	

the subject of a recent safety alert. This patient had joined the practice after the alert was issued and had not been provided with advice on the risks associated with continuing to take this medicine. We asked the salaried GP what the process was for identifying patients who were on medications that were the subject of historical safety alerts when they joined the practice. The GP told us that they did not know how this would be managed.

Effective

Rating: Inadequate

The practice is rated inadequate for providing effective care as we identified concerns around the practice's ability to identify and provide care to patients who were diabetic. Performance for a number of national targets were below local and national averages and there was no evidence that this had improved or that action had been taken to attempt to improve the quality of care for these patients. The practice had also failed to implement effective systems to review and monitor the quality of clinical care provided at the practice.

Effective needs assessment, care and treatment

Patients' needs were not consistently assessed and we saw instances where care and treatment was not delivered in line with current legislation, standards and evidence-based guidance.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
Explanation of any answers and additional evidence:	

We saw evidence of guidelines being discussed in practice meetings.

We found that in most instances patients needs were fully assessed and action taken to meet their needs. However in some instances we found that care was not provided when risks were identified. For instance we found one patient on a high risk medicine who was two months overdue monitoring, ten patients who had missed diagnosis of diabetes who had not been followed up and safeguarding concerns that were not appropriately followed up.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2019 to 31/03/2020) <small>(NHSBSA)</small>	0.13	0.30	0.71	Significant Variation (positive)

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Older people

Population group rating: Inadequate

Findings

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. We were told that a newly appointed pharmacist from the local primary care network assisted with medicines reconciliation.
- The records we reviewed showed that the practice carried out structured medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People with long-term conditions

Population group rating: Inadequate

Findings

- We identified a number of patients who had tests which showed that they were diabetic who had not received appropriate follow up care and treatment. Of the ten patients we identified who had a missed diagnosis of diabetes, the practice told us after the inspection that seven of these patients had not been coded as diabetic, two were confirmed diabetic and one patient was pre diabetic. The practice told us after this concern had been brought to their attention, monthly searches would be introduced to ensure that those patients with a possible missed diagnosis of diabetes were identified.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met although performance against some national clinical targets for patients with long term conditions was below that of other practices locally and nationally.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	54.2%	72.7%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (10)	7.9%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.1%	78.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	2.1% (10)	4.9%	9.4%	N/A

	Practice	CCG average	England average	England comparison
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The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.5%	80.2%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.4% (21)	7.0%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.1%	78.1%	75.9%	Variation (positive)
Exception rate (number of exceptions).	0.8% (2)	3.0%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.0%	92.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.7%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.1%	81.7%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.4% (8)	3.4%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	87.5%	90.1%	91.1%	No statistical variation
Exception rate (number of exceptions).	20.0% (2)	6.0%	5.9%	N/A

Any additional evidence or comments
From reviewing the practice's clinical record system, we identified ten patients who had a missed diagnosis of diabetes. Of the six records reviewed, none of the patients had been informed of their diagnosis. They had not been included in any recall programme for monitoring and had not been referred for eye screening or foot checks or diabetes education.

Of the ten patients we identified who had a missed diagnosis of diabetes, the practice told us after the inspection that seven of these patients had not been coded as diabetic, two were confirmed diabetic and one patient was pre diabetic. The practice told us that some of these patients had been recalled but we were provided with no documentation which supported this claim.

The practice told us after this concern had been brought to their attention, monthly searches would be introduced to ensure that those patients with a possible missed diagnosis of diabetes were identified.

One of the patients had very high blood glucose readings in 2015 and 2016. The patient had been called and sent a letter after their first test and sent a letter after their second test. No further action had been taken. The practice informed us after the inspection that this patient had been removed from their patient list following attempts to contact them since our inspection.

We discussed some of these patients with one of the GPs who was unable to explain why these patients had not been contacted.

Due to Covid 19 the requirements around QOF targets had been relaxed. Therefore, we did not ask the practice to provide us with any up to date figures. However, we asked one of the GPs at the practice what work had been done to improve the care being provided to patients with diabetes and hypertension.

The GP told us that they had contracted a drug company who were planning to start running clinics. The company would then analyse the practice's diabetes performances and take responsibility for recalling patients. Patients would then be given information on how to optimize their care by pharmacists working for this company. The pandemic had prevented this work starting but that the practice would soon reach out to this company to initiate this work.

The GP told us that they had encouraged patients with hypertension to purchase their own blood pressure machine and generally patients have been happy to do this. The practice pharmacist was then tasked with contacting patients to get blood pressure readings. The GP told us that they had not audited this and therefore did not have any information regarding the impact of this work.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisations achievement was below national targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice told us that they had arrangements for following up failed attendance of children's appointments following an appointment in secondary care.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.

- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2018 to 31/03/2019) (NHS England)	7	75	9.3%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	18	66	27.3%	Below 80% uptake
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) (01/04/2018 to 31/03/2019) (NHS England)	34	66	51.5%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	33	66	50.0%	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

When we asked the practice manager about the below average performance in relation to childhood immunisation targets they said the low scores were because the practice was subject to different targets from the CCG and NHSE and that, according to the figures provided by these organisations which were provided at the last inspection, they were performing well and that they had never been subject to any breach notice or oversight from the CCG. The practice manager explained the discrepancy was the result of a contractual variation and that because the practice operated under a GMS contract, as opposed to a PMS or APMS contract, they had different targets and specifications in respect of childhood immunisations.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2019) (Public Health England)	54.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	43.4%	45.1%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	34.9%	46.7%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	66.7%	77.0%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	0.0%	47.0%	53.8%	Significant Variation (negative)

Any additional evidence or comments

We asked one of the GPs and the practice manager about efforts made to improve cervical screening uptake. We were told that the practice nurse maintained a list of patients who needed to be recalled for cervical screening and that this nurse had made efforts to call patients who were due screening both before and during the pandemic, despite this procedure having been suspended until four to six weeks earlier. In addition to this, the practice issued three recall letters to patients who were due screening. The practice manager said that they regularly checked Open Exeter to ensure that reminders were sent on time and monitored the cervical screening cards. We were told that no additional action had been taken to encourage uptake.

We asked one of the GPs about the low rate of two week wait referrals. They told us that two week wait referrals were being sent and did result in the identification of cancers. They could not explain why the figures from Public Health England showed that the detection rate was 0%.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice safeguarding lead was unable to access registers for vulnerable patients and had not reviewed the registers since they began working at the practice in July 2020. Patients who had safeguarding concerns raised were not consistently highlighted on the practice's patient record system and the management of these patients did not always ensure that risks were mitigated.
- Patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

This population group is rated inadequate because effective as a whole is rated as inadequate and the issues identified such as lack of systems for clinical oversight relate to all population groups.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. However, performance for targets related to care plan provision for patients with serious mental illness was below local and national averages. We also reviewed the notes of one patient with serious mental health problems where the assessment of their needs was not adequate.
- Same day and longer appointments were offered when required.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	68.2%	90.4%	89.4%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.3% (1)	9.0%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	91.9%	90.2%	Variation (positive)
Exception rate (number of exceptions).	4.3% (1)	6.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	87.5%	81.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.1%	6.7%	N/A

Any additional evidence or comments

We did not ask the practice about the comparatively low level of achievement in respect of targets related to patients with serious mental health conditions at this inspection.

Monitoring care and treatment

The practice had undertaken a number of clinical audits since our last inspection that demonstrated quality improvement. However, the practice had not fully implemented quality improvement activity that was needed to improve performance against national clinical targets and had not taken all the required actions to assure themselves about the quality of care, that they agreed to take after their last inspection.

Indicator	Practice	CCG average	England average
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Overall QOF score (out of maximum 559)	467.5	534.7	539.2
Overall QOF score (as a percentage of maximum)	85.0%	95.8%	96.7%
Overall QOF exception reporting (all domains)	2.7%	5.8%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
Quality improvement activity was targeted at the areas where there were concerns.	N
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

Any additional evidence or comments

The practice provided us with a number of audits and reviews completed since our last inspection.

One of the reviews related to patients being switched from Emerade to alternative treatment in response to an MRHA alert. The practice reviewed all patients on this medicine. Recalled them and switched them to an alternative medicine.

We were provided with an undated audit related to patients prescribed non-steroidal anti-inflammatory medicines (NSAIDs). The first cycle aimed to review patients prescribed these medicines who were at risk of gastrointestinal effects based on their co-morbidities and to either stop prescribing if the medicine was no longer appropriate or prescribe a proton-pump inhibitor (PPI) if continued prescribing was needed. The practice found that of those patients at high risk from taking NSAIDs only 33% had been prescribed a PPI. At the second cycle the practice found that 100% of high risk patients were prescribed a PPI.

Another undated audit related to end of life care. The audit reviewed the care records of patients who had died in the last 12 months to determine if these patients had been on the practice's palliative care register, had a DNAR (do not attempt to resuscitate) in place, if their preferred place of death was documented and if bereavement support had been given to family members. The first cycle of the audit showed that 25% of patients had been on the palliative care register, 50% had DNARs in place and none had been offered bereavement support or had their preferred place of death documented. The practice discussed this at a meeting, aimed to improve coding and ensure that bereavement support was provided. There was no second cycle provided and no indication from the first cycle of the audit when or if this would be completed.

The practice provided an undated audit of patients prescribed sodium valproate. The audit aimed to ensure women of child bearing age, who are at risk of complications associated with this medicine, were having an annual review by a clinician and had completed a signed acknowledgement risk form. Neither of the two patients identified by the audit had received an annual review and only one of the two patients had signed an acknowledgement of risk form. The findings of the audit were discussed in a

clinical meeting. The practice obtained the risk form for the one patient who did not have this and had recalled another patient.

Finally, the practice had undertaken a review of patients prescribed lithium to see if they had adhered to the lithium monitoring requirements. At the first cycle only 50% of the requirements had been adhered to. At the second cycle, completed in March 2020, all patients had now had their monitoring completed.

The practice had put in place an improvement plan after our last inspection. However, there were a number of areas where the practice had not made changes that related to the provision of clinical care; including the monitoring of controlled drug prescribing and reviewing all 30 of the records reviewed by NHSE where concerns had been raised.

Effective staffing

The practice was unable to demonstrate that staff had all the necessary 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	N
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial

Explanation of any answers and additional evidence:

We were not assured that staff had the skills and knowledge to undertake their role as no induction had been completed for two members of staff. The practice manager acknowledged that it was possible that these induction records had not been completed. They also told us that they might have had some of the staff files at home. The practice manager then said that there had been some data lost when information was transferred over from one system to another. The absence of induction for some staff members was also raised at our last inspection.

The practice submitted partially completed induction forms after our inspection. The forms had been completed after our inspection.

At the last inspection we found that there was no probationary period for staff working at the practice. At this inspection we found that two staff members did not have signed contracts on file therefore there was no evidence that they had agreed to work under the terms of a contract that included a probationary period.

At the last inspection we found that the practice fire wardens and infection prevention control leads did not have the required training in these areas. At this inspection the reception manager provided training certificates for staff who undertook these roles. However, not all staff had completed the appropriate level of safeguarding training.

At the last inspection we found that there was no evidence of clinical supervision happening in the practice. We asked the practice manager if this was now in place and we were directed to speak with one of the doctors who we were told was dealing with this matter. The GP told us that there were slots each day where GPs could discuss queries from other healthcare professionals. We asked the GP if any of this supervision had been documented and we were told that none of the supervision sessions had been documented. This GP then asked one of the other GPs if there was any documented evidence of supervision. The GP showed us a patient record which noted a discussion held as a result of a query brought to them by the PCN pharmacist. They told us that aside from these queries, documented in individual patient records, there was no documented clinical supervision.

As part of the practice's representations against the notice of proposal to cancel the provider's registration, issued after our last inspection, the practice told us that they intended to undertake annual and bi annual internal records reviews.

At this inspection we found that the practice had not undertaken any reviews of clinical consultations that had taken place since mid-2019.

We found that there was a policy in place on how to manage staff performance.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Partial

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centered care when they moved between services.	Partial
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that, while there were multi-disciplinary team meeting discussions being held with external agencies regarding the care of patients, there had been no internal discussion of patient care to ensure that this was being managed consistently across the team. The practice told us as part of their representations that they would start to have clinical meetings where patient care could be discussed two to three times per month. We review the notes of the last three practice/clinical meetings. The meetings were held in March, May and July. We were told that the frequency of meetings had reduced because of Covid 19.</p> <p>We saw instances where the practice had been asked by third parties to undertake an assessment or action for a patient, particularly in respect of safeguarding, but that this had not been done.</p> <p>We saw evidence that the minutes of meetings were circulated to all staff by email so that those who were unable to attend the meeting could review these.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that non clinical staff were putting information about patient's smoking status into the patient records without getting information regarding the current smoking status from patients. At this inspection we were told that a review of the system had been undertaken after our last inspection and that 35 out of 50 records reviewed showed that the patient's status had been put into the system without a consultation taking place. The practice identified that this was done by one member of</p>	

staff and a significant event was raised. However, this member of staff had not returned to work since the issue was identified, so the practice has kept the significant event live until they are able to resolve it fully.

We saw that the practice had encourage patients with hypertension to review their own blood pressure. However, the practice had not followed up patients who had test results which indicated a diagnosis of diabetes and were not consistently following up patients who were vulnerable because of safeguarding issues.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	96.3%	95.0%	Significant Variation (positive)
Exception rate (number of exceptions).	0.8% (8)	0.9%	0.8%	N/A

Consent to care and treatment

The practice did not have a process in place for monitoring consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Partial
Policies for any online services offered were in line with national guidance.	N/A

Explanation of any answers and additional evidence:

At the last inspection we found that there was no system in place to audit and monitor patient consent. We were told by one of the GPs at this inspection that there was still no process now. They said that this was not necessary as coil fittings had been suspended due to Covid 19. The said that they documented and recorded consent for all intimate examinations but there had been no audit of this. We identified no issues regarding the recording of consent in any of the records that we reviewed. However, we looked at one record for a patient where an external agency had requested the practice to undertake an assessment of the patient's capacity, but this had not been done.

Caring

Rating: Inadequate

The practice is rated as inadequate for providing services that were caring as the practice was below local and national averages for most national GP patient survey indicators. Although the practice had acted to address below average performance; the practice had yet to engage with their population to see if any of these actions had improved patient satisfaction.

Kindness, respect and compassion

National patient survey scores related to being treated with kindness and respect were below local and national averages.

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

CQC comments cards	
Total comments cards received.	0
Number of CQC comments received which were positive about the service.	0
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Due to the short announcement of the inspection we were not able to issue comment cards to collect feedback from patients
Patient interviews	Given the way that the service was operating in response to the Covid 19 pandemic and the potential risks associated with speaking to patients face to face; we were unable to speak with patients as part of this inspection.
NHS choices	There were no reviews of this practice since our last inspection or in the previous 12 months.
Google reviews	There were four reviews of the practice in the last 12 months. All were one star reviews.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	71.1%	82.4%	88.5%	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 (01/01/2020 to 31/03/2020)	59.1%	79.1%	87.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	82.7%	91.6%	95.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	54.0%	73.7%	81.8%	Variation (negative)

Any additional evidence or comments

At the last inspection we asked the provider about their below average performance in respect of the National GP patient survey. The practice told us that they had completed their own internal survey which indicated improved satisfaction. The practice developed an action plan but there was no information about when actions would be implemented.

At this inspection we asked if any action had been taken to try and improve patient satisfaction. The practice manager provided evidence of the feedback from the most recent National GP patient survey which he said showed improved satisfaction. However, there were still several satisfaction scores below the local and national average.

In terms of actions the practice had taken since the last inspection, we were told that the practice had increased the number of appointments available although they were unable to provide specific information on the number of additional appointments the practice could now provide. However, we were told that each clinical session had been increased from two to three hours. The practice had also been provided with support from the Primary Care Network (PCN) pharmacist who was able undertake a range of clinical tasks, including medication reviews, which provided GPs with more time for consultations. The practice had also introduced a daily slot in each session where they would be able to respond to patient queries, for instance in relation to lab results.

In terms of appointment times, the practice could book patients between 9 am and 6 pm every week day with the exception on Wednesday when appointments started at 9.30. The practice had also opened the phone lines from 8 am and had an additional staff member answering the phones at this time. The practice also developed a website, which was not functional at the last inspection, that enabled patients to book appointments online or request a consultation by email.

The practice said that they had yet to assess the impact of these changes due to Covid 19. The practice manager said that they did not want to email survey's to patients as this would result in a low response rate and they could not get a sufficient sample from patients coming to the surgery due to the reduced in person attendance due to Covid 19. The practice manager said they had not done another survey since their last survey as they were unable to do a survey more than once a year.

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

Any additional evidence
The practice had not completed a patient survey since the one submitted to CQC after the practice's last inspection.

Involvement in decisions about care and treatment

National patient survey scores related to involvement in decisions with care and treatment were below local and national averages.

	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
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with patients.	Given the way that the service was operating in response to the Covid 19 pandemic and the potential risks associated with speaking to patients face to face; we were unable to speak with patients as part of this inspection.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	78.7%	87.3%	93.0%	Variation (negative)

Any additional evidence or comments

	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:	
At the last inspection the practice did not have a functioning website. At this inspection we found that the practice had developed a website with a range of information around health matters including long term condition management and Covid 19. The practice had links on their website to organisations that provided information about the pandemic in various languages.	

Carers	Narrative
Percentage and number of carers identified.	60 (1%) current list size is 5,500 patients
How the practice supported carers (including young carers).	Carers were offered a flu vaccine and an annual health check. These patients were also offered information and referrals when necessary and had access to priority appointments
How the practice supported recently bereaved patients.	The practice had a bereavement policy, which included sending sympathy letters to patients. We saw from a recent audit that bereavement support had not historically been offered to patients at the end of their lives.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
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:	

If the practice offered online services:

	Y/N/Partia I
Patients were informed and consent obtained if interactions were recorded.	N/A
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	N/A
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	N/A
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	N/A
Explanation of any answers and additional evidence:	

Responsive

Rating: Inadequate

The practice is rated as inadequate for providing services that are responsive. The national GP patient survey scores related to access and appointments were below local and national averages. Although the practice told us of action taken to address the below average scores, they had not undertaken any engagement with patients to see if this had improved satisfaction. We were told after the inspection that the practice planned to undertake a survey in the first quarter of 2020 but considered undertaking feedback exercises during the pandemic to be inappropriate. The practice had not responded to a complaint received in March 2020 in line with their policy.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not 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.	Y
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:	
Since our last inspection the practice had increased appointment times to 6pm and had extended the length of clinical sessions from two hours to three hours.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Appointments available:	
Monday	9 am to 6 pm
Tuesday	9 am to 6 pm
Wednesday	9:30 am to 6 pm
Thursday	9 am to 6 pm
Friday	9 am to 6 pm

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National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	82.0%	91.0%	94.2%	Variation (negative)

Any additional evidence or comments

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This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> All patients had a named GP and were supported in whatever setting they lived. Home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice provided care coordination to enable older patients to access appropriate services. There was a medicines delivery service for housebound patients.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice did not effectively respond to patients with symptoms of diabetes as they were not consistently undertaking follow up and providing support to patients with elevated blood sugar levels. The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Families, children and young people

Population group rating: Inadequate

Findings

- Nurse appointments were available at the practice until 6.15 pm on one evening a week.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. However, systems to review patients where safeguarding concerns had been identified were not clear.
- Parents with concerns regarding children under the age of five were offered a same day appointment.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- There were appointments available at the practice until 6 pm for working patients who could not attend at these times. These patients could also be seen at one of the local extended access hubs.
- Pre-bookable appointments were available to all patients at these locations as the practice was a member of a GP co-operation. Appointments were available Saturday and Sunday from 8am to 8pm.

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided care coordination to enable patients living in vulnerable circumstances to access appropriate services.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability

This population group is rated inadequate because responsive as a whole is related as inadequate and the issues identified especially in relation to patient satisfaction relate to all population groups.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate here

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia and we reviewed care plans for these patients that were comprehensive.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were not always able to access care and treatment in a timely way and survey results indicated that patients had a negative view of the practice's appointment process.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to	51.5%	N/A	65.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	34.9%	56.8%	65.5%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	59.2%	59.8%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	57.6%	64.0%	72.7%	No statistical variation

Any additional evidence or comments

In terms of actions the practice had taken since the last inspection, we were told that the practice had increased the number of appointments although they were unable to provide specific information on the number of additional appointments the practice could now provide. However, we were told that each clinical session had been increased from two to three hours. The practice had also been provided with support from the PCN pharmacist who was able undertake a range of clinical tasks including medication reviews, which freed up GP time. The practice also had introduced a daily slot in each session where they would be able to respond to patient queries for things like lab results.

We reviewed the practice's appointment book and saw that demand for appointments had reduced during the pandemic. The number of booked appointments between January and March 2020 was 3426. The number between April and 4 August 2020 was 1064..

After our inspection the provider sent us screenshots of their appointment system which showed that from January to March 2020 the number of booked appointments was 814 and the number of booked appointments between April and 5 August 2020 was 2489. The practice told us that these figures related to GP and pharmacist appointments; although nothing provided showed these figures related only to these types of appointments.

In terms of appointment times the practice could book patients between 9 am and 6 pm every week day with the exception on Wednesday when appointments started at 9.30. the practice had also opened the phone lines from 8 am and had an additional staff member answering the phones at this time. The practice also developed a website, which was not functional at the last inspection, which enabled patients to book patients online or request a consultation by email.

Source

Feedback

NHS Choices	No feedback submitted in the last 12 months or since last inspection
Google reviews	Two of the four google reviews submitted in the last 12 months referred to difficulty accessing appointments and/or waiting times in the surgery.

Listening and learning from concerns and complaints

The one complaint that we were told of, that was submitted after our last inspection, had not been responded to.

Complaints	
Number of complaints received since our last inspection.	1
Number of complaints we examined.	1
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:	
<p>At our last inspection we found that the lead for complaints could not find the practice's complaint policy and the person who prepared complaint responses was not trained for the role. There was no evidence that learning was shared as a result of complaints and we saw that practice manager threaten staff in front of the inspection team for not having made a complaints policy.</p> <p>The practice said in their representations to our notice of decision to cancel their registration that they did have a policy in place, but this had yet to be moved onto their new computer system. They provided us with a policy dated May 2019.</p> <p>At this inspection we asked for a complaints policy. The reception manager searched the system and found four items that all looked to have possibly been the practice complaint policy, they then searched their emails and retrieved a document titled complaint policy and then asked one of the practice GPs if this was the current compliant policy. This policy was emailed to the inspection team. The practice manager told us that they acted as the lead for complaints and this was confirmed by the practice policy. They said that they acknowledged, investigated and responded to every complaint and then undertook a review of complaints at the end of each year.</p> <p>The practice provided minutes of a meeting where complaints were discussed in March 2020. The only written complaint mentioned in the meeting had an action point for the practice manager to submit a response within 48 hours. The target date for completion was 16 March 2020. We asked the practice</p>	

manager if this complaint had been responded to. The practice manager asked the reception manager if the complaint had been responded to and the reception manager said no. We again asked the practice manager to confirm if the complaint had been responded to and they told us that they had been unwell so did not think a response had been sent. The practice manager said that the patient had not contacted the practice again since submitting the complaint. The practice policy stated that complaints would be responded to within 28 working days of receiving the complaint.

The practice told us after the inspection that this complaint was misplaced, and the response had not been issued due to staff absences at the peak of the pandemic.

We were provided with example complaint responses. These all predated our last inspection visit.

Staff we spoke with on inspection were unaware of who would deal with a complaint about the complaint lead and there was nothing detailed in the policy about who would deal with these complaints. Some staff we spoke with could not tell of us any learning or action taken in response to complaints. There was limited evidence of learning and discussion detailed in the minutes from the meeting which took place in March 2020.

Examples of learning from complaints.

Complaint	Specific action taken
Written complaint received about waiting time in Reception to see the Dr for a booked appointment.	N/A

Well-led

Rating: Inadequate

The practice is rated as inadequate for being well-led. Staff told us that they were reluctant to raise concerns because they were worried of being shouted at by the practice manager. Staff we spoke with told us that the leadership within the practice was not capable of undertaking the required duties and that new leadership was needed. The practice has not been able to recruit new clinical partners, a practice manager or merge with another service despite the practice indicating, after the last inspection, was necessary to ensure the viability of the service. We identified deficiencies in key areas including clinical governance and systems and processes around complaints, infection control, recruitment and safeguarding.

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.	N
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
<p>As part of the submission to our notice of decision to cancel the provider's registration the practice told us that they were pursuing different succession strategies to ensure the future viability of the service including recruiting two new clinical partners or merging with another practice. We were told that all this had changed as a result of Covid 19. We were told that, while conversations around mergers had continued, there were no firm plans at present to merge with any other GP practice. In respect of partnership recruitment; we were told that one prospective GP, who still works at the service, had a change of circumstance that would prevent them from becoming a partner and another prospective partner had left the practice. A salaried GP had been recruited since our last inspection. We were told after our inspection that they had been recruited with a view to becoming a partner.</p> <p>At the last inspection staff at the practice told us that management were not approachable and they were unable to raise concerns for fear of the practice management shouting at them. We also witnessed the practice manager shouting at staff and they also shouted at members of the CQC team.</p> <p>At this inspection we did not observe the practice manager shouting at any staff and they did not act aggressively towards CQC staff. However, we were told by staff on inspection that the practice manager still regularly shouted at staff and had threatened to fire staff when they raised concerns. This had made staff frightened to raise concerns.</p>	

Staff also told us that the practice manager was incapable of carrying out the requirements of the role and that a new practice manager was needed to make necessary changes and improvements.

Vision and strategy

The practice did not have a realistic strategy that would enable them to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection the practice had no strategy in place and no clear objectives. The provider included a business plan as part of their response to the last inspection which identified a number of ways they intended to establish a culture of learning, improvement and safety, including regular clinical meetings where vulnerable patients would be discussed and reviews of clinical records would be undertaken. The practice told us that they would act to improve clinical governance including holding meetings several times a month and undertaking regular audits of clinical records; including the 30 records reviewed by NHSE. We found that clinical staff were only meeting every other month, clinical audits did not contain sufficient information to enable learning and only 15 of the 30 records audited by NHSE had been reviewed.</p> <p>The practice also intended to introduce improvements aimed at increasing patient satisfaction; including the introduction of telephone consultations. Though we were told this had been implemented, the practice had yet to review the impact of these measures on patient satisfaction. The practice told us they had planned to undertake a feedback exercise in the first quarter of 2020 but that this had been postponed as they felt it was inappropriate to conduct this during the pandemic.</p> <p>The practice told us that they intended to ensure the viability of the service by merging with another service and recruiting new clinical partners. However, the practice had been unable to do this and staff told us that the current leadership was incapable of making the necessary changes needed to make the practice successful. One staff member we spoke with told us that the leadership within the practice lacked the necessary vision to improve the service.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	N
There was a strong emphasis on the safety and well-being of staff.	N
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Not reviewed
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we asked the practice for a copy of their whistleblowing policy. The policy was difficult for staff to find and dated 2017. There were no details of the practice's freedom to speak up guardian within the policy. The practice manager then downloaded a generic policy and told us that they had reviewed this in April 2018.</p> <p>At this inspection we were provided with a policy dated April 2020. The policy stated that whistleblowing concerns were to be reported to the practice manager in the first instance. If the concern was about the practice manager, then the concern was to be reported to their superior. Given that the practice manager was a partner in the business and the other partner had been absent from the service since September 2019; it was unclear who this was. The policy also contained details of the practice's freedom to speak up guardian. Staff we spoke with were able to access the policy and told us they knew how to raise concerns in the with the policy.</p> <p>We were provided with an updated policy after our inspection. However, the policy noted the practice manager's superior as a relation of the practice manager who no longer worked at the practice.</p> <p>Staff told us that they were frightened to raise concerns with leadership in the practice and that the leadership in the practice was not able to adequately fulfil the duties of their role. This could have the potential to prevent compliance with the duty of candor. In addition, staff at the practice were not aware of the requirements to raise certain events with external agencies.</p> <p>At the last inspection we found that the practice had not undertaken appropriate health and safety risk assessments for staff. At this inspection we saw evidence that the practice had assessed the risk presented by Covid 19 for all members of staff.</p>	

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

Source	Feedback
Staff interviews	We spoke to several staff about working at the practice. We were told that practice manager regularly shouted at staff when things went wrong and had threatened to fire people for raising concerns. Other staff said that management within the practice was not effective and that new leadership was required.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <p>As part of the practice’s representations against the notice of decision to cancel the provider’s registration, issued after our last inspection, the practice had developed a protocol regarding the management of clinical responsibilities and how this would be shared amongst the clinical staff who worked on different days. The composition of the staff working different days had changed since the last inspection; with some staff having left the practice and others having changed their working hours. However, we were told by the one of the GPs that the protocol had yet to be updated as the change had only occurred the previous month and this was only an interim solution. There was limited documented evidence of clinical supervision taking place and no systems in place to review consent or audit controlled drug prescribing.</p> <p>The practice had a range of policies which had been reviewed and updated. However, some of the information contained within policies was missing or out of date. For instance, the child safeguarding policy referred to agencies that no longer existed, the practice complaint policy was unclear on who dealt with complaints about the practice management (although this was contained in the complaint leaflets available to patients) and the practice whistleblowing policy did not outline who to report concerns about the conduct of the practice manager to.</p> <p>The practice provided an updated complaint policy after the inspection which included information about how to make a complaint against the complaint manager.</p> <p>An updated whistleblowing policy was also provided. However, the person who staff should report concerns about the conduct of the practice manager was related to the practice manager and no longer worked at the practice.</p> <p>Staff we spoke to on the inspection were unclear about some areas of governance. For example, some staff were not clear systems and processes related to safeguarding or significant event management.</p>	

Systems and process were ineffective in some areas; for example, not all staff had completed the required training. Recruitment files were stored in several places and missed key pieces of information including contracts and induction information. The most recent practice complaint had not been responded to in line with timescales in the practice policy.

Responsibility for acting on areas of risk was unclear to staff and not all risks were mitigated; including those associated with infection control, legionella and substances hazardous to human health.

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.	Partial
There was a systematic programme of clinical and internal audit.	Partial
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:	
<p>At our last inspection we found that the practice had a number of policies which were generic, out of date or being updated by staff who were not competent to do so. At this inspection we found that a number of policies had been updated. However, there were several policies that lacked detail including the fire safety, whistleblowing and complaint policy or contained out of date information including the practice's child safeguarding policy.</p> <p>The practice provided an updated fire evacuation plan after our inspection which addressed the concerns raised. However, the updated child safeguarding, and whistleblowing policies (provided by the service after the inspection) did not satisfactorily address the issues we identified.</p> <p>We also found at this inspection that the practice had not adequately responded to risks related to infection control and legionella. Although some of these risks had been audited and monitored; action to ensure risks were mitigated was not always taken.</p> <p>The process for managing staff performance was unclear.</p> <p>The practice had completed a number of clinical audits some of which demonstrated quality improvement.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had not followed up on all patients whose blood test results indicated a diagnosis of diabetes. Of the ten patients we identified who had a missed diagnosis of diabetes, the practice told us after the inspection that seven of these patients had not been coded as diabetic, two were confirmed diabetic and one patient was pre diabetic. The practice told us that some of these patients had been recalled but we were provided with no documentation which supported this claim.</p> <p>The practice told us, after this concern had been brought to their attention, that monthly searches would be introduced to ensure that those patients with a possible missed diagnosis of diabetes were identified</p> <p>At the last inspection we found that some information was inaccurate as staff were recording things in patient notes without having consulted with patients, risk assessments were not comprehensive, staff found it difficult to find documentation, did not know the organisations to report significant events to externally and that the national patient survey had not been acted upon as the practice manager felt that the numbers surveyed were insignificant.</p> <p>At this inspection we found that the registered manager was not aware of what things were required to be reported to CQC as a statutory notification. The registered manager later printed out a list of items that needed to be reported although they were unable to find their internal policy with detailed the requirements. A policy related to notifiable incidents was provided after our inspection.</p> <p>Certain risks, particularly those associated with infection control, were not well managed.</p> <p>The practice had not completed a review of all 30 clinical consultations which were identified by NHSE as being unsatisfactory despite making a commitment, as part of their representations to CQC notice of decision to cancel their registration, to do so. Subsequent consultations reviews provided after the last inspection were not sufficiently detailed to enable effective reflection, learning or improvement and there had been no other consultation reviews completed since.</p> <p>The practice told us after the inspection that they had started reviewing these consultations after our last inspection but that this work had been paused due to pressures associated with Covid 19.</p>	

No further patient engagement exercise had been completed since the practice's last inspection to assess whether changes made in the practice had improved patient satisfaction. The most recently published patient survey results, which continued to show below average levels of patient satisfaction, had yet to be discussed or an action plan agreed.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	N/A
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

There had been limited engagement with patients, public and staff since our last inspection. We found evidence that the practice worked with external partners to deliver care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Not reviewed
Staff views were reflected in the planning and delivery of services.	No
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<p>The practice had not undertaken any patient feedback exercises since our last inspection to determine if satisfaction with the service had improved.</p> <p>After our inspection, the practice told us they planned to undertake a survey in the first quarter of 2020 but considered it inappropriate to undertake a patient feedback exercise during the pandemic.</p> <p>Staff we spoke with on inspection said that they had the opportunity to provide suggestions in practice meetings, but no staff member we spoke to could think of any suggestion made which had been adopted by the practice. We did see evidence of a staff suggestion being discussed at a practice meeting which took place in March 2020.</p>	

Staff we spoke with on inspection told us that they were deterred from speaking up as their feared reprisals from the practice manager.

Feedback from Patient Participation Group.

Feedback

Due to the short announcement of the inspection we did not ask the practice to request that member of their patient participation group attend the practice to speak with us.

Any additional evidence

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
At the last inspection we found that there was limited evidence of learning or innovative practice. At this inspection we reviewed several audits aimed at improving the quality of clinical care provided to patients at the practice.	
However, the practice had not undertaken the necessary learning and improvement work to satisfactorily address all the concerns identified at the last CQC inspection.	

Examples of continuous learning and improvement

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 CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **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.