Care Quality Commission

Inspection Evidence Table

Riverbank Medical Service (1-7083665300)

Inspection date: 10 August 2022

Date of data download: **09 August 2022**

Overall rating: Inadequate

We have rated Riverbank Medical Services overall as Inadequate because:

- The practice's systems and processes did not always keep people safe.
- Risk to patients' staff and visitors were not always assessed, monitored or managed effectively.
- The arrangement for managing medicines did not always keep people safe.
- There were not always effective processes and systems to support good governance.
- The practice's processes for managing risks, issues and performance were not effective.

Safe Rating: Inadequate

We have rated the safe domain as inadequate because:

- The practice did not have systems, and processes in place to keep people safe and safeguarded from abuse.
- The practice had insufficient assurance around the recruitment of staff including staff training and vaccination status of staff.
- There was poor oversight of the property and maintenance including fire, legionella and infection control.

Not all clinical staff had completed training to help identify and deal with sepsis.

- There were concerns relating to the storage of medicines.
- There were concerns relating to the monitoring of patients taking high risk medication and repeat prescribing.
- There was poor management of care information and task management issues.
- The practice could not demonstrate the prescribing competence of non-medical prescribers.
- The practice could not demonstrate an effective system to ensure that learning was implemented when things went wrong.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No[1]
Partners and staff were trained to appropriate levels for their role.	No[2]
There was active and appropriate engagement in local safeguarding processes.	No[3]
The Out of Hours service was informed of relevant safeguarding information.	No[4]
There were systems to identify vulnerable patients on record.	No[5]
Disclosure and Barring Service (DBS) checks were undertaken where required.	No[6]
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial[3]

Explanation of any answers and additional evidence:

- [1] The practice safeguarding policy for adults and children did not include sufficient information to support staff to raise concerns via local procedures. For example, the contact details to raise concerns were incomplete.
- [2] We reviewed training for staff members and found staff had not completed the appropriate level of training as set out in the intercollegiate guidance. Those that had not completed the mandatory training included clinicians.
- [3] We were told that the practice held safeguarding meetings with multi-disciplinary teams such as midwives, healthy families team and social workers. However, we were not provided with evidence of any meetings.
- [4] During the inspection we carried out random searches of patient clinical records. We found that the practice did not operate an effective system to ensure patients with safeguarding concerns were highlighted to the out of hours service.
- [5] The practice did not operate an effective system to ensure patients subject to safeguarding concerns were always recorded or highlighted on a patient's record. Therefore, staff working within the practice including locum staff would not be made aware that there were safeguarding concerns or that a patient was vulnerable.
- [5] On the day of inspection the practice was unable to identify vulnerable adults or children registered at the practice and did not have evidence of a safeguarding register.
- [5] During the inspection we carried out random searches of correspondence awaiting review. We found an incident where a safeguarding concern was flagged by secondary care and there was no evidence the practice had acted upon the concerns raised.
- [5] During the inspection we found several concerns relating to vulnerable adults and children who had not been reviewed or considered as safeguarding referrals despite visits to secondary care raising areas concern.
- [6]We found that a staff member employed as a health care assistant who had direct contact with patients did not have evidence of a disclosing and barring service (DBS) check. We were told other staff working at the practice did not have DBS checks and the practice was currently applying and updating individual staff records.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No[1]

Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No[2]

Explanation of any answers and additional evidence:

- [1]We reviewed recruitment files for four staff members. We found that there was gaps in recruitment checks for example, three of four staff members did not have references. We found that for three of the four staff members who were clinicians, three did not have evidence of qualifications.
- [2]We reviewed four staff members records for evidence of vaccinations. We found insufficient evidence of staff vaccinations provided. For example, one staff member had evidence of Hepatitis B only. Another staff member had evidence for Hepatitis B and MMR. Two staff members did not have any copies of any vaccinations. There was no evidence to show that all staff members had received vaccines as recommended in the green book by the UK Health Security Agency.

Safety systems and records	**Y/N/Partial**
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 27/04/2022	No[1]
There was a fire procedure.	Yes
Date of fire risk assessment: 26/04/2022 Actions from fire risk assessment were identified and completed.	No[2]

Explanation of any answers and additional evidence:

- [1]The practice had completed a health and safety risk assessment of the premises. We were told this was completed annually with a walk around of the practice with a GP and practice manager. The risk assessment did not highlight all areas of risk. For example, the practice blinds had looped cords and chains on window blinds which can present as a strangulation hazard.
- [1]We found the security of the building to be insufficient. There was the potential for unauthorised access to areas storing patient data, medical equipment, medicines and prescriptions. We were told that the door should always be locked and a key code to be used however, during our inspection we found the door to be propped open during the day.
- [1]On the day of inspection, we were not provided with assurance that the practice had considered the risks of Legionella bacteria. For example, we were not provided with a risk assessment or steps taken to prevent or control the risk. On the day of inspection, we found a consultation room to have an odour and were told this was due to the drainage and taps.
- [2]The practice manager had completed a fire risk assessment of the practice. Actions were identified and completed however the risk assessment stated quarterly checks of areas were required. We were not provided with any evidence of the checks.
- [2]We found fire doors were propped open and not closed. This was not included in the risk assessment and we were told staff had been made aware of this issue in the past.
- [2]On the day of inspection, we were not provided with evidence of fire extinguisher checks, emergency lighting, fire alarm tests or fire drills. We were told that this was the responsibility of the property owner but did not see a service level agreement in place. Of the fire extinguishers we viewed we found that checks were in date. We were provided with evidence of Portable appliance testing and found that equipment was calibrated within 12 months.
- We were provided with a training matrix for 10 staff members. Six out of 10 staff had received fire training and health and safety training dating from 2018 to 2021. Two staff members had

received training but the dates on the training matrix were incomplete. Two staff members had not received any training.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	No[1]
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 27/04/2022	Yes[2]
The practice had acted on any issues identified in infection prevention and control audits.	No[3]
The arrangements for managing waste and clinical specimens kept people safe.	No[4]

Explanation of any answers and additional evidence:

- [1]We were provided with a training matrix for 10 staff members. Six out of 10 staff had received infection control training dating from 2018 to 2021. Two staff members had received training but the dates on the training matrix were incomplete. Two staff members had not received any training.
- [2]The practice manager, GP and nurse conducted an audit in April 2022. All actions required had been completed.
- [3]We asked but were not provided with any cleaning schedules. We were told that cleaning was completed daily by an external company. We found the building to be visibly clean. However, we were not assured of the cleaning processes in between patients or pre and post minor surgery.
- [3]We found equipment to manage the reduction in spread of infections to be out of date. For example, we found disinfectant granules that expired in March 2019 and sanitisers used for ear irrigation equipment expired on 31 January 2016. We also found hand sanitiser that expired in April 2022.
- [4]On the day of inspection, we found staff were not adhering to the practice policy on disposal of waste. We found evidence of staff disposing of waste in domestic bins instead of clinical waste bins. We found two clinical waste bins to be broken posing an infection control risk.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Partial[1]
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	No[2]
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial[2]

There were enough staff to provide appointments and prevent staff from working excessive hours	Partial[3]
Explanation of any answers and additional evidence: • [1]We spoke with temporary staff who told us they had received an induction and were aware of practice policies and procedures. The practice did not operate an effective system to ensure patients subject to safeguarding concerns were always recorded or highlighted on a patient record. Therefore, staff working within the practice including temporary staff would not be made aware that there were safeguarding concerns or that a patient was vulnerable. • [2]The practice team did not have the understanding to respond to medical emergencies and had not received training in sepsis. For example, on the day of inspection staff could not locate the keys to the medical emergency cabinet. We were provided with a training matrix for 10 members of staff and found that none of the staff members had received training in sepsis awareness. • [2]The practice team could not demonstrate they were able to respond to medical emergencies. On the day of inspection, we asked for keys to the medical emergency medications. The practice team were unaware of the location of the sets of keys. Therefore, we did not have the assurance that in an emergency the practice would be able to respond. • [2]The practice team held an in-house event for basic life support and automated external automated defibrillator (AED) training for adults in March 2022. There was no evidence that paediatric training was also included. • [3]The practice team expressed staffing difficulties. At the time of inspection, the practice was recruiting for a salaried GP and had been since November 2021. The team spoke of difficulties in recruiting due to receiving minimal interest. In the interim, locum GPs were used. The nursing team had reduced hours due to retirement and there was no plan in place to recruit further nursing staff. Staff told us they felt under pressure at times to see all patients.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No[1]
There was a system for processing information relating to new patients including the Summarizing of new patient notes.	Yes[2]
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	No[3]
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial[4]
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: • [1]On the day of inspection, we found several concerns relating to the security of care records and clinical data. We found records stored in rooms which were unlocked and accessible to the	

public. We found individual care records in clinical drawers and were not given an explanation as to why these were kept there. The practice did not assure us there was any oversight of GDPR for patient details within the practice.

- [2]The practice had a member of staff who was trained in summarising patient records. At the time of inspection there was around 30 notes awaiting summarisation. The practice manager was enrolled onto a course to be trained on summarising to meet the requirements of the practice contingency plans.
- [3]On the day of inspection we found 98 letters with outstanding actions. Of the 98 letters the earliest date was October 2020. We found evidence of requests made by secondary care for patients to reduce medication, prescribe medication and change medication. We found on these occasions this had not been actioned. There was no evidence or process in place to review information by the appropriate staff to deliver safe care and treatment.
- [4] The practice did not have a protocol or policy relating to processing referrals. We were told during the inspection that the GP would speak to the administration team in person to send referrals. There was no audit of referrals for potential missed referrals or delays.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.21	0.80	0.79	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	7.5%	8.1%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	5.50	4.61	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	160.5‰	130.0‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.71	0.52	0.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.4‰	6.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	No[1]
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No[2]
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No[3]
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.	No[4]
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No[5]
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.	No[6]
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.	No[7]
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Partial[8]
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	No[9]

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	No[10]
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	No[11]

Explanation of any answers and additional evidence:

- [1]Medications were not stored securely. Medication was stored within lockable cabinets, but they were unlocked. Rooms where medicines were stored were accessible by patients or members of the public due to doors being left open.
- [1]On the day of inspection the recorded temperature inside the cupboards storing the medications reached 28^{o}C. The summary of produce characteristic for each of the medicines stated not to be stored above 25^{o}C. The stability of some medicines is affected by extremes of temperatures and advice should be sought to ascertain if the medicines continue to be fit for use. We were not assured that the practice had considered the temperature of the storage of the medicines or sought advice to ensure medicines remained fit for use.
- [1] We found medicines in clinical rooms which had been dispensed to patients and it was not clear why the practice had kept them. We found medication kept by the practice that was dispensed to a patient in April 2019 which had expired in February 2022. We also found medication from patients who had died; the practice was unable to explain why the medication was kept at the practice.
- [1] We found medication that was part used which was dispensed to a patient in December 2019 and expired in July 2022. It was not clear why the practice had opened or continued to store the medication.
- [2] We found blank prescriptions were not kept securely. Prescriptions were kept inside printers in clinical and nonclinical rooms which were left unlocked. The practice did not have a process for security of prescriptions and there was no log of prescription pads indicating how many were kept or used.
- [3] We found patient group directions (PGDs) which are a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients without having to see a prescriber were not being used. For example, we found PGDs were not signed by all staff members who were administering specified medications.
- [4] We were told by the provider that informal reviews and discussions took place relating to the prescribing of staff employed in advanced clinical practice. However, no formal audit of practice or peer review was undertaken to ensure prescribing was appropriate.
- [5]There was no clinical oversight for request for repeat medicines and there was not always a clear process in place to demonstrate what actions had been taken. We carried out random searches of patients who were taking high risk drugs. Our search revealed 672 patients prescribed a specific high-risk drug with 110 patients who had potentially not had the required monitoring within the last 18 months. We reviewed five records and found the practice continued to prescribe high risk repeat medicines despite some patients not having had a blood test since 2016, and the majority since 2020 instead of the recommended annual review. We found there was no evidence that the practice had reviewed the patients and risk assessed the lack of monitoring information before prescriptions were issued.

- [6]The practice did not have an effective process and audit trail for the management and changes to a patient's medicines including changes made by other services. During our review of clinical notes, we identified a patient who had been advised to stop taking a high-risk medicine during

Medicines management	Y/N/Partial

a secondary care consultation in April 2022 however the medicine was continued to be prescribed during the periods of May, June, July and August 2022.

- [7] The process for monitoring patients' health in relation to the use of medicines including high risk medicines was not effective. On reviewing patient records we found a patient receiving prescriptions for a high-risk medication who had not had a review or necessary monitoring since 2010 (12 years). This patient was at risk of serious harm.
- [8] The practice had not achieved the local integrated care board average or England average targets of ensuring appropriate antimicrobial prescribing. The practice had taken steps to address this by conducting an audit of prescribing of antibiotics over a three-month period in 2021. The audit found 31% of prescribing was appropriate however 38% of prescribing was an incorrect prescribing of antibiotics, 19% did not have a clear indication as to why antibiotics were chosen, 12% did not have the correct choice of antibiotic or incorrect duration. Following the audit there was no action plans in place to further improve the prescribing or repeat the audit.
- [9] Not all recommended medical emergency medicines were present however, there was no risk assessment in place to determine which emergency medicines were suitable for the practice to stock. The practice policy on emergency drugs included a list of drugs kept however, on the day of inspection, this list did not reflect what was found in the emergency medicines cupboard. Emergency medicines were stored in a locked cupboard, however access to the emergency medicines was not readily available. We were not assured that in an emergency staff were able to respond quickly. This puts patients at risk and is outside of the British Resuscitation Guidelines which requires that staff have immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation.
- [10] We found the checklist located with the defibrillator to ensure it was working correctly stated it was to be checked daily however, we found it had only been checked once in August and four times during July. The practice policy did not reflect the information on the checklist which stated the defibrillator should be checked monthly. National guidance from the British Resuscitation council advises that checks should be conducted at least weekly.
- [11]We found vaccines were not stored appropriately. Fridges containing medications had temperature checks taken by staff twice a day however we saw that on 15 occasions from April 2022 to July 2022 the temperature of the fridge reached over the maximum storage requirement for the vaccinations as outlined in the practice policy and stipulated by national guidance. We found no evidence to suggest that action was taken in line with the practice policy to or advice was sought to ensure that medicines and vaccines within the fridge continued to be safe to use and effective for patients.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	No
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial[1]
There was a system for recording and acting on significant events.	Partial[2]
Staff understood how to raise concerns and report incidents both internally and externally.	Partial[3]
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	1
Number of events that required action:	1

Explanation of any answers and additional evidence:

- [1]The practice had a Significant event monitoring analysis template which was a document similar to a policy. The documentation was created in 2012 and was reviewed on a three-yearly basis. The document had several inaccuracies and did not include updates such as information on the Duty of Candour.
- [2]Staff we spoke to told us they understood how to report concerns which was through their line management. We were told by staff the practice manager would launch an investigation where staff involved would write down their account of the incident and be interviewed separately to ensure no coercion. A decision was then made by the manager if an individual learning or team learning is needed and change implemented by the practice manager. This was reflected in the steps in the template provided. On the day of inspection, we asked if Significant events were discussed in team meetings and were told that staff felt significant events could be a blame scenario and not a learning exercise.
- [3]Staff could not demonstrate they understood how to identify a significant event. For example, on the day of inspection we found several examples of incidents that should have been considered or raised. Such as fridge temperatures recording higher than required, out of date medication, and patient concerns raised during a complaint.
- [3]Significant events were not an agenda item on regular staff meetings. Significant events and complaints were discussed annually as a team where learning points were discussed. At the meeting in April 2022 there was no evidence of learning discussed and staff had no comments or concerns to raise.
- [3]During the inspection we were told there had been one significant event for the period of 2021 to 2022. We were also made aware of a threatening letter sent to the practice, we were told the practice had considered that this was a significant event but there was no evidence of this.
- [3]During the inspection we were made aware of a patient complaint which would have been appropriate to consider as a significant event.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Security incident involving patient	• Complaint received by the practice and apology given.

	• Meeting with staff and practice manager to discuss incident. • Email reminder sent to staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	No

Explanation of any answers and additional evidence:

- As part of our clinical searches we looked at a range of safety alerts. The provider was unable to demonstrate that all relevant safety alerts had been responded to. We reviewed records of patients receiving a combination of medicines which had an alert due to carrying a risk to health. There was no documentation to indicate this had been identified and the risk discussed with the patient or alternative treatments considered.
- The practice did not have assurance that once alerts were received, they were acted upon and embedded within the practice.

Effective Rating: Inadequate

We have rated the Effective domain as inadequate because:

- The practice could not demonstrate they had systems and processes to keep clinicians up to date with current evidence based practice.
- Patients with long-term conditions or potential long-term conditions had not received up to date monitoring and review.
- Not all staff had completed training required for their role.
- The practice was below national target for cervical smears.
- Staff did not always work together and with other organisations to deliver effective care and treatment.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	No[1]
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No[2]
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No[2]
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No[3]
There were appropriate referral pathways to make sure that patients' needs were addressed.	No[4]
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	No[5]
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

Explanation of any answers and additional evidence:

- [1]The practice could not demonstrate they had systems and processes to keep clinicians up to date with current evidence-based practice. There was no evidence of clinical meetings taking place between the GPs and practice nurses where current guidelines were disseminated and discussed, this is consistent with what staff told us on the day of inspection. Some staff we spoke to did not seem sure of what evidence-based guidelines, relevant to their roles, were used in the practice.
- [2]Patients' immediate and ongoing needs were not fully assessed. This included their clinical needs and their mental and physical wellbeing. For example, we reviewed a selection of clinical records on the day of inspection. We identified a patient who had attended the practice for blood pressure monitoring, which was found to be raised, they were advised to return in one month. The patient attended after one month and presented with continued high blood pressure. There was no clinical advice or follow up documented. We highlighted this on the day of inspection and were told that the patient would be booked in for an appointment with a GP.
- [3] Patients' treatment was not regularly reviewed and updated. We found that the recall system in place was ineffective in ensuring patients with long-term conditions were offered a structured annual review in line with national guidelines to check their health and medicines needs were being met.
- [3] We conducted a search of patients taking high risk medication. The recommended guidance for this medication was a review of patients as a minimum annually. The practice had a total of 672 patients prescribed high risk medication with our search revealing 110 as potentially not having had the required monitoring for 18 months. We reviewed six records and found the patients last blood tests were between 2010 and 2020. The practice was subsequently able to demonstrate that five patients had received unprompted blood tests due to A&E attendances or hospital admissions. It was evident the practice was unaware of these blood tests prior to our inspection and had continued to issue these prescriptions without this information. The remaining patient had not had a blood test since 2010 (12 years). This patient was at risk of serious harm.
- [4]We saw correspondence from secondary care requesting patients be referred for additional support. We saw no evidence that this had been actioned or followed up.
- [5]We found that patients were not always told when they needed to seek further help and what to do if their condition deteriorated. For example, we saw evidence of patients who had abnormal blood pressure results who were not followed up or told what to do when they needed to seek further help during consultations at the practice.

Effective care for the practice population

Findings

- 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.
- NHS checks for patients aged 40 to 74 were paused during the pandemic. The practice did not supply evidence of how many patients were eligible but had completed 13 in 12 months. They had not contacted any patients to invite them for checks.
- All patients with a learning disability were offered an annual health check. The practice had completed 43 out of 50 eligible for an annual health check. We were told six patients were not suitable for checks due to being under 18 years of age.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held multidisciplinary team meetings to discuss end of life care for patients.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had discovered a theme of patients not returning for follow up appointments for their mental health needs. We were told the practice was looking into how they could try to improve. We were not provided with any action plans or evidence on this.

Management of people with long term conditions

Findings

Patient treatment was not regularly reviewed and updated. As part of our inspection we carried out a remote search of patients' clinical records. We found examples of unsafe care where patient treatment and care was not regularly reviewed or updated, and clinical staff failed to follow up risk to patients health and wellbeing.

- We conducted a search of patients diagnosed with Chronic Kidney Disease (CKD) stage 4 or 5 who had potentially not received monitoring for the past nine months. We found one patient who had not had the required monitoring for 14 months.

- We conducted a search of patients diagnosed with Hypothyroidism who had potentially not had monitoring for the past 18 months. The search revealed 34 patients out of 198. We reviewed five patients and found none of the patients had received the required monitoring. Although the practice had recognised and contacted some patients who were overdue monitoring, they continued to prescribe medication without checking to see if blood monitoring was up to date. There was no evidence of a mechanism in place to ensure patients had their blood monitoring annually.

- Patients with asthma were not suitably offered an asthma management plan. There was also no adjustment of their regular asthma treatment following an acute exacerbation of asthma. We conducted a search of patients with asthma who had been prescribed two or more courses of rescue steroids. There was 318 patients on the asthma register with a total of 27 having been prescribed rescue steroids within a 12-month period. We reviewed five records and found one patient had received rescue steroids on five occasions without an adequate asthma assessment or review following each exacerbation in line with national guidance. We found one patient had received rescue steroids on three occasions during October 2021 and had not had an asthma review since January 2020. We found one patient to have requested medication which was issued by a clerk on four occasions during October 2021 to January 2022 without an assessment. We spoke to the practice on the day of inspection and were told the practice had generated a new protocol to ensure acute prescription requests are no longer issued by clerks.

- We conducted a search of patients diagnosed with diabetes retinopathy, which is a complication of diabetes, caused by high blood sugar levels that causes damage to the back of the eye. Our searches revealed a total of 40 patients out of 341 where blood sugar levels were above the acceptable range. Although patients were having reviews by the practice which included blood pressure readings it did not appear there was appropriate follow up action taken. For example, we reviewed five records and found all five patients had blood pressure readings which were not within the recommended range. None of the five patients had their blood pressure optimised by the

practice, including a patient with a possible stage three hypertension which carries a risk of severe harm to the patient without treatment.

- The practice did not provide us sufficient evidence to show that staff who were responsible for reviews of patients with long-term conditions such as diabetes had received specific training or were subject to competency checks.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	35	35	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	41	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	41	92.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	41	92.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	55	61	90.2%	Met 90% minimum

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	71.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) **(UKHSA)**	76.5%	64.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) **(UKHSA)**	72.6%	67.7%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	40.0%	55.7%	55.4%	No statistical variation

Any additional evidence or comments
The practice articulated difficulties within staffing in the nursing department in the past and explained that during 2020 – 2021 they had a lower than national average. The practice appointed a cervical cancer screening lead who would improve the rates of attendance by training staff. The practice staff were due to receive training in October 2022. The practice was also developing a policy and contingency plans.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	No

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

- The practice had paused audits during the Covid-19 pandemic and we were told by leaders the plan was to reintroduce audits in 2023.
- The practice had not achieved the local integrated care board average or England average targets of ensuring appropriate antimicrobial prescribing. The practice had taken steps to address this by conducting an audit of prescribing of antibiotics over a three-month period in 2021. Following the audit there was no action plans in place to further improve the prescribing or repeat the audit.
- The practice had outsourced a company to review patients at risk of Osteoporosis and calcium deficiency which was conducted on 26 May 2022. The aim was to identify patients at risk who required a review; 51 patients were identified. Outcomes from the review also included a recommendation that 116 patients to be reviewed for potential Vitamin D deficiency, are offered DEXA scans or should have codes added to their medical records. The practice had not taken any steps to address the findings. We were told they would be reviewed in September when the lead GP had time available.
- The practice also completed base line cancer care audits in 2020 which reviewed the care of patients between July 2019 and March 2020. The aim was for the practice to increase the percentage of cancer cases which are reviewed and learnt from, from 0% to 100% over six months. The audit did not include an action plan and the audit had not been repeated.
- We were told by the practice they regularly reviewed unplanned admissions and readmissions and took appropriate action. However, on reviewing letters received by other healthcare services and professionals we saw examples where action had not been taken. For example, the ambulance service had requested the practice send a referral for additional support for the patient. We did not find evidence that the practice had actioned this.
- We reviewed patient records of children with a safeguarding code on file and found they had unplanned admissions which were not reviewed, or appropriate action taken.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	No[1]
The practice had a programme of learning and development.	No[1]
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial[2]
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No[3]
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial[4]

Explanation of any answers and additional evidence:

- [1]The practice provided us with details of the training completed by staff. From the practice training matrix, we found none of the 10 members of staff had completed confidentiality training. Out of 10 staff one staff member had completed sepsis awareness training in 2019 and the GP had completed it in 2016. Eight staff received fire safety and infection control training. Safeguarding was not completed by all staff or to the appropriate level as set out in the intercollegiate guidance. Those that had not completed the practice required training included clinicians.
- [1]We found the provider did not have a system for oversight of staff competencies. There was a lack of oversight of roles that required supervision. We saw that staff requiring supervision were working unsupervised during our inspection.
- [2]The practice had an induction programme for new staff but could not provide evidence of completed inductions for staff. The induction programme was ineffective as staff were not aware of the practice processes, for example staff were not aware of the location of the defibrillator.
- [3] The practice could not demonstrate they were assured of the competence of staff. For example, we found staff to be working without supervision. We carried out a review of patients' records and found concerns relating to the competency of staff. For example, staff had taken blood pressures from patients which was found to be out of range. There was no clinical advice documented and no clear clinical protocol in place. We could not be assured that patients had received appropriate care.
- [4] We were not provided with evidence of staff competency checks for any staff member working in advanced clinical practice. We were told by the provider that, as the practice list size was small, the provider informally reviewed competency by viewing notes of patients. We carried out random searches on patients' clinical records and found several occasions where patients had presented with high blood pressure to members of the clinical team, there was no further clinical advice sought.

- [5] We found there was no clear and appropriate approach for managing staff performance. During the inspection it became apparent that some staff members did not understand how to carry out their responsibilities and management were unable to articulate plans to address this.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	No
Patients received consistent, coordinated, person-centred care when they moved between services.	No

Explanation of any answers and additional evidence:

- We reviewed correspondence from secondary care services where requests to change or stop medication were advised. We found that requested actions were not always carried out with no evidence that this had been an active decision. For example, we reviewed a patient's records where a letter requested that the GP review the patient's medication due to the impact of worsening of an existing medical condition. The practice had no record that they had reviewed the patient's medication, this placed the patient at risk of worsening of their condition and increased side effects from the treatment used to manage their condition.
- The practice had not always reviewed blood tests taken by secondary care before prescribing medication. We found staff were unaware of how to access all areas of information from secondary care for example the system used to record blood test results.
- We found for some patients prescribed high risk medications who were managed by secondary care did not have a shared care protocol in place defining the responsibilities of the GP and the specialist. This meant that it was not clear who was responsible for monitoring the patients' treatments.

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.	No[1]
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial[2]
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial[3]
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Explanation of any answers and additional evidence:

- [1]The practice could not demonstrate how they identified patients at risk of developing a long-term condition. As part of the inspection we reviewed a random sample of patients' medical records which indicated a potential diagnosis of diabetes. Four of these patients should have been identified as 'pre-diabetic'. None of them had this recorded in their clinical notes. This meant patients would not be identified as being at risk of diabetes by anyone accessing their clinical records, placing them at risk of harm and excluding them from necessary screening or follow-up for this.
- [1]We found examples where patients identified by secondary care as potentially needing extra support had not been followed up by the practice.
- [2]Although patients had access to appropriate health assessments and checks they were not always conducted or completed by suitably trained and competent staff.
- [3] We found a Do not Attempt Cardiopulmonary Resuscitation record had been completed without the patient or next of kin involvement, and no record of consent.

Any additional evidence or comments

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial

Explanation of any answers and additional evidence:

- We reviewed five Do not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions on patient records. We found that one record had been filled in without the patient or next of kin awareness. There was no record that consent had been appropriately sought and obtained.
- We found that one record was not signed, and the decision was unclear on the record.
- We spoke with representatives from a care home which was assigned to the practice by the integrated care board. We were told that it was the community team who would review DNACPR decisions and the GP at the practice if any changes were required.

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: • The practice had received complaints regarding staff members not always displaying a good attitude towards patients. The practice management had tried to address this by speaking to staff members involved.	

Patient feedback	
Source	**Feedback**
Patient interviews	On the day of inspection, we spoke with two patients. One patient told us that it was easy to get an appointment and they were very happy with the service they received. Another patient told us it was on occasions difficult to get an appointment but overall, they were happy with the care and treatment they received.
Google reviews	The practice had received eight reviews within 12 months. Four were positive praising the customer service of the staff. Four were negative describing rude staff and access difficulties.
Representatives from local care homes	We spoke with representatives from a care home which was assigned to the practice by the Integrated Care Board (ICB). Representatives told us that the staff were always caring to residents and regularly reviewed their care.

National GP Patient 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 (01/01/2022 to 30/04/2022)	75.7%	85.0%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	76.0%	83.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	84.5%	92.7%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	74.3%	74.8%	72.4%	No statistical variation

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

Any additional evidence
Whilst the practice conducted their own questionnaires the questions related to access only and did not seek feedback on the quality of care and treatment.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	No[1]
Staff helped patients and their carers find further information and access community and advocacy services.	Partial[2]

Explanation of any answers and additional evidence:

- [1] We found several instances during searches of the practice clinical system where patients were not provided with information to understand their care. For example, patients prescribed drugs which had potential for addiction did not have evidence that discussions around tolerance or addiction had taken place.
- [2] During the inspection we spoke with several members of the team and found that not all staff members were aware of how to find further information for patients to access community and advocacy services. However, the practice was supported by the Patient Participation Group (PPG) who had set up a wellbeing group due to start in September for patients and their carers to come into the surgery to speak with experienced volunteers about community and advocacy services available.

National GP Patient 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 (01/01/2022 to 30/04/2022)	90.8%	90.5%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Partial[1]
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	No[2]

Explanation of any answers and additional evidence:

- The practice told us they used language line as an interpreting service for patients who did not have English as a first language, and this was booked in advance.
- There was an option to translate the practice website however, this was not working.
- We were told that information leaflets were available in other languages but were not provided with examples.
- The practice website did not include information about support groups available.

Carers	Narrative

Percentage and number of carers identified.	3.8% (175) of patients were identified as carers.
How the practice supported carers (including young carers).	• The practice had a booklet with information to direct patients to other services. • The practice had an active patient participation group (PPG). A member of the PPG was in the process of setting up a drop-in clinic for carers. The group was focused on wellbeing for the carer. It was an opportunity to seek further advice such as support groups, financial help and befriending.
How the practice supported recently bereaved patients.	• The lead GP would contact families to offer condolences.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Partial
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: There was arrangements in place to speak with patients in separate rooms if a patient requested to ensure confidentiality at reception. However, on the day of inspection we saw that consultation rooms with patients were left open. Confidential conversations could be heard in the corridors.	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

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	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
	Extended hours on a Tuesday morning 6:45am to 8am. Extended hours on a Wednesday 6:30pm to 8pm.

Further information about how the practice is responding to the needs of their population
• Patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The primary care network (PCN) had implemented a home visiting service. The practices in the PCN were able to book patients eligible for home visits directly into two appointments each morning. Once those appointments were booked there was the opportunity to book in further visits throughout the day dependent on the demand. If the PCN team were fully booked, we were told the practice GP would visit. • Additional GP and Health care assistant appointments were available from 6:45am on a Tuesday and until 8pm on a Thursday for working age patients so they did not need to miss work. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. • We spoke with representatives from a care home which was assigned to the practice by the integrated care board. We were told by the care home they were able to get appointments for residents if required easily and the home had weekly ward rounds by the practice team. Prescriptions were issued in a timely manner. • The practice rate of accident and emergency attendances during the period of October 2020 to September 2021 was lower than both the Integrated Care Board and national average.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

Explanation of any answers and additional evidence:

- The practice business plan stated that the practice had completed a feedback exercise on preference of appointment. We were unable to locate the date as to when the preference exercise was completed. The results were, 64% wanted their appointments in a 50/50 face to telephone triage ratio, 29% wanted their appointments all face to face and 7% wanted their appointments all telephone triage. Following the feedback, the practice implemented a change in appointments to include patients being able to book in advance and offering additional face to face appointments.
- We viewed the practice clinical system and saw the practice had on the day appointments that opened at 8am. There was advanced pre bookable appointments including 24 hours, 48 hours, 96 hours and up to seven days in advance.
- Patients were able to book appointments by phoning the practice throughout the day, face to face, in advance following an appointment or online.
- The practice had dedicated urgent appointments available throughout the day for emergencies. The practice told us they would not turn an emergency away.
- Patients were able to request fit notes, prescriptions and view test results online.
- Following feedback from patients regarding busy telephone lines the practice implemented a voice mail system for prescriptions. Patients could phone and leave a message to request a prescription instead of waiting on the telephone. However, there was no evidence that the

practice had risk assessed this or implemented a system to ensure that these were dealt with appropriately.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	59.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	67.0%	59.5%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	56.2%	58.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	77.0%	74.5%	71.9%	No statistical variation

Source	Feedback
Google reviews (unverified)	The practice had received eight reviews within 12 months. Four were positive praising the customer service of the staff. Four were negative describing rude staff and access difficulties.
NHS UK	There was no review on the NHS UK website.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial

Explanation of any answers and additional evidence:

- The practice manager categorised complaints into formal and informal.
- Informal complaints were described as complaints that were dealt with on the day, such as in person or over telephone. The practice manager would clarify if the patient was happy that their complaint was dealt with and if they would like to pursue further. There was no record of informal complaints, but the practice manager told us there had been an estimated 20. Whilst staff were responding to informal complaints there was no evidence of learning from them.
- Formal complaints were described as complaints where a patient requests a follow up or an investigation is required. The practice had received four complaints within the past 12 months. Complaints were dealt by the practice manager with clinical support if required. Complaints were responded to quickly and apologies were given when required.
- There was complaints leaflets at reception and on the website.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complaint regarding staff conduct	• Investigation conducted by practice manager. • Apology given to patient. • Advice sought from human resource and discussion with staff member.
Security incident	• Investigation conducted by practice manager. • New policy implemented. • Discussed with all staff. • Apology given to patient.

Well-led Rating: Inadequate

We rated the practice as inadequate for the Well-led domain because:

- Leaders could not demonstrate they had the skills to deliver high quality sustainable care.
- Governance processes were ineffective.
- Processes for managing risks were poor.
- There was not always a supportive and open culture.
- The practice did not always act on appropriate and accurate information.

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.	No[1]
They had identified the actions necessary to address these challenges.	No[2]
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No[3]
Explanation of any answers and additional evidence: • [1]Leaders were new to roles and could not demonstrate they had the capacity and skills to address quality and sustainability. For example, leaders had not identified areas of health and safety, learning opportunities and staff development. We found several areas of absent leadership, demonstrating a significant lack of clinical oversight. • [2]Following inspection, we found the leaders of the practice required further support to address areas of concerns found on the inspection. • [3]We asked for but were not provided with a succession plan.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: • The provider told us that due to the pressures on the practice within the last two years of the Covid-19 pandemic, they had concentrated on trying to meet the demands of the day to day running of the practice but acknowledged there were gaps in areas.	

- We were not provided with evidence that staff were involved with the development of the visions, values and strategy.
- The practice had a business development plan which included progress against delivery of their mission statement. The business plan did not identify all areas of progress or improvement to deliver their mission which was “To provide an appropriate and rewarding experiencing for our patients whenever they need our support”. For example, the business plan acknowledged that patient questionnaires from the GP survey had areas to address but there was no plan in place to address these.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Partial[1]
There was a strong emphasis on the safety and well-being of staff.	No[2]
There were systems to ensure compliance with the requirements of the duty of candour.	No[3]
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No[4]

Explanation of any answers and additional evidence:

- [1] Whilst staff told us they felt able to raise concerns without fear of retribution. We found limited evidence that staff were speaking up when things went wrong. Significant events were discussed annually the provider told us they were concerned that staff did not report concerns because of fears of retribution. We were told that staff felt significant events could be a blame scenario and not a learning exercise.
- [2] We did not see any examples of staff surveys of where the practice sought staff views around the services or the safety and wellbeing of staff.
- [3] The practice did not demonstrate an awareness of duty of candour. There was no policy or process to guide staff, and we found an example where duty of candour should have been considered.
- [4]The practice did not provide evidence to show all staff had received equality and diversity training.

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

Source	Feedback
Staff interviews	Staff reported they felt they worked well as a team and enjoyed working at the practice.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No[1]
Staff were clear about their roles and responsibilities.	No[2]
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

- [1]We found that there were a lack of processes for the practice's governance arrangements which included oversight of correspondence, record keeping, health and safety and updating of policies and procedures. The risks identified during our inspection visit had not been identified through audit or other quality assurance processes.
- [1]During our inspection we found that several policies and procedures had been reviewed but information had not been updated to include the latest guidance. For example, the practice did not have any documentation relating to the Duty of Candour. Several policies referred to the previous partnership at the practice.
- [2]We spoke to staff who told us they were clear of their roles and responsibilities. We found on the day several areas that lacked oversight such as stock control and correspondence where it was evident staff did not understand their roles or responsibilities.

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.	No[1]
There were processes to manage performance.	No[2]
There was a quality improvement programme in place.	No[3]
There were effective arrangements for identifying, managing and mitigating risks.	No[4]
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial[5]

Explanation of any answers and additional evidence:

- [1]There were insufficient processes for identification of risk, such as audits or reviews of processes based on national guidance. For example, we found risks identified with medication reviews and administrative processes. Risks were not comprehensively understood, for example in relation to legionella, health and safety, medical emergencies and the responsibilities for monitoring risk and escalation. Staff had not ensured readiness for a medical emergency as there was gaps relating to staff training, for example sepsis awareness training. These inadequate systems placed patients at extreme risk of harm.
- [2] Performance of staff was not always monitored. For example, there was no clinical oversight of clinical letters coming into the practice. The provider had not considered the need for a system of oversight to ensure staff had the necessary knowledge and competencies for the tasks.
- [2]There was no process in place in relation to monitoring the care provided by locum GPs or advanced prescribers. For example, ensuring the referrals they made to secondary care were carried out and followed up. There were also no assurance systems in the monitoring of at-risk patients.
- [3]There was no systematic programme of clinical and internal audits. Therefore, quality improvement was limited
- [4]Although the practice had conducted risk assessments for health and safety and infection control. On the day of inspection, we found areas of concern which was not identified during the practice risk assessments. Some of these areas related to products available to use in the practice that had expired several years ago which had not been found on multiple audits.
- [5]The practice did have a business plan however, the impact on quality and sustainability was not always assessed.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	No
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	No
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: • Data was used to monitor and improve performance in some areas. However, not all areas were considered. • Policies and processes were in place and available to staff. However, we saw instances of where policies were not being followed. The provider did not have a system to monitor adherence to policies. • Staff who dealt with correspondence were not always acting on patient information appropriately. There was a lack of monitoring in regard to the management of data on patients' clinical notes and letters received from secondary services.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
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.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
The practice had an active Patient Participation Group (PPG) with approximately eight members who met on a quarterly basis. The PPG were keen to expand their group and were actively seeking members through open days, social media advertisement and practice staff inviting patients to join. The PPG were complimentary of the practice describing them as caring and kind. The PPG told us that the management team and GP would attend the meetings where complaints and feedback were discussed, and future events were planned collaboratively. The PPG were aware of the needs of the local community and were in the process of setting up a weekly drop in "Take Time Out" group which was due to start on the 1 September 2022. The aim of the group was for carers to come to the practice and meet with members of the PPG and healthcare professional volunteers. The carer could use the time to socialise with other carers and PPG members, for signposting to other services such as financial help, or to take time out and sit quietly for wellbeing time. The PPG had advertised this service on social media forums and had been contacted by other health care professionals to volunteer their services. The PPG also attended events such as Flu clinics to recruit members and support patients by offering support for nervous patients and talking to patients who were at risk of social isolation.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: • We were not assured of a strong focus on continuous learning and improvement. For example, there were significant gaps and weaknesses in processes and arrangements intended to identify and deliver learning and continuous improvement in areas such as safeguarding, significant events, medicines managements, patient care, complaints and overall governance of the practice.	

- There was limited evidence of effective learning and improvement systems were not comprehensively evaluated. There was limited evidence of learning in relation to significant events and patient safety alerts.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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