

## Inspection Evidence Table

Northfield Surgery

(1-555712914)

**Inspection Date: 25 May 2023**

Date of data download: 25/05/2023

## Overall rating: Inadequate

At the previous inspection in May 2018, the practice was rated good in all areas. At this inspection, the practice was rated inadequate. The practice also declined in quality in relation to how effective, caring, and responsive they were in delivering services to the practice populations.

### Safe

### Rating: Inadequate

At the previous inspection in January 2018, the practice was rated good for providing safe services. At this inspection, the practice was rated inadequate at providing safe services because they were unable to demonstrate that safe systems or practices were in place or working effectively in relation to medicines management, safeguarding, recruitment, or the management of risks to patients or staff.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented, and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N

**Explanation of any answers and additional evidence:**

A safeguarding policy was in place and there were arrangements for a safeguarding lead, along with processes for ensuring that staff had information available to them to raise concerns where necessary in relation to safeguarding. For example, there was a folder which contained local safeguarding numbers and a flow chart for staff to follow. The practice used an online administration management system that all staff had access to, where information necessary for staff was uploaded. However, communication systems in place were not always effective. For example, there was no evidence of discussions about safeguarding in meeting minutes or evidence of clinical meetings when asked. Following the inspection, the provider supplied us with clinical meeting minutes from prior to the inspection in March 2023 and one set of minutes for a meeting that occurred following the inspection in July 2023. Neither of these meeting minutes contained discussions on safeguarding. The provider did not routinely attend safeguarding meetings with other organisations and professionals to ensure they shared information more widely. Following the inspection, the provider supplied us with evidence that they had access to a proforma that could be completed to contribute towards child protection conferences, but could not demonstrate that these had been completed or used in a meaningful way.

The practice provided us with a training matrix, but this did not contain all staff at the practice, in particular GPs. Although the practice provided us with details of one of the partners safeguarding training appropriate to their role, the practice told us that the other had not completed this training and they were unable to resolve this. The practice was unable to provide details of training for the two salaried GPs or other long term locum GPs working at the practice. The training matrix did not detail the level of safeguarding training for any staff, so was not able to provide sufficient assurances that all staff had appropriate training in this area.

Of the 5 staff files we reviewed, 1 non-clinical staff member did not have a DBS check evident and 1 longstanding GP, who had online DBS checks completed, had one dated 2021. The practice had checked the online system the day of the inspection and this check stated that the DBS had expired. There was no consideration of this risk or system of adequate oversight in place. Following the inspection, although the provider supplied us with a recruitment and DBS policy, along with information that online checks were in place for some staff, not all staff were represented in their evidence including the majority of the clinical staff.

We asked the practice to provide evidence of multi-disciplinary team (MDT) meetings or communication, but they were unable provide this, or that communication with other professionals had occurred. Following the inspection, the provider supplied us with limited evidence of clinical meeting minutes, which occurred once in March and once July 2023. These showed elements of a multi-disciplinary approach.

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

**Explanation of any answers and additional evidence:**

Upon reviewing 5 staff files:

- We found that staff did not always have DBS checks,
- Practice records showed that a member of staffs Nursing and Midwifery Council (NMC) registration had expired in October 2022 with no mitigating actions taken. From our checks, we found that this nurse was registered, but the practice could not demonstrate that they had an effective system in place to assure themselves that this was the case.
- A pharmacy registration (with the General Pharmaceutical Council - GPhC) had not been checked.
- Not all staff had evidence of inductions or appraisals to ensure they were aware of practice systems and protocols at employment or on an ongoing basis,

- No evidence of role specific training in place, such as diabetes care, childhood immunisations or cervical screening.
- There was no evidence of any staff member having a signed contract in their files,
- There was no evidence of a check of conduct from a previous employer for one member of staff, whilst 3 others had limited checks completed in this area.

We also asked to see the checks completed by the practice in relation to their locum staff, the practice was unable to demonstrate that these checks had been completed.

Following the inspection,

- The provider supplied us with their recruitment policy which included staff recruitment checklists aligning with recruitment good practice. They were unable to demonstrate that they had adhered to their policy, or that checklists in their policy had been used to ensure all information was in place. Similarly, they supplied us with a DBS policy and evidence demonstrating that online DBS checks were in place for some staff, but this did not provide assurances that all clinical staff had current DBS checks in place.
- The provider supplied us with evidence that checks were completed for those staff registered with the NMC in March 2023 and for those staff registered with the GPhC were completed in October and September 2022.
- The provider supplied us with evidence that nurses had completed some diabetic training, that two of the three nurses had completed cervical screening training, but no evidence was submitted that demonstrated that nurses were trained in delivering immunisations.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment: Not available	N/A
There was a fire procedure.	Y
Date of fire risk assessment: April 2023	N/A
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:            The practice did not own the building they operated from and were unable to demonstrate that appropriate assurances had been sought from the building managers in relation to health and safety. When asked, the practice was unable to provide a health and safety risk assessment or assurance they had sought that any remedial actions required had been taken by the building managers. The provider supplied us with minutes from a building residents meeting in December 2022, as well as a duplicate of this meeting, dated March 2023, but this showed no contribution from the practice in this area, except to state that portable appliance tests (PAT) had expired in May 2022.            Following the inspection, the provider supplied us with a 'risk assessment audit' document that was to be completed on a monthly basis. We saw that it had been dated as being established in January 2022 but had not been reviewed until 3 July 2023 (following the inspection). This audit document included risk areas such as 'slips and trips', ventilation, and lighting, but contained only one completed date (2019) and provided no evidence of assurances that had been sought from building managers.            Although the fire risk assessment for the building had been completed on 18 April 2023, the actions outlined were to have been completed by July 2023. The practice was unable to demonstrate that they had sought assurances from building managers of progress on these areas, including amongst others electrical wiring, risk</p>	

of arson, heating installations and dangerous substances. The practice was unable to demonstrate that they had considered the risk of these areas to their patients or staff. For example, the risk assessment outlined the risk of oxygen cylinders being kept in unlocked rooms, without appropriate signage. We found that oxygen was kept in an unlocked room that lacked appropriate signage. Oxygen cylinders were also free standing, which was outlined in the risk assessment as being inappropriate. No actions had been taken to mitigate this. Following the inspection, the practice demonstrated that some but not all actions had been taken from the fire risk assessment that was relevant to the area of the building the practice was responsible for.

**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.	Partial
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit: 2019	N/A
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The training matrix provided to us by the practice demonstrated that all but three staff had recent and up-to-date infection prevention and control (IPC) training completed. Two of the three had non-clinical roles, but one was partly responsible for IPC processes within the practice and held a more clinical role. Following the inspection, the provider supplied us with evidence that the member of staff with a more clinical role, had had IPC training in March 2023, but the training matrix had not been updated, no evidence was supplied in relation to the other two outstanding members of staff.</p> <p>The practice was unable to demonstrate an effective and consistent system in place for IPC. When asked to supply evidence of assurance, the practice gave us an internal yearly infection control audit that had been completed in 2019 and acknowledged that it was out of date. They were unable to demonstrate that they had sought assurance from the building managers in this area. The audit supplied had no details of who had completed it, when actions identified were to be completed by or a review date. In the detail of the audit, we found that several areas for consideration had been missed and actions that had been identified had not been completed. Consultation and minor surgery/phlebotomy rooms had been missed entirely. Furthermore, the practice provided monthly internal IPC audits completed by the responsible member of staff but could only demonstrate that three had been completed for January, February, and March 2023. In the detail of these audits, although some areas were identified as not being compliant, there were not always actions to address these recorded. Where actions were recorded, there was no indication on whether these had been completed. Some areas like the kitchen, had been missed entirely.</p> <p>We found no concerns with the management of waste and the practice were able to provide details from building management for waste.</p>	

**Risks to patients**

**There were considerable gaps in systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice was asked to provide evidence that there was a system in place to ensure the correct number and skill mix of staff, perhaps in the form of a rota. The practice was unable to demonstrate that there was a system in place. We also asked about clinical rotas for doctors to ensure that all periods of patient contact were covered by clinical oversight. The practice was similarly unable to demonstrate a formal system and told us that one of the GP partners covered what was required, when it was required. They were unable to articulate any fail safe for periods of illness or unplanned absence of this GP. This was made more acute because the practice oversaw three sites, two of which they have failed to register with the Care Quality Commission (CQC). They were also unable to demonstrate that these sites were adequately staffed.</p> <p>All 5 staff files we reviewed lacked evidence of inductions for staff.</p> <p>We saw that all but one non-clinical staff member was trained in sepsis but were unable to verify that all clinical staff had suitable training in this area as the training matrix provided was incomplete. We found that the practice had a comprehensive emergency policy and procedure in place and had emergency equipment on the premises.</p> <p>We found that the staff had a “care navigation” protocol to draw upon when making decisions about patient symptoms and where and how to escalate these if necessary.</p> <p>We were unable to verify that there was sufficient staff for appointments and to prevent excessive hours, as the practice was unable to demonstrate any system for the oversight of staff numbers and skill mix.</p>	

**Information to deliver safe care and treatment.**

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

	Y/N/Partial
Individual care records, including clinical data, were written, and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	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
<p>Explanation of any answers and additional evidence:</p> <p>Review of patient records in relation to the clinical searches identified that care records were not always managed in a way to protect patients or in line with national guidance. In all areas we reviewed, medicine reviews (MRs) to be completed by the practice, along with other patient reviews were incomplete, missing or completed to a standard that was not in line with national expectations or guidance.</p> <p>We found evidence that communication with multi-disciplinary (MDT) colleagues was not always effective. The practice was unable to demonstrate that they had attended any meetings, with the exception of safeguarding meetings, which were attended by the practice but infrequently. Following the inspection, we saw that one meeting had occurred and been minuted in March 2023, and another had occurred after the inspection in July 2023, both of which showed elements of MDT working.</p> <p>The practice had an informal approach to the management of test results, including relying on whichever GP came across them, would action them, but this appeared to be working as all the tasks we reviewed had occurred during the 48 hours prior to the inspection. Following the inspection, the provider sent us a copy of their policy for managing incoming pathology results.</p>	

### Appropriate and safe use of medicines

#### The practice had insufficient systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.90	0.89	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	4.3%	6.0%	8.1%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)	5.70	5.09	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	183.3‰	166.7‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.18	0.33	0.56	Variation (positive)

Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	5.5‰	4.0‰	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.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N/A
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	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.	N
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 and Improvement 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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored, and transported in line with UKHSA guidance to ensure they remained safe and effective.	N
Explanation of any answers and additional evidence. We found that rooms containing some medicines, that were used for allergic reactions, were unlocked and accessible to patients. The practice told us that they had made this decision to ensure staff had quick access to	

these in an emergency but were unable to demonstrate that they had formally considered the risk of this or had put mitigations in place to protect patients.

The practice only used electronic prescriptions (EPS) and kept no paper prescriptions on-site.

The practice was unable to demonstrate that the lead clinicians at the practice had formal oversight of the other GPs working at the practice in the role of long-term locums in relation to their prescribing. When asked about this the lead clinician told us that as clinicians registered by the General Medical Council (GMC), they were responsible for their own practice.

The practice demonstrated that they had established a new system to ensure medication reviews are completed for those missing patients and on an ongoing basis from April 2023, we found evidence that patients had not been appropriately reviewed before this and a number of patients remained outstanding. We found evidence that medicine and condition reviews for patients were not in line with national guidance, missing detail or absent in the records we reviewed.

Medicine reviews:

- We found 167 out of 248 patients who had an antiepileptic medicine prescribed more than three times in the last 6 months appeared not to have had a medicine review in the last 12 months, which was confirmed by our sample of 5 records.
- Of the 38 patients prescribed an immune suppressant medicine, our headline search indicated that most of these patients had not had a medicine review (MR). All 5 records we reviewed did not contain an MR and 2 were missing documented shared care arrangements (an agreement between the patient, the GP, and the hospital consultant enabling care and treatment received by the patient for a specific health condition to be shared between the hospital and GP).
- Of the 266 patients prescribed direct oral anti-coagulants (DOACs), we sample reviewed 5 records and found that all 5 did not have MRs in place.
- We found in our headline search that 211 out of the 508 patients prescribed more than 10 separate medicines appeared not to have had a medicine review recorded in the last 18 months. We sample reviewed 5 over 75 (years old) patient records who we saw *did* have medicine reviews in the last 3 months; these were not recorded in line with good practice guidance. For example, they were noted as single entry points in the record and showed no evidence of patient or carer involvement and side effects had not been considered. Furthermore, the practice was unable to demonstrate evidence of MRs or of an effective call or recall system for any of these patients when asked. We were told the new review process the practice began in April 2023 was assessing up to 40 patients per month, which would mean up to 6 months before all of these patients had been fully reviewed.
- Patients continued to be prescribed medicines, despite the lack of appropriate reviews or monitoring.
- Of the sample of 5 high-risk diabetes patient records we reviewed, 2 had appropriate reviews recorded by a GP or specialist nurse. Two had not had any review at all, and for 1 patient there was evidence that a review had been requested, this had not been followed-up. In another instance (included in the 5 records we reviewed), a patient had been identified by the district nursing (DN) team as needing a review, but they had been unable to get through to the practice to make an appointment for the patient. In addition, none of the sampled group had a MR in place. Following the inspection, the provider told us that they were raising the concerns relating to the DN team with the contractors to ensure that this did not reoccur.
- For asthma long-term condition care, patients were being asked to book reviews, but were not followed-up should they not respond once to a request by the practice. Four out of the 5 records we reviewed showed a lack of quality asthma reviews in the last 12 months. Medication reviews were absent or coded as having been done, but with no evidence of these having taken place.
- For those patients with Hypothyroidism, we sample reviewed 5 records and found medicine reviews had not been completed in the last 12 months.



In relation to the above cohorts of patients, we also found evidence that these patients were not always monitored appropriately. The practice demonstrated that they had begun to review patients as part of a new system established in April 2023, but this was not yet fully embedded.

- We found that 1 patient was identified as being at high risk of dependency due to the prescription of an anti-epileptics and opioids for chronic pain. The practice could not demonstrate it had considered a structured dose reduction.
- For those patients prescribed DOACs, we found that in 3 of the 5 records we sampled, patients had not had annual creatinine clearance calculations in line with national good practice guidance.
- For patients with hypothyroidism, we sample reviewed 5 records and found 2 were being monitored by secondary care, but a further 2 had continued to have thyroxine issued, without appropriate monitoring. The practice was unable to demonstrate that they had attempted to contact the patient. In the 1 patient record where there was evidence a contact letter had been sent, no follow-up had occurred, and no appointment had been made. The practice was unable to demonstrate the clinician issuing prescriptions had considered the need for monitoring.

The practice was unable to provide sufficient evidence to demonstrate that medicines, (controlled or not controlled) were fully monitored or that reviews were in place to enable them to determine unusual prescribing, quantities, dose, formulations, or strength.

The practice did not have controlled drugs on the premises.

The practice did not prescribe remotely or online.

The practice could not demonstrate that they had all the recommended emergency medicines in line with good practice guidance but provided us with a risk assessment (RA) for the 10 that were missing. The RA, however, insufficiently considered the risk associated with mitigating actions cited by the practice. For example, the document outlined that pain relief medicines (opioids) were not in-stock due to risk of theft and these would be available from a local pharmacy if needed. We asked if there was a formal arrangement with the pharmacy to have these items needed in stock, should they need them. The clinical lead told us an arrangement was in place but was unable to demonstrate it when asked. Similarly, the document explained that the practice did not have a medicine used to counteract opioid overdose in stock because they did not have opioids on-site. The practice told us that they had patients that misused substances but had not considered the risk to these patients of not stocking this medicine. Another example included an explanation that ambulance times were likely to be very short, but the practice was unable to demonstrate that they had assessed local ambulance call out times formally.

The practice had three cannisters of medical oxygen on-site, but these were kept in an unlocked room with no signage present to indicate that compressed gasses were being stored there. We asked to see documented checks of oxygen levels, but the practice was unable to demonstrate that these were effectively in place. Following the inspection, the provider demonstrated that that appropriate signage had been added but were unable to demonstrate that systems to ensure effective checks of gas levels had been improved.

The practice was unable to demonstrate that vaccines were stored within good practice guidance, or that systems in place were effective in ensuring safe delivery of these medicines. We found that the room where the fridges were and the fridges themselves were unlocked and accessible to patients. Furthermore, we found 9 examples of cold chain breaches that had been documented, with no associated actions recorded. When we asked about these, the practice was unable to provide any explanation or evidence of mitigating actions. The practice showed us that there was a protocol for fridge temperature monitoring was in place, but staff had not followed it and there was insufficient oversight to ensure it had been completed. Clinical leaders told us that various staff members, whose role it had been to oversee these, had left but could not account for the lack of general oversight provided by the leaders at the practice.

Following the inspection, the practice outlined some unverified information about their prescribing, but were unable to provide any data or additional evidence to support it.

They explained,

- *“Opiate data from the ICB showed that the practice had reduced its opiate prescribing in the last year by 8%. The top quartile practices achieved -2.7% or better. The practice received 8.4%.*
- *The practice was the lowest prescriber of antibiotics across the PCN it was part of.*
- *They were the only practice in the PCN to reduce prescribing costs. The practice reduced its cost by £15,000.*
- *They requested a practice visit report from the ICB to review their prescribing data.*
- *The practice has allowed the ICB to make cost effective switches in medications”.*

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

**There were gaps in the practice system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	6
Number of events that required action:	6
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to provide evidence that confidently demonstrated that they reviewed sources of information to monitor safety effectively throughout their delivery of care and treatment.</p> <p>The practice had a system in place to identify and record significant events, however this was not fully effective. Of the 6 significant events we were provided with by practice leaders from the last 12 months, 5 were clinically related and although there were some learning points recorded, there was no overall analysis completed and no action plan in place to address this. Individual significant events did not contain action points to be achieved and included learning points such as “importance of coding”, which was also a recurrent theme, without the practice recognising this.</p> <p>Of the 15 examples of different team meetings, we asked for, including clinical, nurse, MDT, whole and individual team meeting, the practice was able to demonstrate 1 reception meeting dated 10 May 2023. This meeting did not demonstrate any meaningful staff involvement or contribution and significant events were not discussed. The practice was therefore unable to demonstrate that any learning from significant events was disseminated to the staff team. Following the inspection, the provider supplied us with two additional meeting minutes, from March and July 2023, neither of which showed discussions about significant events.</p>	

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

Event	Specific action taken
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Missed 2 week wait referral from Nov 2022	This issue had been identified by the practice in Feb 2023, the practice recorded they did not know why it had occurred and recorded the learning point of adopting a local protocol for this going forward. There was no attempt to contact the patient and ensure a correct referral was made recorded.
Inappropriate prescribing	In response to a medicine being prescribed incorrectly, the practice identified that the GP involved had not followed local or practice prescribing guidelines. The learning point was to ensure all GPs follow the guidance, there was no indication that the practice had identified lack of oversight as a learning point. No direct actions were documented, although they do comment that the “only reason it was picked up” was because the patient came back to the practice to ask for a different medicine.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
<p>Explanation of any answers and additional evidence:  The practice demonstrated that there was a system in place for identifying and acting on recent safety alerts, which included receiving these through email and disseminating to all relevant staff. Pharmacy staff employed by the practice had oversight of this. However, we found in 4 of the 5 sample records we reviewed in this area, that the practice had not attempted to contact or counsel patients of childbearing age prescribed medicines that could affect their pregnancies, should they become pregnant. The remaining patient had been given verbal advice in 2013 but not received any up-to-date guidance. The practice was unable to demonstrate any evidence of a system to ensure historic safety alerts were reviewed or patients advised. Following the inspection, the provider provided us with evidence that a patient prescribed this class of medicine had been given advice in March 2022, but it was not clear if this related to our searches. Similarly, after the inspection the provider told us that a safety alert where action was needed had been completed but did not provide any evidence of this.</p>	

## Effective

## Rating: Inadequate

The practice was rated inadequate for providing effective services because they were unable to demonstrate that action taken to address below target uptake for childhood immunisation and cervical screening had led to any improvements in these data. Additionally, the practice was unable to demonstrate that patients' needs were always met, that staffing was effective or that they had actively engaged in joined up working.

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

### Effective needs assessment, care, and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients' treatment was regularly reviewed and updated.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to fully demonstrate that systems in place to keep clinicians up to date with evidence-based practice were effective. For example, we found that local guidance around prescribing was not always followed and national guidance in relation to medicine and condition reviews were not followed.</p> <p>We found evidence that patients' needs were not always fully met. For example, in relation to being monitored when prescribed higher risk medicines, or multiple medicines.</p> <p>We found evidence that patients were not always followed-up by the practice who had symptoms of a potentially serious illness. For example, we found diabetic patients who required reviews had not been followed-up and patients who should have been referred under the two week wait protocol which were identified by the practice during a significant event had not been followed-up or re-referred.</p>	

In relation to those patients that had not been sufficiently monitored or reviewed in the last 12 months, the practice's assessment of these patients was proceeding at a rate of 4 per week. This did not indicate that their needs had been prioritised as it would take up to 6 months to address this.

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age. The practice had developed an over 65 policy for those patients that were not on the long-term condition registers. The practice called this the “lost tribe” policy, and it was designed to consider those patients that do not routinely get seen because they have less clinical need. The policy document the practice provided to us as part of the inspection did not reflect this aim and indeed, was unclear in its aims or purpose.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group and the practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. However, given the cold chain breaches that had occurred and lack of practice actions in relation to these, we had no confidence that vaccines had been as effective as they should have been.
- Patients did not have access to NHS checks for patients aged 40 to 74, the provider told us following the inspection that they no longer held the contract to provide this service to patients. There was evidence that appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified had been missed.
- Practice managers told us that all patients with a learning disability (LD) were offered an annual health check. We asked the practice to provide us with details of the numbers of LD health checks that had been completed, but they were unable to provide these. Following the inspection, the provider supplied us with evidence that showed that 76 of these checks were completed in the financial year 2023-2024, but no evidence was supplied in relation to how many patients were eligible for these checks.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- We found that 142 patients appeared to fulfil the criteria for chronic kidney disease (CKD) with a severity of 3-5 (5 being worse) but had not been coded as such in the record. In the sample of 5 records we reviewed, there was no evidence in 3 that the patient has been informed of the diagnosis.
- Patients with long-term conditions were not always offered an effective annual review to check their health and medicines needs were being met. However, the practice had begun reviewing these patients from April 2023.
- For patients with the most complex needs, the practice was unable to provide evidence that GPs 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.

- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with COPD were offered rescue packs.
- The practice couldn't always demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Following the inspection, the provider supplied us with additional information but could not provide evidence to support all of it. For example,

The provider was able to evidence,

- They had acquired a mobile ECG machine, which they told us was used to help with early detection of Atrial Fibrillation (AF).
- Spirometry was used to detect undiagnosed Chronic Obstructive Pulmonary Disease (COPD).
- They also evidenced the presence of a 'self-monitoring' blood pressure machine, which they told us was used to opportunistically screen patients for high blood pressure.

The practice was unable to evidence,

- The practice told us they ran teaching sessions on AF, but it was unclear to whom,
- They furthermore told us they routinely screened all patients over the age of 65 for dementia,
- That all patients over 75 who did not have a chronic disease attended the practice for a review to screen for AF, high blood pressure, loneliness, depression, diabetes, and cardio-vascular disease (CVD).
- The practice told us they ran monthly reports to identify missed coding and diagnoses,
- Mobile cardiac monitoring was used by clinicians to screen for AF in appointments,
- Patients that have not attended for 5 years are prompted to use the 'in-practice' testing devices,
- That text messages are sent out to patients inviting them in.

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 influenzae type b (Hib), Hepatitis B (Hep B) (i.e., three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	73	79	92.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	91	112	81.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	89	112	79.5%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps, and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	90	112	80.4%	Below 90% minimum



The percentage of children aged 5 who have received immunisation for measles, mumps, and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	85	109	78.0%	Below 80% uptake
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

The practice was aware of their lower than target uptake for 4 out of 5 indicators for childhood immunisations. They told us that their population had elements of highly transitory patients who were resistant to such interventions, such as a traveller population. They were unable to demonstrate what proportion of their population this was relevant to, and thus what impact this population had on their uptake data, but they told us they were beginning to ask all new patients about their ethnicity to ensure they could start to build a picture of this going forward. In recognition of the age of this data, we asked the practice about updated data in this area, and they provided unverified data from the clinical system which showed that for 1-year immunisations, there were 20 patients outstanding, and for preschool patients, there were 99 patients outstanding. The practice had held a Saturday morning clinic to try to address this and were sending letters to patients to inform them of overdue immunisations and the importance of these. They were recording any declined immunisations but were unable to provide any data on how many of these had been received. They were unable to provide any other data that indicated any improvements had been made as a result of any of these interventions. The practice told us that they were arranging a meeting with the vaccination and immunisation lead for the area to discuss strategy for addressing this but had not yet taken this step.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	53.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	66.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	61.9%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	52.0%	49.7%	54.9%	No statistical variation

### Any additional evidence or comments

The practice was aware of their lower than target uptake data in relation to cervical screening. They explained that after 3 invites for screening, the admin team were to contact patients and if there was still no further contact, then the nurse was to contact and discuss. The practice was unable to demonstrate a formal policy in

place for this. Unverified data provided by the practice from their clinical system demonstrated that in the 25-49 cohort of eligible persons, 216 had never been screened, and from the 50-64 cohort, 35 had never been screened.

### 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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: The practice had begun reviewing patient records from April 2023 and had begun filling in some of the gaps that we identified through our searches of the clinical system, although many patients remained outstanding. They could not demonstrate that they had identified those patients with the highest need in this group of patients and that they had prioritised them as a result. We asked the practice to demonstrate evidence of other quality improvement activity such as clinical audits. They provided us with details of 6 clinical audits that had been started, the oldest of which was started in Oct 2022, but 5 of these had not yet been repeated and therefore did not show any evidence of improvements in patient outcomes, care or treatment. We saw that one audit was a repeat but did not demonstrate improved outcomes.	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge, and experience to deliver effective care, support, and treatment.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	N
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision, and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists, and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: The practice had a system in place for training, learning and development, but were unable to demonstrate that it was effective or that all staff therefore had the skills, knowledge, and experience to deliver care. The training matrix the practice provided, used to monitor staff training did not contain all clinical staff and could not demonstrate that all training was completed to an appropriate level. The practice also told us that a GP partner at the practice had not completed any training, but they were unable to resolve this situation. In addition, the	

practice was unable to demonstrate that any role specific training had been completed, such as immunisation training.

The practice was unable to demonstrate that any inductions had been formally completed by staff whose files we reviewed.

Staff files we reviewed did not always contain information to demonstrate that appraisals had taken place.

We asked the provider to demonstrate that there were systems in place to ensure that healthcare professionals had appropriate clinical supervised in their role. The practice told us that regular “debriefs” occurred with these staff and that clinical supervision and oversight from the clinical lead at the practice was in place with all staff performing any clinical roles. For example, nurses and health care assistants (HCAs).

The practice demonstrated that one member of clinical staff kept a record of continuing professional development (CPD) and that the first annual appraisal of this staff member had occurred in March 2023. This appraisal was not one of the “debriefs” the practice had referred to. The appraisal had not involved audits of consultation notes, any prescribing decisions, or patient feedback. The practice was unable provide evidence that “debriefs” had occurred or that appropriate supervision was in place for any other staff who had clinically related roles.

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to provide any evidence when asked about coordinated communication with professionals outside of the practice, with the exception of a safeguarding meeting attended by the lead clinician in 2022. There was evidence that district nurses, were unable to contact the practice in relation to a diabetes patient. We had no confidence that the systems in place at the practice in relation to this were effective or working as intended. Following the inspection, the provider told us that they were raising the concerns relating to the DN team with the contractors to ensure that this did not reoccur.</p> <p>The practice was unable to demonstrate that there were any clinical meetings in place to discuss and oversee patients care. They had failed to consider the risk of this lack of coordinated care delivery.</p> <p>Following the inspection, the provider supplied us with evidence of meetings with elements of multi-disciplinary working, however, neither meeting, only one of which was held prior to the inspection, demonstrated discussions in relation to safeguarding or significant events.</p>	

### Helping patients to live healthier lives.

**The practice was not always consistent and proactive in helping patients to live healthier lives.**

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We asked the practice to demonstrate how many learning disability reviews had been conducted in the last 12 months, but they were unable to provide us with these data. Following the inspection, the provider supplied us with unverified data for 2023/24, but it was unclear what proportion of their learning-disabled patients this represented. They told us that 76 reviews had been completed in this time.</p> <p>We found evidence that relatives and carers were not always involved in the review of patient's treatment when necessary. For example, in relation to medicine reviews.</p>	

**Consent to care and treatment**

**Due to time constraints, we were unable to ascertain whether the practice obtained consent to care and treatment in line with legislation and guidance.**

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

## Caring

## Rating: Requires Improvement

The practice was rated requires improvement for providing caring services because they were unable to demonstrate that they had taken action to address poor satisfaction of patients who responded to the GP patient survey, or those patients in their internal survey that were less satisfied than others. They were also unable to demonstrate that a carers register was in place or was being used to provide caring services for those patients.

### Kindness, respect, and compassion

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

	Y/N/Partial
Staff we spoke with understood and respected the personal, cultural, social, and religious needs of patients.	Y
Staff we saw interacting with patients displayed understanding and a non-judgemental attitude towards patients.	Y

Patient feedback	
Source	Feedback
NHS choices	Two reviews of the practice had been posted on the NHS Choices website in the preceding 12 months, both of which were negative in terms of getting through to the practice by phone and care and treatment. We saw that the practice had not responded to reviews on NHS choices because they were unable to gain access to the administration section of the website.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	71.8%	82.5%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	66.0%	80.5%	83.5%	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 (01/01/2022 to 30/04/2022)	87.4%	92.4%	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)	30.8%	66.6%	72.4%	Significant variation (negative)
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**Any additional evidence or comments**

The practice was aware of their lower-than-average feedback in relation to being “caring” from the GP patient survey (GPPS) but were unable to demonstrate that they had taken any actions to address the concerns of patients. The GPPS for this practice consisted of 111 responses returned from 352 surveys sent out, a 32% completion rate.

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

**Any additional evidence**

The practice showed us that they had conducted an internal survey of patient satisfaction on the 25 May 2023 with a total of 48 responses. Questions posed to patients about GPs somewhat reflected those asked of patients in the GPPS. Unverified data presented to us by the provider suggested that the majority of the 48 respondents represented answered the questions positively, but we saw no evidence that the provider had created an action plan to address areas of low satisfaction in either this survey or the GPPS. Similar results were obtained for the nurse results, with 27 patients responding and no patients being unrepresented. The practice was unable to account for the patients that were unrepresented by their data.

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

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

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	88.4%	89.3%	89.9%	No statistical variation



	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	When asked to provide data on the carer register, the practice was unable to provide this.
How the practice supported carers (including young carers).	The practice was unable to provide any details on how they support carers.
How the practice supported recently bereaved patients.	The practice was unable to provide any details on how they support bereaved patients.

### Privacy and dignity

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

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

## Responsive

## Rating: Inadequate

The practice was rated inadequate for providing responsive delivery because services were not planned or delivered in a way that met people's needs. They were unable to demonstrate that they had taken appropriate actions to address lower areas of satisfaction from patient feedback, unable to demonstrate that any actions had been taken to record or address complaints. We found that satisfaction had declined in most areas of satisfaction over time, there was no system in place to address this.

### Responding to and meeting people's needs

**Services did not always meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard (AIS).	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice leaders told us of a group of patients that belonged to the traveller community but were unable to demonstrate what proportion of their patients this was, or in what ways they had changed the way they delivered services to meaningfully respond to their specific needs. They were also unable to demonstrate that they yet had any data on any other demographic but had taken the step of beginning to ask new patients for their ethnicity.</p> <p>The practice operated from an NHS managed property and although oversight of various aspects of safety and more general governance was not always in place, the property was appropriate for services within the scope of general practice. All services were delivered from the ground floor and physical access to the building took account of those with mobility issues and other impairments such as hearing or sight loss.</p> <p>Translation services were available, should patients request or need it.</p> <p>We saw that generally AIS was considered, with the exception of the complaint's information for patients. This was printed in a small strip of paper with a font size that excluded patients with sight impairment.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am – 8.30pm
Wednesday	8am - 6pm
Thursday	8am - 6pm

Friday	8am - 6pm
Saturday (additional hours provided by primary care network (PCN))	8am – 1pm
Appointments available:	
Monday	8.30am – 5.30pm
Tuesday	8.30am - 8pm
Wednesday	8.30am – 5.30pm
Thursday	8.30am – 5.30pm
Friday	8.30am – 5.30pm

### Further information about how the practice is responding to the needs of their population

- 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 practice also offered ward rounds to patients in a neighbouring care home, although not all their residents were registered patients.
- The practice was unable to demonstrate that they liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. Following the inspection, additional evidence was supplied by the provider demonstrating that communication with some external professionals (medical examiner) was in place, but this did not provide sufficient assurances that regular contact was in place with professionals involved in managing the needs of patients with complex needs with the exception of the latest meeting, which was held after the inspection in July 2023.
- Practice policy included all parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8.30pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday from 8am until 1pm through the Primary Care Network (PCN).
- 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 but were unable to confirm during the inspection the number of learning disability reviews they had carried out.

### Access to the service

**Some people reported they were not always able to access care and treatment in a timely way.**

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment, or advice.	N
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).	N

Patients were able to make appointments in a way which met their needs.	N
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:  Patient's feedback reflected a mixed picture in relation to their satisfaction with access to appointments.</p> <p>The practice told us they did not offer telephone or online appointments for their patients, face to face appointments only were available.</p>	

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	11.1%	N/A	52.7%	Significant variation (negative)
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)	25.5%	49.0%	56.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	29.1%	49.4%	55.2%	Variation (negative)
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)	57.8%	69.8%	71.9%	No statistical variation

### Any additional evidence or comments

The practice was aware of their lower-than-average satisfaction results in the GP patient survey. They were unable to demonstrate that they had taken any action to address the areas of low satisfaction. The GPPS for this practice consisted of 111 responses returned from 352 surveys sent out, a 32% completion rate. We saw that patient satisfaction had continued to decline over time and there were no systems in place to address this trend.

The practice had conducted an internal survey with 48 respondents, conducted on the 25 May 2023. Questions were reflective of the questions asked in the GPPS. Unverified data provided by the practice showed that some areas of satisfaction were identified as low in this survey. Large number of patients responses were

not represented in the data received from the practice. In all questions, 9 to 12 patients responses were not represented, as we saw numbers of patients asked and their responses did not correlate.

The practice could not demonstrate that they had taken any action to address the areas of lower satisfaction, accounted for the responses that were not represented or produced an action plan in response to these data from their survey or the GPPS.

### Listening and learning from concerns and complaints

#### Complaints were not used to improve the quality of care.

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

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

#### Any additional evidence or comments

The practice was unable to demonstrate that there was a system in place to log, respond to and address complaints. We asked about complaints and were told that there were some that had been logged and that the practice had employed a patient experience manager to be the contact for all patients wishing to complain. We also saw that there was an email address where patients could complain. Practice Managers who we spoke with told us that there were numerous written and verbal complaints but that they did not have access to them on the day of the inspection. They presented us with a complaints folder containing two written complaints from patients, the folder was otherwise empty and there was no evidence that the complaints had been responded to. We asked to see the inbox for the complaints email address, but the practice did not provide us with access. We gave the practice a further 24 hours to provide us with details of complaints and their actions, but they were unable to provide this. Following the inspection, the provider demonstrated that a complaints policy was in place and showed us that seven complaints had been logged in the last 12 months, along with the details of those complaints. They were unable to demonstrate if they were written or verbal, or if they had been responded to or addressed.

## Well-led

## Rating: Inadequate

The practice was rated inadequate for providing well-led services because systems and process in place were not working as intended, overseen effectively, or structured in a way that enabled the provider to fulfil their responsibilities to the practice population. Clinical and non-clinical leadership were unable to demonstrate adequate capacity to deliver high-quality or fully safe services which had led to significant gaps throughout the service.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
<p>Explanation of any answers and additional evidence:</p> <p>Leaders of the practice were unable to demonstrate that appropriate systems and processes were in place to enable them to understand the quality and sustainability of the service. They had taken action to address areas of concern in clinical governance prior to our inspection (from April 2023), but much was left outstanding, and the pace of their actions did not reflect the severity of the concerns we identified. In relation to non-clinical governance, the practice was unable to demonstrate that systems in place were effective, working as intended or had the necessary oversight to ensure long-term sustainability.</p> <p>We asked what role the other GPs employed by the practice (not those who were long-term locums) had in the running of the service, in terms of succession and responsibility (for example, in a duty rota), but the practice was unable to provide any insight into this and viewed these staff members as independent operatives in their own right. Discord between GP partners and the lack of insight into registration responsibilities may have further hampered their ability to establish a cohesive and effective model of care.</p>	

### Vision and strategy

**The practice did not have a clear vision, nor was it supported by an effective 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.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p>	



The practice did not have a vision or values statement available on their website or throughout the building and there was evidence of an ineffective communication system where limited numbers of meetings had been held and no evidence that staff had contributed to the discussions. Following the inspection, the provider supplied us with evidence that nurse meetings had taken place in May and March of 2023, but no further evidence that staff more generally were involved or able to contribute to discussions.

The practice was unable to demonstrate that they had effective systems in place to monitor the delivery of services. They had begun a programme to address clinical elements of this from April 2023, but there was no evidence that non-clinical or general oversight and leadership was in place or working well.

## 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.	N
Staff we spoke with reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	N
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	N
The practice encouraged candour, openness, and honesty.	N
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was no evidence that the practice had a cohesive vision from which to judge behaviour, but the practice did have human resources processes in place.</p> <p>We asked the practice to provide evidence of the well-being offer to staff, but the practice was unable to demonstrate that any system was in place for this. Risks apparent for patients and staff alike were not always monitored or mitigated, the system in place for this was ineffective.</p> <p>As the practice was unable to demonstrate any system for complaints, we could not verify if systems to comply with the duty of candour were always effective.</p> <p>The practice was unable to demonstrate that they had provided access to, or informed staff about freedom to speak up procedures or a champion. Following the inspection, the provider supplied us with evidence of a whistleblowing procedure and policy detailing the speak-up procedure, which was dated February 2021.</p> <p>We reviewed the practice training matrix and found that not all staff on the matrix had completed equality and diversity (E&amp;D) training, in addition, not all clinical staff were represented on the training matrix and therefore the practice could not demonstrate that all staff had completed this training. Following the inspection, the provider evidenced that 5 members of staff had not completed E&amp;D training, but 3 of those staff were indicated to have started within 6 months of the inspection, 2 were more longstanding members of staff, but none had completed the training. No GPs were represented on the training matrix.</p>	

## Governance arrangements

**The overall governance arrangements were generally ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff we spoke with were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The lead GP held all clinical governance roles including being safeguarding lead and clinical lead for the practice, the other employed GPs at the practice fulfilled no governance or leadership roles. We saw evidence that policies and other formal documents were out of date and that the practice had not sought sufficient assurances in relation to governance arrangements with their property managers.</p> <p>We saw that the practice had initiated a new system to address patients who had not been appropriately monitored or reviewed, but this process was lacking in urgency. We saw evidence from significant events, and our review of patient records which demonstrated that delays with referrals were not always followed-up or successfully completed.</p> <p>Generally, governance systems were in disarray and unstructured, including registration responsibilities. We are aware that the provider has taken on additional services but has not yet completed registration processes. During the inspection, we prompted the provider to ensure that this was completed as a matter of urgency and the provider continues to be deficient in this area.</p>	

## Managing risks, issues, and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There was a quality improvement programme in place.	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.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to demonstrate that they had effective systems of assurance in place. We asked the practice to provide evidence that they had sought assurances from building managers in relation to environmental risk and they were unable to do so for all areas. For example, they were unable to provide any health and safety risk assurances or comprehensive and up to date fire and IPC risk assurances.</p>	

The practice was aware of areas of low performance, in relation to cervical screening, childhood immunisations, clinical oversight of patients that required monitoring, and patient feedback. Although they had begun to think about addressing these areas and had taken some actions, they were ineffective and insufficient to bring performance in line with good practice, or indeed to have addressed the issues effectively.

Staff had access to a policy concerning emergency situations, but the practice was unable to demonstrate that staff had read or understood this document, they were also unable to demonstrate that all staff had had health and safety, fire or infection control training when asked.

The practice was unable to demonstrate a comprehensive, proactive, or effective system of risk assessment, consideration, or mitigation.

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	N
<p>Explanation of any answers and additional evidence:            We asked the provider to demonstrate an effective system to ensure that performance was managed, and that oversight of these systems was also effective, the practice could not demonstrate this. They showed us data of outlying data but had no mitigating actions in place. Where actions had been taken in reference to those patients without appropriate monitoring, this lacked the urgency associated with the risks.</p> <p>The provider failed to comply with registration expectations, when asked to provide information to support this process during the inspection, the provider was unable to do so.</p>	

**Engagement with patients, the public, staff, and external partners.**

**The practice did not always effectively involve the public, staff, and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	N
The practice had an active Patient Participation Group (PPG).	N/A
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
<p>Explanation of any answers and additional evidence:            The practice systems in place to gather feedback were not always working, for example complaints. Those systems that had provided patient feedback for consideration had not been acted upon and no process or action plan to address feedback from survey data was evidenced when asked.</p>	

The practice did not have a patient participation group or any other form of patient reference group. We saw no evidence of any attempt to try and establish a group.

Evidence provided by the practice demonstrated that communication systems were ineffective, and staff did not have the opportunity to contribute in a meaningful way to discussions.

We saw evidence that outside professionals and other stakeholders were not able to access the practice. The practice told us that they were unaware of the makeup of their population with the exception of the large traveller population, which they also could not adequately define making it impossible to ensure that the services delivered met the specific needs of their patient population.

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:            The practice gave us 6 examples of clinical audit that had been started but not completed, starting from September 2022. There was therefore no evidence of improvements to patients care, treatment or outcomes. They had begun quality improvement activity in other areas of the business, but these had not yet been completed or expedited in line with the risks associated with them.</p>	

**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.