

Care Quality Commission

Inspection Evidence Table

Dr Touseef Safdar (1-548913045)

Inspection date: 13 and 15 October 2021

Date of data download: 13 October 2021

Overall rating: Inadequate

The practice was rated as Inadequate at the Care Quality Commission (CQC) inspection in June 2021 and was placed in special measures. Following the inspection, the practice was issued with a requirement notice in respect of Regulation 12 (Safe Care and Treatment) and a warning notice in relation to Regulation 17 (Good Governance).

At our inspection in June 2021:

- We identified issues with recruitment processes and ongoing employment checks.
- We found concerns in relation to some of the monitoring of high-risk medicines.
- There was a lack of systems and processes for oversight of clinicians working in the practice.
- The practice was not always responsive to the needs of their patients and complaints were not always used to improve the quality of care.
- There were gaps in governance which resulted in oversight in respect of certain aspects of medicines management which had not been identified prior to our inspection.
- The practice was not always able to demonstrate that systems in place to consider or mitigate risks were effective, or that there was an overall system of oversight to ensure systems were updated or working as intended.
- There were systems for managing risks, issues and performance, however this needed strengthening to ensure that the services were safe or that the quality was effectively managed.
- There was limited evidence to demonstrate that the practice involved patients, staff or stakeholders in shaping the service.

This follow-up inspection was undertaken in October 2021 to review compliance with the requirement notice and warning notice that were issued and had to be met by the end of September 2021. The inspection was not rated and therefore the ratings remain unchanged until we undertake a further full comprehensive inspection.

Safe

At the inspection in June 2021, we found areas of concerns impacting upon patient safety. This was because:

- We identified issues with recruitment processes and ongoing employment checks.
- We found concerns in relation to the monitoring of high-risk medicines.

- There was a lack of systems and processes for oversight of clinicians working in the practice.

This inspection was not rated and therefore the rating of Inadequate from our inspection in June 2021 remains unchanged.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|--|-------------|
| There were systems to identify vulnerable patients on record. | 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. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in June 2021 we found:</p> <ul style="list-style-type: none"> • There was limited evidence which showed that the practice had regular contact with health and social care professionals. Multi-disciplinary meetings (MDT) were being held through the primary care network (PCN) on a monthly basis, however there had been no engagement by the practice in attending these meetings in the last 12 months. <p>At this inspection we found:</p> <ul style="list-style-type: none"> • A locum part time GP had attended an initial multi-disciplinary team meeting held on 21 September 2021. The practice told us that all future meetings will be attended each month by the GP locum who was acting as the clinical lead for the practice. We saw evidence in patient records that liaison was being undertaken with multi-disciplinary teams to coordinate care. • We found that safeguarding registers were in place for adults and children. We found that alerts were used on the clinical system to ensure staff were aware of any safeguarding concerns for children; however we found this did not extend to all household members and some vulnerable adults who were on the register who did not have an alert. We raised this with the practice who told us they would review their safeguarding registers to ensure appropriate coding in patient records as part of good practice. This would support locum clinicians working in the practice who were not familiar with patients registered who had safeguarding concerns. | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |

Explanation of any answers and additional evidence:

At our previous inspection in June 2021:

- We examined several staff personnel files, including staff members recruited during the last 12 months and found that there were gaps in the recruitment checks undertaken prior to employment for two members of staff. We found that interview schedules were missing and there was no evidence in staff files that references had been undertaken.
- After the inspection, the practice sent us evidence of staff immunisation, references and interview schedules in line with safer recruitment, however, we noted that one staff member's reference check contained no signed date of completion. The practice told us that some of the information was not held in staff personnel files and was held electronically.

At this inspection we found:

- The practice had reviewed and improved recruitment files. We reviewed the files of two newly employed staff members and found all the appropriate checks had been carried out prior to employment, such as references, proof of identity and staff vaccinations in line with relevant guidance. This included an induction checklist for each staff member. The practice was in the process of embedding a system and working through existing staff recruitment files to ensure they contained all relevant information in line with safer recruitment.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

| | Y/N/Partial |
|---|-------------|
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |

Explanation of any answers and additional evidence:

At the previous inspection in June 2021 we found:

- There was a heavy reliance on locum staff for the delivery of clinical services in the practice. Long term locum arrangements were in place and a locum induction pack was available. However, non-clinical staff were not always provided with an induction. For example, a receptionist who had been appointed in the last 12 months had not received a formal induction, however informal buddy arrangements were in place.
- Staff were able to describe how they would identify and deal with a rapidly deteriorating patient. However, non-clinical staff reported that they had not received specific sepsis identification training, and this was an area that was identified during our last inspection for improvement.

At this inspection, we found:

- There remained a heavy reliance on locum staff for the delivery of clinical services. A locum pack and induction process had been reviewed and was available for locums who were new to the practice. Long term locum GPs supported with tasks such as workflow. However we found there remained some gaps in appointments offered to patients due to difficulties in obtaining additional GP locum cover at short notice.
- Two non-clinical staff members had been appointed since our last inspection and had been provided with an induction checklist. The practice told us that they were providing staff inductions through an experienced trainer with oversight from the practice manager. We saw evidence of induction processes in place. Although the trainer appointed had no formal training experience, they provided new workers with oversight in their role through previous experience of working in general practice. Newly appointed staff told us they were working through their induction and were being supported. The practice manager told us they had plans to carry out a formal review at 12 weeks.
- The practice was able to evidence that staff had completed sepsis training and were aware the procedures to take to respond in a medical emergency.

Information to deliver safe care and treatment

Staff had 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. | Yes |
| 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:

At the previous inspection in June 2021 we found:

- There was a system in place to monitor test results, however these were not always actioned in a timely manner. For example, we found evidence that there had been a three month delay in recording the blood results of a patient who was prescribed a high-risk medicine that required regular monitoring.
- During our inspection we found that patient information was not always recorded. For example, we found patient records had been coded as having had a medicine review, however there was no information recorded in the patient records and we could not be assured that individual medicines had been reviewed.

- Support and advice to staff, such as members of the nursing team, was ad hoc. We saw no evidence of oversight or clinical meetings between the GPs and the nursing team. We were told that the nursing team would send a message to the locum GP's through the computer to action, however at the time of our inspection there was no formalised system in place.

At this inspection we found:

- There was clinical oversight and a system in place to monitor test results. A long term locum GP worked remotely each day and would review and action test results. We found that these were being managed in a timely way.
- We found evidence of appropriate record keeping during our clinical records reviews in line with best practice. For example, we found evidence that structured medication reviews were being performed by the clinical pharmacist and safety netting advice was clearly documented and in line with evidence-based guidance when managing patients.
- We were unable to evidence any formalised system in place for oversight of nurses working in the practice during our inspection. The practice had initiated a GP locum audit of consultations; however, this did not extend to the nursing team and advice and information from the clinical GP lead continued to be ad hoc with no formalised arrangements in place for oversight.

Appropriate and safe use of medicines

The practice had some systems in place for the appropriate and safe use of medicines, including medicines optimisation

| Medicines management | Y/N/Partial |
|---|-------------|
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | 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. | Yes |
| 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. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in June 2021 we found:</p> | |

- There was a lack of systems and procedures for supervision, peer reviews or clinical oversight of clinicians working in the practice.
- Patients registered at the practice were able to request repeat medicines through a prescription ordering service (POD). This is a service where patients can order prescriptions through a centralised telephone system. However, during our inspection we found that this was not being effectively monitored and systems needed to be embedded further to ensure the practice had oversight and processes in place to review medicine reviews taking place. After the inspection, the practice sent us evidence of a monthly monitoring process they would undertake to ensure the practice were monitoring and had oversight of medicines being issued to their patients.
- Our review of clinical records found that some patients had not received appropriate reviews or monitoring of their medicines. We were told that monthly searches were carried out to identify patients who required monitoring and these patients were contacted and reviewed appropriately. However, a random sample of clinical records showed high-risk medicines were not consistently being monitored appropriately, which meant that monitoring was not always managed in a way that kept patients safe.
- Patient Group Directions (PGD) were in place to allow the practice nurse to administer medicines in line with legislation, however on reviewing a sample of the PGDs we found that one PGD had not been authorised by a senior person at the practice to ensure the appropriate, qualified staff followed the directions. The practice told us this was an oversight and it was immediately rectified.

At this inspection we found:

- The practice continued to rely on locum staff to carry out all aspects of clinical work. Systems were being embedded to support the delivery of the quality of care and to assure the competencies of locums working in the practice. For example, the practice had implemented a policy and process to support audits of GP locum consultations. We saw evidence that this was being undertaken each month by the practice manager. Although the policy stated that the evaluator did not need to be a clinician, we saw that this work did not extend to the clinical GP lead. Although we found that steps were being taken to support prescribing practice, we found limited evidence of clinical oversight for nurses working in the practice, as there was no evidence of specific clinical meetings, supervision or audit of their consultations to support best practice.
- We found the practice had reviewed their systems for monitoring high risk medicines and was supported by a practice-based pharmacist. We saw evidence that structured medicine reviews were being undertaken by a pharmacist and found appropriate monitoring was largely in place however, we also found areas the practice could improve further, for example:
- We reviewed the clinical records of five patients on Methotrexate. We found all patients were receiving regular monitoring, however, for all five prescribed the day of week for taking the medicine was not recorded in line with best practice.

| Medicines management | Y/N/Partial |
|---|-------------|
| <ul style="list-style-type: none"> We found that patients prescribed Lithium were being routinely reviewed and all lithium levels, urea and electrolytes and thyroid function tests were up to date, however some patient's calcium, weight and body mass index (BMI) checks were overdue. We found that patients who were being prescribed simvastatin and amlodipine had all completed appropriate medication reviews in line with a drug safety alert which outlined the increased risk of myopathy (clinical disorder of the skeletal muscles). We saw evidence that the practice had initiated a process for carrying out an audit for patients who ordered repeat medicines through the prescription ordering service (POD). During our site visit we reviewed Patient Group Directions (PGD's) for the administration of medicines and found these were in date and appropriately authorised by a senior person and nurse locum. | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in June 2021, we found:</p> <ul style="list-style-type: none"> The practice had a significant events policy and procedure in place which was reviewed annually. The significant events procedure outlined that learning from significant events would be analysed and shared in practice meetings to review the effectiveness. However, we were not assured that learning was taking place or had been reviewed with staff as there had been only one practice meeting that had taken place during the last 12 months. <p>At this inspection we found;</p> <ul style="list-style-type: none"> Significant events were a standing agenda item in practice meetings and were being reviewed with staff. We saw evidence that two significant events had been reported and investigated since our last inspection. | |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Yes |

| | |
|--|-----|
| Staff understood how to deal with alerts. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in June 2021 we found:</p> <ul style="list-style-type: none">• There was a system in place to review safety alerts, however this needed reviewing further as we found that a drug alert issued in 2014 regarding simvastatin and amlodipine had not been actioned appropriately. <p>At this inspection we found:</p> <ul style="list-style-type: none">• The practice had taken action to address the issues identified at the last inspection regarding a specific safety alert. There was now a system in place for monitoring, reviewing and actioning any new and historical safety alerts. | |

Effective

At the inspection in June 2021, we found:

- Long term condition outcomes, asthma reviews, chronic obstructive pulmonary disease (COPD) and hypertension reviews were below local and national targets.
- The practice's childhood immunisation uptake rates were below the World Health Organisation (WHO) targets for three out of five indicators and there had been a decline in outcome performance since our last inspection. The practice had seen improvements in some of their immunisation outcomes, however this was unvalidated data at the time of our inspection.
- The practice had seen a slight improvement in their cervical screening rates, however the actions they had taken to improve had not yet been fully effective and uptake remained significantly below the Public Health England coverage target.
- Mental health indicators were below the local and national averages. Although the practice had demonstrated improvements in their personalised care adjustment rate (PCA), overall outcomes for mental health had declined further since our last inspection in 2019 from 68.2% to 41.4%.
- The practice could not demonstrate how they assured the competence of clinicians working in the practice as there were no systems for supervision or clinical oversight.
- The issue around oversight of clinicians affected all population groups so we rated all population groups as inadequate for providing effective services.

This inspection was not rated and therefore the rating of Inadequate from our inspection in June 2021 remains unchanged.

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Partial |
| Patients' treatment was regularly reviewed and updated. | Partial |
| Explanation of any answers and additional evidence: | |
| At our previous inspection in June 2021, we found: | |
| <ul style="list-style-type: none"> • The practice had systems to keep clinicians up to date with current evidence-based practice; however, a random view of clinical records showed clinicians did not always assess patients' needs and deliver care and treatment in line with current guidance. For example, patients prescribed a high-risk medicine were not routinely monitored in line with NICE guidance. • A random sample of clinical records we viewed remotely showed patients treatment was not always reviewed or updated. In particular, we saw the use of medication reviews added to | |

clinical records; however, we were unable to evidence that an actual review had been carried out.

At this inspection we found:

- The practice had reviewed their processes for the monitoring of high risk medicines and were currently being supported by a clinical pharmacist. A random review of records demonstrated that structured reviews were mostly being carried out in line with best practice, or where monitoring was overdue steps were being taken to review this further.
- The systems and processes for the review of long term conditions such as asthma, diabetes and chronic kidney disease (CKD) needed strengthening as we found backlogs in the monitoring and annual reviews for these patients. The practice told us that long term conditions work was put on hold for a while during the pandemic and the pharmacist had identified these were largely overdue. However, during our records review we found that four patients had been prescribed more than two courses of oral steroids in 12 months and were overdue their annual asthma reviews, and one patient had been issued with five courses of steroids in a few months without review. We raised this with the practice who said they would investigate this further with clinicians through their significant events process.
- We found that the practice had a recall system in place, but this was not always effective. For example, there was no process in place to contact and review patients who were still collecting prescriptions despite not having regular monitoring checks. The practice told us that they had appointed a non-clinical staff member to support them with their recall of patients, however we found that the recall system in place needed reviewing to ensure there was a failsafe system to ensure monitoring checks are carried out when required.

Effective staffing

The practice was able to demonstrate that most 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. | Yes |
| Staff had protected time for learning and development. | Partial |
| There was an induction programme for new staff. | 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 |

Explanation of any answers and additional evidence:

At the previous inspection in June 2021, we found:

- We saw evidence of an induction pack for clinical staff; however, we were unable to evidence that there was an induction process in place for non-clinical staff. A non-clinical staff member had joined the practice in the last 12 months, however there was no formal induction in place and on reviewing a sample of staff personnel folders, we found no documentation to support an induction had taken place. The practice told us that buddy arrangements were in place to support the non-clinical staff during this time.
- Training required by the provider was completed via an electronic training system which was monitored by the practice manager. The practice had oversight of completed training for locum staff and non-clinical staff.
- There was no protected time for learning and development for staff, however the practice told us that non-clinical staff were able to use quieter periods throughout the day to undertake required learning.
- We found that non-clinical staff had received an appraisal. Although this had been fully completed by staff members this needed to be embedded further as there was limited evidence to demonstrate how objectives, competencies or further development would be reviewed or agreed by the management team.
- There was no evidence to demonstrate that the practice had assured themselves of the competencies of long-term locum clinical staff working in the practice. The practice could not demonstrate acceptable levels of competence for staff who carried out their roles unsupervised and there was no system in place to ensure the clinical team received regular clinical supervision.

At this inspection we found:

- Induction processes had been strengthened to support newly employed staff. For example, we found the practice had recently employed two reception staff and saw evidence of an induction checklist and arrangements for oversight to support them in their role. We spoke to staff who told us they were working through their induction. Although there was no structured time to complete training, staff felt supported by other staff when required.
- There was a named locum GP lead who was responsible for clinical oversight of the practice. Although we were able to evidence that there was a clinical lead in place, we were still not able to demonstrate clinical oversight for nurses working in the practice, nor were we able to determine any specific time allocated to manage this role effectively. We found there was no formalised clinical supervision and clinical meetings did not take place, nor was there any structured debrief slots allocated for nurses to discuss patients during the working day. We were told that if nurses had concerns then they would contact a locum GP working on-site during the day.

Coordinating care and treatment

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

Indicator

Y/N/Partial

| | |
|---|-----|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Explanation of any answers and additional evidence: | |
| At the previous inspection in June 2021, we found: | |
| <ul style="list-style-type: none"> No multi-disciplinary meetings (MDT) had been held by the practice in the last 12 months. The practice told us that they had difficulties arranging multi-disciplinary team meetings (MDT) face to face during COVID-19. The practice told us they planned for an MDT meeting to take place in March 2021, however this was cancelled by other agencies at short notice. Regular monthly MDT meetings were being held within the local network and part of the primary care network (PCN); however, the practice had been unable to attend these meetings and liaised directly with agencies to coordinate care for their patients. | |
| At this inspection, we found: | |
| <ul style="list-style-type: none"> Multi-disciplinary meetings had been established which took place on a monthly basis with a neighbouring practice. We saw evidence that the practice had recently attended an MDT meeting held in September 2021. Records we reviewed saw evidence of liaison with multi-disciplinary teams. | |

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| Patients had access to appropriate health assessments and checks. | Partial |
| Explanation of any answers and additional evidence: | |
| At the previous inspection in June 2021, we found: | |
| <ul style="list-style-type: none"> Patients did not always receive the required monitoring of their health. Systems and processes had not always been effective, which meant that some patients had not had a structured and comprehensive medication review for the monitoring of high-risk medicines. | |
| At this inspection, we found: | |
| <ul style="list-style-type: none"> The systems and processes for the review of some long term conditions such as asthma, diabetes hypothyroidism and chronic kidney disease (CKD) needed strengthening further as we found issues with long term condition reviews and potential missed diagnosis. We found that some patients were overdue monitoring of long term conditions and this had already been identified by the pharmacist who was reviewing this further within the practice. We found that the practice needed to review the coding of patients with potential diagnosis of diabetes and chronic kidney disease and embed a robust system for recalls as we found there were 108 potential missed | |

diagnoses of chronic kidney disease (CKD) and two potential missed diabetes diagnoses.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

| | Y/N/Partial |
|---|-------------|
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Yes |
| Explanation of any answers and additional evidence: | |
| At the previous inspection in June 2021, we found: | |
| <ul style="list-style-type: none">The practice told us that alerts were added to patients with DNACPR's in place and these were reviewed. However, we reviewed two DNACPR's and found one patient's DNACPR was put in during COVID-19 and had been overdue a review by 11 months. Following our inspection, the practice told us they had taken action to address this. | |
| At this inspection, we found: | |
| <ul style="list-style-type: none">We reviewed two do not resuscitate decisions (DNACPR) and found evidence that these had been discussed with the patient or their representative and were appropriate. We found action had been taken to review an overdue DNACPR during our last inspection. | |

Responsive

At our inspection in June 2021, we found concerns relating to responding and meeting people's needs. This was because:

- The practice was not always responsive to the needs of their patients and complaints were not always used to improve the quality of care.

| | Y/N/Partial |
|--|-------------|
| There was evidence that complaints were used to drive continuous improvement. | Partial |
| Explanation of any answers and additional evidence: At the previous inspection in June 2021 we found: <ul style="list-style-type: none">• CQC had received a number of complaints from patients who told us that they had raised formal complaints with the practice on more than one occasion and were told this had not been received. During our inspection the practice had told us they had received three complaints in the last 12 months, however we found that a further formal complaint involving the information commissioner's office (ICO) had not been shared with CQC and therefore we were not assured that the practice were being open and accurate with their complaints process. We reviewed the complaints policy and found this needed embedding further. For example, the practice outlined that complaints would be handled in a timely manner and reviewed as a practice to learn and drive improvements, however only one practice meeting had taken place in the past 12 months where one complaint had been discussed. At this inspection, we found: <ul style="list-style-type: none">• The practice had reviewed their complaints policy and were in the process of strengthening and embedding a new system. A new procedure had been implemented for reception staff on handling complaints and a meeting had been held to ensure staff understood the process for reporting complaints. The practice provided evidence that all staff had signed documentation of the new complaints process in place. We also saw evidence that complaints were a standing agenda item in the monthly practice meetings. Although the practice had taken steps to review a new process, as the process had been recently initiated, we were unable to establish if this was embedded and was being used to drive continuous improvement. | |

Well-led

At our inspection in June 2021, we found concerns relating to how the practice was led and the effectiveness of practice systems and processes. This was because:

- There were gaps in governance which resulted in oversight in respect of certain aspects of medicines management which had not been identified prior to our inspection.
- The practice was not always able to demonstrate that systems in place to consider or mitigate risks were effective, or that there was an overall system of oversight to ensure systems were updated or working as intended.
- There were systems for managing risks, issues and performance, however this needed strengthening to ensure that the services were safe or that the quality was effectively managed.
- The provider was unable to provide assurances that staff were working competently with effective oversight of their work.
- There was limited evidence to demonstrate that the practice involved patients, staff or stakeholders in shaping the service.

This inspection was not rated and therefore the rating of Inadequate from our inspection in June 2021 remains unchanged.

Vision and strategy

The practice had a vision and 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. | Partial |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: | |
| At the last inspection we found that: | |
| <ul style="list-style-type: none"> • The practice aimed to provide a traditional family general practice which focused on personalised continuous care and had an emphasis on building relationships with the patients. Whilst some staff understood this vision, other staff were not aware of this. | |

- We found that that the practice was continuing to provide continuity of care through the use of long-term locums and this was being reviewed by the management team to ensure services were meeting the clinical needs of the practice population.

At this inspection we found:

- There continued to be a reliance on locum clinicians to carry out clinical services to patients and during our inspection we saw some gaps in clinical sessions being delivered by the practice due to the locum cancellation of clinics. At the time of our inspection, the leadership team was reviewing the long term arrangements of the practice as part of their strategy and succession planning as all clinicians were currently employed on a locum basis.
- During our inspection we saw that steps had been taken to address areas of risk which were highlighted from our inspection in June 2021, for example, high risk monitoring. The practice had completed an action plan which was monitored monthly and areas had been reviewed with staff working in the practice.
- We found that the practice had employed a further two non-clinical staff members to support the team further in improving the quality of care. Whilst we acknowledged that some areas had been addressed during this inspection, other areas were in the process of being embedded or needed to be strengthened. For example, the complaints process, practice meetings, multi-disciplinary meetings and long term condition reviews.

Culture

The practice had improved its culture to support high quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |

Explanation of any answers and additional evidence:

At the last inspection we found:

- Staff we spoke to were not aware of the freedom to speak up guardian in the practice but told us they could go to the practice manager or GPs to discuss their concerns.
- The practice had policies and procedures in place to ensure compliance with the duty of candor, however they needed to improve how they captured and dealt with complaints in order to respond appropriately and share learning to seek improvement.
- There was limited evidence of a systematic approach to staff meetings. We saw evidence that one practice meeting had taken place in the last 12 months and were not assured that learning

from safety incidents, complaints and safeguarding concerns were regularly shared with practice staff.

At this inspection we found:

- Steps were being taken to embed a culture to support high quality and sustainable care. Staff meetings were being held on a monthly basis with standing agenda items such as complaints, significant events and safeguarding. The practice manager was the appointed freedom to speak up guardian and we found that work was underway to address areas of culture within the practice. For example, a staff survey had been completed for all staff to look at ways to improve the culture in the practice. We found that the complaints process had been reviewed and was in the process of being strengthened to capture complaints and investigate them and share learning to drive improvements. The practice had held a specific meeting to review the complaints process in detail to ensure all staff understood the requirements in their role to learn from complaints and foster a culture of openness.

Governance arrangements

There were governance arrangements in place, but this needed strengthening further.

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Partial |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • Since the inspection in June 2021, we found that the practice had carried out work to improve the oversight of clinical and managerial systems along with governance arrangements. Non-clinical staff had been assigned lead roles to support the quality and care being delivered, however we did find that some areas required further improvement. For example, the recall system for long term conditions and coding for potential missed diagnosis needed strengthening to ensure patients were recalled and followed up in a timely way. We acknowledged that these would take some time to embed and will be further reviewed at our next CQC inspection. • Although steps had been taken to assess the competencies of locum GP's working in the practice through audit of their consultations, we found that this did not extend to the nursing team or was not being managed by the clinical lead as part of their oversight. We found that the clinical lead had no specific allocated time to manage clinical oversight effectively. Although practice meetings were in place, there was no evidence of clinical meetings or assurances to oversee and maintain clinical leadership within the practice to ensure all were working to an appropriate standard. | |

Managing risks, issues and performance

The practice did not always 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. | Partial |
| There were processes to manage performance. | Partial |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> At this inspection we found that the practice was focusing on addressing the issues raised in the condition and warning notices served following the inspection in June 2021. This had helped to improve the governance assurance systems and processes and the arrangements for managing risks. We found that the practice had taken steps to address the issues identified, however some areas required strengthening further to support the delivery of good quality care. We found there was still a lack of clinical oversight for clinicians working in the practice and governance systems needed embedding further, for example, recall systems for the management of long term conditions. Whilst we acknowledged some of these issues were being addressed, we found that some areas required time to be established. These will be reviewed in more detail at the next inspection. | |

Appropriate and accurate information

The practice could not evidence that they always acted 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. | Partial |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Following our inspection in June 2021 the practice had completed an action plan and were monitoring this each month to improve performance. There was evidence that some improvements had been made to the governance systems in place, for example high risk medicine protocols, recruitment processes, staff meetings and the management of complaints. However, we did find that further improvements were needed to monitor, manage and mitigate risks for patients with long term health conditions and areas within the effective oversight of clinical leadership. These areas needed strengthening further to ensure that performance and safety was being monitored effectively and there was oversight of all clinicians working in the practice. | |

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. | Partial |
| The practice had an active Patient Participation Group. | No |
| 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. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • During our inspection we found that the practice was reviewing the complaints process to improve services and the culture within the practice, however there was no active patient participation group in place. • The practice was reviewing areas of performance with practice staff and involved them in shaping and improving the delivery of services. For example, non-clinical staff were assigned lead roles within the practice to improve the quality of care. • The practice had engaged with a neighbouring practice and had attended a joint multi-disciplinary team meeting (MDT) which was being held on a monthly basis. • As a result of our inspection in June 2021 the practice had engaged with the Clinical Commissioning Group (CCG) and was being supported by a clinical pharmacist in the monitoring of patients on high risk medicines. | |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Partial |
| Learning was shared effectively and used to make improvements. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • During our inspection we found that practice meetings had been re-established and were taking place monthly. We saw evidence that complaints and significant events were being discussed and were standing agenda items, however clinical meetings were not in place. | |

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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