

Inspection Evidence Table

Dr Mahbub's Surgery

(1-2301236031)

Inspection Date: 20th June 2023

Date of data download: 16/06/2023

Overall rating: Inadequate

We have rated the practice as inadequate because:

- The practice did not have clear systems, practice and processes to keep people safe.
- Patients were not always assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice did not always organise and deliver services to meet patients' needs.
- Leaders did not have sufficient governance and clinical oversight to ensure high quality, sustainable care.

Safe

Rating: Inadequate

We have rated the practice as inadequate for providing safe services as we identified significant concerns in the management of patient safety. This included safeguarding, recruitment checks, health and safety, safe care and treatment, medicines management, significant event management and patient safety alerts.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Partial
There were systems to identify vulnerable patients on record.	No

Disclosure and Barring Service (DBS) checks were undertaken where required.	N
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us they had a safeguarding policy in place and in addition to this the practice told us they had a female genital mutilation (FGM) policy, but we did not see any evidence of these. We saw evidence of a children's safeguarding policy. We found that not all staff's training records had been completed to the appropriate level for safeguarding. For example, we reviewed staff's training records and found: <ul style="list-style-type: none"> 6 of the team had completed adult safeguarding training at levels 1 and 2, however, they were all due to be renewed. The safeguarding lead had completed adult safeguarding 3 but this was out of date. They informed us they had completed recent face to face training but were unable to provide evidence to confirm this. We identified that 5 of the 7 staffs training records we reviewed had completed level 1 safeguarding children, 3 of the records were in date. We identified that 6 of the 7 had completed level 2 safeguarding children training, 3 were in date. The safeguarding lead had completed safeguarding children level 3, but this was out of date. The practice told us they had a safeguarding list which was reviewed monthly. We reviewed safeguarding registers and found they were incomplete and required updating to ensure they reflected an accurate list of patients with safeguarding concerns registered at the practice. For example, we found that patients were not being routinely monitored and coded on the system with other members of their household or followed up appropriately when they did not attend for appointments. We could not identify evidence of safeguarding meetings being held to review registers. This meant there was inadequate oversight or a lack of systems in place to mitigate and manage safeguarding risks for patients in the practice. This placed vulnerable patients at the risk of harm from potential safeguarding concerns. <ul style="list-style-type: none"> 2 out of the 3 children we reviewed did not have safeguarding alerts and family members were not linked on the clinical system to demonstrate there were safeguarding concerns within the family. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed 6 staff records which included clinical and non-clinical staff. We found gaps in the recruitment checks which included: 1 which had no proof of identity and 3 which had no references. Disclosure and barring checks (DBS) had not been completed for 1 member of staff and 2 DBS checks had not been reviewed since 2016. On reviewing clinical registration checks for 4 members of staff, we found 1 had been completed. 	

- We reviewed 6 staff records, 5 of the team had received vaccinations in line with UKHSA guidance, however one clinical record showed no record of immunisation status.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 17 th April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 3 rd April 2023	Y
Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • NHS property services maintained and had oversight of the building and the practice premises. • The premises were maintained to a high standard with appropriate access and equipment, including a hearing loop and appropriate disabled access. • We reviewed the fire risk assessment action plan and risks had been identified but no review dates of comments had been actioned. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We reviewed 7 of the 16 staff training records, 5 staff had completed Infection control Level 1, the further 2 staff had completed infection level 2, however, one of these was significantly out of date. • The practice had an infection prevention and control (IPC) lead. • We reviewed the Integrated Care Partner (IPC) audit which had been completed on 1st June 2023, the practice had scored 93% overall. The outstanding action plan had been completed. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	No
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the practice reception team rota, we noted staff did not start work until 09.00, the practice contracted hours were 08.00 to 1830. The practice phone calls were diverted to the provider's other CQC registered practice between 08.00 and 09.00 each morning. However, as the staff at the other practice did not have visibility of clinical records for this practice, they were unable to respond to patients queries or make appointments. The practice had a locum induction pack in place to support temporary staff. Patients and administration staff told us there were long delays for the phones to be answered often over an hour, this was due to lack of team members picking up calls, and that the patients struggled to be given an appointment. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	N
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Clinical searches identified that care records were not managed in line with current guidance. For example: On reviewing a sample of consultations we found some clinical staff had not maintained accurate, complete, and contemporaneous records in respect of each patient, and of decisions taken in relation to the care and treatment provided. 	

- We reviewed the records of a patient on the pharmacy list for review of discharge letters and found there was no documentation of the actions taken. Due to the lack of oversight, an appointment had been made in error with the phlebotomist for an Hba1C (a blood test to monitor blood sugar control). However, the discharge summary requested a haemoglobin level (Hb) to check for anaemia. There is a risk that the patient would get the wrong blood tests.
- We found evidence that secondary services had requested a patient was prescribed medicines for their mental health, however we found evidence that the practice had prescribed the medicines at the wrong dosage. On reviewing this we were unable to gain assurances that the clinician had followed up on the change to dosage.
- We identified a patient who had been given a steroid injection for plantar fasciitis an inflammation of the fibrous tissue (plantar fascia) along the bottom of the foot which was not in line with National Institute for Care Excellence (NICE) guidance that recommends this condition is treated with exercises, self-care, analgesics and physiotherapy and if an injection was given it should ideally be done under ultrasound control to reduce the risk of complications. In addition to this, we found the consent form used was not appropriate for steroid injections as it was intended for use with minor surgery and did not outline the specific potential risks associated with the procedure. We found this patient had been put at risk of unnecessary treatment and not been made aware of the potential risks associated with this procedure.
- We observed that there were 4 new patient records requiring summarising, 2 of these were dated from July 2021.
- We found delays in the actioning of clinical referrals and outstanding tasks and found no effective processes were in place to monitor that systems were being followed. On reviewing the clinical system, we found 781 GP2GP electronic patient records outstanding (patient records between surgeries for handing over new patients etc) and 36 referrals awaiting action which dated back to 22 October 2019. We sampled outstanding tasks and one of these was a medicines query sent by a pharmacist to a clinician who was not working. We were not assured there was oversight or a system in place to manage this effectively.
- We found 19 laboratory reports that had not been attached to a patients record, some dating back to August 2022 with the most recent result dated 01 June 2023. Some of the results appeared to be for patients from the provider's other practice. During our inspection the lead GP reviewed these and managed to match all results to patient records.
 - One of the unmatched reports for a patient showed an abnormally high HbA1c of 164mmol/mol (normal range 20-41). There was a reference to the high reading in a clinic letter, but the result had not been filed into the patients record and so did not appear on their investigations results screen. The results for a repeat HbA1c 10 months later were filed into the patient's computer record by a receptionist. We found the medication history showed a poor compliance prior to the original test, and this had been highlighted by a clinician 6 years earlier. The last documented medicine review was completed in January 2022 and included no information other than the code "medication review done". The patient poor compliance and poor diabetic control were not addressed. The patient has subsequently been started on insulin.
- We found multiple fit notes left uncollected in a box. One fit note was issued in June 2022 but had no corresponding consultation note. There was no record of the patient being seen or requesting the fit note. This was the first time the fit note had been issued and there were no consultations documented in the patient's clinical record. On further review we found a further 5 fit notes which were uncollected and three of them were dated as expiring on 19 June 2023, 30 December 2022, and 28 November 2022.
- As part of our remote inspection on 3 July 2023 we reviewed a sample of patients records and found further examples of unsafe care. We observed history or review of symptoms was not adequately documented and there was not always a clear rationale for management decisions which did not align with NICE guidance.

- We found evidence of a patient who was prescribed a medicine used to treat mood problems at night for sleeping difficulties. An adequate history was not taken in relation to this symptom to exclude other causes for the insomnia, such as pattern of sleep disturbance, other potential triggers and what other actions had been taken to resolve the patient's condition.
- A further patient had also been prescribed a cholesterol lowering medicine at a dosage lower than that recommended by NICE guidance for primary prevention of cardiovascular disease. We found there was no clear management plan or rationale recorded for giving this lower dose. (Prescribing a lower dosage of statin could result in the patient's cardiovascular risk not being adequately reduced). For both patients, we found there was no documentation to suggest lifestyle advice was given before prescribing medications for insomnia and or in conjunction with medication to lower cholesterol levels for treatment of raised cardiovascular risk, as recommended by NICE guidance.
- We identified a patient who had been prescribed a course of antibiotics to treat a productive cough and found there was a lack of clear documentation, the history did not adequately explore the patients' current symptoms.

Appropriate and safe use of medicines

The practice did not have 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) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	1.39	0.92	0.91	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	4.5%	5.6%	7.8%	Tending towards 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 (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	4.06	5.22	5.23	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	145.3‰	142.3‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.65	0.63	0.55	No statistical variation

Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	8.6‰	9.0‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicine.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
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.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<ul style="list-style-type: none"> There was no consistent prescription tracking system in place. The last record of serial numbers had been made on 12 April 2023 and this had been entered in a notebook that was marked controlled drugs. We found that two patient group directives (PDG's) for Meningitis B and the Meningitis B for high-risk patients were both out of date and had expired in February 2021. 	

- We found there was no assurance or clinical oversight for non-medical prescribers working at the practice to provide an adequate and safe service for patients registered at the practice. We found evidence of staff working without sufficient clinical oversight with no assurances that they were prescribing within their scope of competence. We saw that the clinical GP lead was unaware of the pharmacist's areas of competence. For example, during our inspection we were told that the pharmacist only issued repeat medicines, however we found evidence that they were issuing acute medicines and repeat medicines. This may have potentially exposed patients to the risk of harm from the unsafe management of medicines.
- We found there was no system in place for managing uncollected prescriptions. For example, we found that repeat prescriptions were left uncollected in the prescription collection box. We sampled these and found prescriptions from December 22, January 23 and February 23.
 - We found that a prescription for an insulin pen was left uncollected, we noted another prescription had been issued one week later for the same medication.
 - A prescription was left uncollected for a mouth ulcer gel, and we found that the prescription had been started by a receptionist and there was no corresponding consultation note to state why it had been started or issued.
 - We found that a prescription for a statin remained in the box uncollected and dated. The prescription prior to this issue for the same medication had been issued the day before. The same patient was also prescribed a medicine to treat type 2 diabetes, and a prescription remained in the box uncollected. The prescription prior to this issue for the same medication had been issued 5 days earlier.
- We found there was no assurance that 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.
 - Our searches showed that there were two patients prescribed methotrexate, however the medicines prescribed did not specify which day of the week the patient should take their medicines in line with NICE guidance. In addition, we found that for both patients' urea and electrolytes blood tests to check kidney function had not been completed. This medicine requires regular blood test monitoring every 3 months for full blood count, urea and electrolyte (U&E) and liver function checks. This places the patients at risk of toxicity from the medication not being monitored appropriately.
 - One patient, who was prescribed Lithium, had blood tests to check kidney function, but had not had Lithium, Thyroid or Calcium levels checked. Lithium is a very toxic medicine that requires close monitoring to ensure levels remain within a narrow therapeutic range. Lithium levels should be checked every 3 months. A further patient had their last lithium levels checked 11 months earlier. Not checking lithium and other monitoring blood tests regularly, places patients at risk of harm from the medicine which can be fatal.
- We reviewed emergency medicines and found that during our inspection one piece of equipment had to be removed due to cleanliness. An example was the aero chamber was left in the cupboard unwrapped and uncovered and the face mask was visibly dirty and covered in dust.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
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The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	0
Number of events that required action:	0
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us that if there were any errors or issues they were logged or raised as significant events and discussed in team meetings. However, we saw no evidence of this. Significant events were not consistently being managed effectively and investigated in the practice. We saw evidence of multiple missed opportunities to raise a significant event and there was no consistent approach to managing this effectively and driving improvements. Not having effective systems in place to identify and respond to concerns placed patients at the risk of harm. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider was unable to demonstrate that all relevant safety alerts had been responded to. Our searches showed 2 examples on patients given Methotrexate, where specified days to take the medicines were not added. We found examples where procedures had been carried out that were not recommended by clinical guidelines. For example, one patient had been administered a steroid to treat hay fever, however it was not licensed or in line with NICE or MHRA guidance. There were no details documented in the consultation to demonstrate that the patient had been informed that this was off license, or about the potential side effects and risks. 	

Effective

Rating: Inadequate

We have rated the practice as inadequate for providing effective services as we identified significant concerns in the management of delivering services in line with current legislation, there was a lack of monitoring of outcomes of treatment, and the practice was unable to demonstrate that staff had the skills and knowledge and experience required to carry out their role.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Unknown
The practice prioritised care for their most clinically vulnerable patients.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We identified significant concerns about the way the practice managed the care of patients. We found a clinician was undertaking minor surgery when we were informed that they had been suspended by Black Country Integrated Care Board (BCICB) from undertaking surgical procedures due to their training not being up to date. <ul style="list-style-type: none"> During our inspection we found: <ul style="list-style-type: none"> Consent forms were not always accurately completed in terms of the local anaesthetic administered, the procedure undertaken and clarity around who signed the consent form. Consultations for minor surgery procedures were not always accurately documented and were sometimes recorded under the name of people not competent to deliver treatment. For example, a health care assistant. Batch numbers and expiry dates were not documented in the consultation records and prescriptions issued for the medicines administered did not always match those written on the consent form or documented in patients' consultation records. Excised material had not always been sent for histology in line with good practice guidelines to determine the nature of the lesion. 	

- We found for one patient, who was a child, they did not have an assessment of Gillick competency documented (a review to determine a child's capacity to consent) before an operation to remove a scalp cyst was undertaken. In addition, consultation documentation was inaccurate and incomplete. For example, the consultation notes stated that 2ml 2% lidocaine had been administered but the consent form said xylocaine had been used. The batch number and expiry date were not recorded in the consultation records. The consultation had been entered under the GP's name and the consent form was signed by them, but it was not clear if the child or their parent had given consent on the form. The cyst had not been sent off for histology to confirm the diagnosis in line with recommended practice. Failure to properly assess a child's competency before seeking consent places them at risk of harm.
- We identified that two tennis elbow injections had been administered to a patient two weeks apart, once for the left elbow and once for the right elbow. The consent form used was not appropriate as it listed potential risks associated with minor surgery not those relating to joint injections and there was no evidence the patient had been informed of the specific risks associated with this treatment on either occasion. The consultation was recorded as having been completed by the health care assistant who does not have the competency to undertake this procedure. There were no details documented regarding the severity of the patient's symptoms. This puts the patient at risk by not being adequately informed of the risks associated with treatment that did not follow the recommended NICE guidance that says a steroid injection should not routinely be offered to patients with tennis elbow (lateral epicondylitis) unless for severe pain for short term relief as it is unlikely to affect long-term outcomes.
- We identified another minor surgery procedure consultation had been documented under the name of a health care assistant (HCA). This had been for excision of a sebaceous cyst on a patient under local anaesthetic where 3 stitches were applied. Minor surgery is beyond the competency of a health care assistant. The consent form appeared to have been signed by a GP, however, there were no details of the batch number or expiry date of the local anaesthetic solution in the consultation notes and information on the consent form suggested the incorrect medicines had been administered. Inaccurate records place the patient at risk as it is not clear what procedure and treatment have been given.
- The practice could not demonstrate that guidelines were monitored through risk assessments and audits. The practice could not produce any completed clinical audits.
- We found there were delays in the actioning of clinical referrals and found no effective processes in place to monitor that systems were being followed. For example, on reviewing the clinical system, we found 36 referrals were awaiting action which dated back to 22 October 2019. This delay would or may have potentially exposed patients to the risk of harm and management of health conditions.
- Our searches identified a patient with a very raised HbA1c of 96 in October 2022, consistent with a diagnosis of diabetes. There was no code indicating the patient had diabetes on their computer record and there was no evidence the patient had been informed they were diabetic.
 - This patient also had a missed diagnosis of chronic kidney disease (CKD) stage 3. It is important that blood pressure is well-controlled in patients with diabetes and kidney disease, but there was no record of a blood pressure reading coded in the medical records.
 - Our Searches showed 18 patients with a potential missed diagnosis of chronic kidney disease (CKD). We reviewed 5 patients and found, 1 patient was known to have an underlying kidney condition but was not on the CKD register and the other 4 patients had not been coded or informed that they had CKD.

Effective care for the practice population

Management of people with long term conditions

Findings

- As part of our remote searches, we carried out a review of the clinical system through a range of searches and sampled a number of patients records and found evidence of unsafe care. For example:
 - Patients with long term conditions did not always have appropriate coding and were not receiving reviews in an appropriate timescale.
 - We identified that 6 patients had not had thyroid function tests (TFT), taken in the last 18 months, and their last test had not been in the normal range. We reviewed 5 of these and found, 3 patients had not had TFT tests for 3 years. Tests should be performed every 12 months to ensure that patients are taking the correct dose of thyroxine medicine to maintain normal thyroid hormone levels.
 - One patient had not been coded as having chronic kidney disease (CKD) following 2 blood tests showing reduced renal function 4 months apart in 2022. Their last blood pressure reading was elevated, and they had abnormal protein levels in the urine, which suggested kidney damage.
 - One patient was coded as having polycystic kidney disease but was not on the CKD register. Their latest blood pressure reading was very elevated and had not been repeated since. This places the patient at risk of worsening renal function.
 - We identified 12 patients with asthma who had been prescribed rescue steroids to treat and exacerbation of their condition and reviewed the records of 5 patients. We found that none of them had been reviewed within 48 hours to ensure they were responding to treatment in accordance with NICE guidance.
 - We found there were 3 patients who were not followed up following an asthma exacerbation and did not have medication adjusted. A further 2 patients had not had an adequate annual asthma review in the last 12 months. Not having effective systems in place to identify and respond to concerns about clinical care would or may have potentially exposed patients to the risk of harm.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	52	90.4%	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)	34	40	85.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	35	40	87.5%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	36	40	90.0%	Met 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)	46	54	85.2%	Below 90% minimum

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

Findings

- The practice had not met the minimum 90% indicator for 3 of the 5 childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the five childhood immunisation uptake indicators. Due to the significant concerns, we had identified in the management of patients care and treatment, we had no assurances that the practice had appropriate systems in place to monitor those patients that needed immunisations, systems for calling them in for appointments and then escalating to the safeguarding lead if patients did not attend for their appointment.

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)	40.7%	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)	57%	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). (12/31/2022 to 12/31/2022) (UKHSA)	55.9%	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) (4/1/2021 to 3/31/2022) (UKHSA)	33.3%	48.3%	54.9%	No statistical variation

Any additional evidence or comments

- The practice's uptake for cervical screening was below the target for the national screening programme. The practice were unable to demonstrate how they were encouraging patients to attend for screening.
- Due to the significant concerns, we had identified in the management and care of patients, we were unable to gain assurances that patients who failed to attend for immunisations were followed up

appropriately. Safeguarding processes at the practice needed strengthening to ensure patients were clinically coded appropriately.

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.	N
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: <ul style="list-style-type: none"> We could not identify any clinical audits that had been completed in the last 2 years for this practice. 	

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.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found limited oversight or clinical supervision. We found a lack of clinical oversight of non-medical prescribers who were working on-site and offsite. We reviewed 7 patients who were on the practice pharmacist appointment screen and found there were no consultation notes or records of any 	

interventions for any of the patients. During our inspection we asked the lead partner what arrangements were in place for clinical oversight, and we were not assured adequate systems were in place. This placed patients at the risk of harm from the unsafe management of medicines.

- We could not be assured that the provider had assurance that non-medical prescribers were clinically competent as there was no evidence of a system in place to demonstrate clinical review and supervision. We saw that there were no random reviews of clinical consultations, auditing of prescribing and clinical meetings for non-medical prescribers who worked on-site and remotely. This placed patients at the risk of potential harm by not receiving safe and effective care and treatment.
- We identified a lack of oversight of a physician associate (PA), and it appeared in the consultation notes that they were prescribing medicines, which is outside of the competencies of this role. There was no evidence of oversight by an appropriate clinician.
 - On reviewing the records of one patient who had a history of weight loss over a considerable amount of time we found the history and examination documented in the clinical record had not included sufficient information to exclude potential serious diagnoses that could cause the patient symptoms. This places the patient at risk of having a potentially undiagnosed condition.
 - We found that a patient's record stated intermittent left sided abdomen pain. There was an inadequate history taken and lack of appropriate examination and investigation completed. This places the patient at risk of having a serious missed diagnosis as a cause for their symptoms.
- We reviewed 6 staff records (a mix of clinical and admin) none of them had received an appraisal in the last 2 years

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff told us that multi-disciplinary (MDT) meetings were held every 2 months, but there was low attendance. We were not provided with any evidence of discussions with services or community teams to ensure patients received the appropriate care and treatment. • We found evidence to demonstrate that referrals to secondary care had not been acted on, which posed a potential risk to patients not being followed up appropriately. 	

Helping patients to live healthier lives

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

	Y/N/Partial
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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.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	N
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff told us that the practice healthcare assistant proactively spoke with patients whilst they were waiting to see a GP about healthy living and lifestyle choices. • The practice had access to a social prescriber from the primary care network (PCN) and their priority at the time of the inspection was to identify carers, and ensure they were captured and coded, so they could be offered the support they needed. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	N
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	N
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> • As part of our remote searches, we sampled a number of patients records and found examples of unsafe care. For example: <ul style="list-style-type: none"> ○ We could not evidence that documentation around patients' needs, wishes and preferences were being recorded for palliative care patients. ○ One patient record which had a code added to indicate a do not attempt cardiopulmonary resuscitation (DNACPR) form had been completed, however, we found no evidence to demonstrate that there had been a discussion about this decision recorded in the patient's record. ○ We identified that minor surgery consent forms were not always accurately completed in relation to the local anaesthetic used. 	

Caring

Rating: Requires improvement

We have rated the practice as requires improvement for providing caring services as there was no evidence to demonstrate patients' feedback had been considered to improve services and we 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 did not always treat patients with kindness, respect and compassion. Feedback from patients was negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During our inspection we identified that patients' difficulties to get through to the practice and obtain an appointment in a timely manner, and due to other significant concerns, we were not assured that patients were given information to cope emotionally with their care, treatment or condition. 	

Patient feedback	
Source	Feedback
Patient Feedback	We spoke to 3 patients in the waiting room who told us they had difficulties in access to the practice.
NHS UK	<p>There were 4 reviews on NHS UK in the last 2 years, 3 rate the practice 1 out of 5 stars and comments included:</p> <ul style="list-style-type: none"> Unable to contact service (waits of over an hour) Appointments not available No response to e-consults Argumentative reception staff <p>There was 1 review which rated the practice 3 out of 5-stars. Feedback included clinical staff are welcoming and passionate, but the reception staff were rude.</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
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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)	70.9%	79.0%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	67.1%	76.9%	83.5%	Tending towards 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)	91.6%	89.5%	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)	54.1%	62.3%	72.4%	No statistical variation

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment / patients were not involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The surgery had easy read material for patients with learning disabilities, however during our inspection we found that patients had not always been provided with the support and advice to manage their health conditions. 	

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)	81.4%	85.2%	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.	The practice did not have a carers' register. The practice told us that searches for carers were done through the clinical system. At the time of our inspection the social prescriber was in the process, of identifying carers within the surgery.
How the practice supported carers (including young carers).	All carers that had been identified were offered a flu vaccination.
How the practice supported recently bereaved patients.	The practice told us that the GP would contact the family and letters were sent out with leaflets and contact numbers for support services available to the 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

We rated responsive as inadequate as patients could not always access care and treatment in a timely way, complaints were not handled appropriately, and the practice was unable to demonstrate they had processes in place to act on patient feedback.

Responding to and meeting people's needs

The practice did not always organise and deliver services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	N
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found there was no staff available to answer calls each day between 8am and 9am and patients calls were being diverted to the provider other CQC registered practice. We found that staff from the provider's other site did not have visibility of clinical records and patients were being instructed to ring back at 9am when staff were available to book an appointment. We found that this was impacting on delays for patients to obtain an appointment and the provider was not taking appropriate action to manage sufficient staffing during contractual hours. We reviewed appointment availability and found the practice were not always flexible to offer face to face appointments for patients. We found gaps in the clinical rotas which suggested that there were hours when there was no GP available within the building. The practice had a hearing loop, and good disabled access. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	9am – 6.30pm (lines diverted to other surgery between 8am – 9am)
Tuesday	9am – 6.30pm (lines diverted to other surgery between 8am – 9am)
Wednesday	9am – 12.00pm (lines diverted to other surgery between 08.00-09.00), PCN Cover 1300 – 1830
Thursday	9am – 6.30pm (lines diverted to other surgery between 8am – 9am)
Friday	9am – 6.30pm (lines diverted to other surgery between 8am – 9am)

Access to the service

People were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Patients told us that they struggled to access the surgery and appointments. Patients could not book an appointment until after 9am. We found there were delays in getting through on the phone lines and patients were being asked to call back. The surgery offered telephone access/online access and video consultation appointments as well as face to face. Double slots were made available once a week for patients with complex needs. Staff told us that patients under 2 were offered same day appointments and patients under 5 were prioritised. 	

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)	31.8%	N/A	52.7%	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)	41.3%	46.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with	48.4%	48.6%	55.2%	No statistical variation

their GP practice appointment times (01/01/2022 to 30/04/2022)				
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)	56.6%	64.8%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There were 4 reviews over the last 2 years, 3 of which highlighted the following access issues:</p> <ul style="list-style-type: none"> • Unable to contact service (waits of over an hour) • Appointments not available • No response to e-consults

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.	0
Number of complaints we examined.	0
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff told us that the practice manager dealt with some verbal complaints, and these were documented within the patient record. • The practice could not demonstrate that they had a complaints policy in place, and we could not see complaints leaflet available for patients within the practice. • As no complaints were captured, there was no evidence of identifying themes or learning. Complaints were not referenced within the minutes of staff meetings. 	

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

Well-led

Rating: Inadequate

We have rated the practice as Inadequate for providing well-led services as the practice was unable to demonstrate they had effective leadership in place to provide high quality sustainable care. The practice did not have fully embedded governance systems and had not proactively identified and managed risks.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The lead GP worked between two practices and the other one was a single-handed practice. We found the provider lacked capacity to effectively manage and have oversight of all clinical areas of the practice.• The lead GP did not recognise that there were any challenges to quality or sustainability at this surgery.• There was no succession plan for the practice.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Practice staff were unaware of the practice vision, values and strategy.	

- The practice could not demonstrate a strategy or outline their priorities to deliver good quality sustainable care.
- The practice could not demonstrate that the leadership of the practice had been planned to ensure sustainability of the service. The GP had recruited additional clinicians, however there was ineffective processes in place to ensure safety, oversight and continued leadership in the practice. For example, there was no leadership development programme and appraisals were not routinely held so conversations about staff development were not regularly reviewed.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
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.	N
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had recently employed a human resource specialist company to support them with any staffing concerns. • Staff told us that they were able to raise concerns. However, due to staff relationships they did not always feel comfortable to do so. • The practice had a duty of candour policy, however, as no complaints were recorded, or themes captured for informal complaints we did not feel assured around the practice's duty of candour. • The practice had a Freedom to Speak Up Guardian who worked in an adjoining practice in the building. • Equality and diversity training was available, but not all staff had completed this and some staff training was out of date. 	

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

Source	Feedback
Staff questionnaires and interviews	They are a good team, and the GP is kind. Staff get along, GPs are good. Feel supported

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• We found there was ineffective leadership and governance at Dr Mahbub's Practice. There was no evidence of clinical oversight nor was there evidence of management oversight across the practice as a whole to sustain the leadership, business continuity and contingency planning of the practice to provide an adequate and safe service for patients.• There was limited evidence of systems and processes to oversee clinical governance and supervision. We found a lack of clinical oversight of non-medical prescribers who were working on-site. We could not be assured that non-medical prescribers were clinically competent as there was no evidence of a system in place to demonstrate clinical review and supervision. We saw that there were no random reviews of clinical consultations, auditing of prescribing and clinical meetings for non-medical prescribers who worked on-site and remotely. This may have potentially exposed patients to the risk of harm by not receiving safe and effective care and treatment.• There were gaps in the practice's mandatory training schedule, in areas such as safeguarding, basic life support and infection control. No staff members had received an appraisal in the last 12 months, and we could not identify evidence of effective induction systems.• The practice had not always ensured patients were monitored or being followed up appropriately. Therefore, we were not assured that there were embedded systems and processes in place that operated effectively to ensure compliance with safety and good governance. Not having effective systems in place to ensure patients were safely monitored may have potentially exposed patients to the risk of harm.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	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> <ul style="list-style-type: none"> • We could not identify effective systems to manage risk and performance. We saw no learning or trend analysis from significant events or complaints. • The practice had employed a human resource company to support them with performance management, but this had only recently been applied and we had seen no evidence of a performance management plan being followed up until that date. • The practice could not demonstrate any clinical audit or other practice improvement activity to learn from and create a continuous improvement cycle. • Safety alert systems had not been effective, and we identified occasions when safety alerts had not been followed. • Multi-disciplinary team meetings were not routine, and we saw no evidence of them being recorded, therefore, we had no assurance that vulnerable patients and those with complex care needs were given the appropriate care and treatment. • We found there were gaps and inconsistencies in patients care and treatment which did not follow best practice guidance and these risks had not been effectively managed by the practice's own quality assurance system. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Unknown
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We could not identify any clinical audits or prescribing audits; we did not identify any data that was analysed to improve performance. • We reviewed 6 staff records, and we could not identify any appraisals had been completed in the last 12 months. 	

- We reviewed staff meeting minutes and found that appraisals were a standard agenda item, but in the 3 months we reviewed February, March and May 2023, each time it stated that these were overdue.
- We did not identify any significant events or complaints, so were not assured that staff whose responsibilities for making statutory notifications understood what this entailed.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Partial
Patients were informed and consent obtained if interactions were recorded.	Partial
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Patient records were not always held in line with guidance and requirement. <ul style="list-style-type: none"> ◦ We found that patient records requiring summarising were not completed and documents were not available. ◦ We found unmatched laboratory reports had not been actioned. ◦ We found that fit notes that were not collected were not being routinely reviewed as we found examples where they had been reissued. • We identified consent forms for procedures undertaken were not always accurately documented. 	

Engagement with patients, the public, staff and external partners

The practice did not 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.	Partial
The practice had an active Patient Participation Group.	Partial
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed minutes of the last patient participation group meeting (PPG) from 6th April 2023, this was the first meeting since prior to Covid 19. We saw no evidence of staff views being reflected in the delivery of the service. The practice was part of a primary care network and engaged in meetings. 	

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw no evidence of continuous learning or improvement. For example: <ul style="list-style-type: none"> There had been no clinical audits within the last 2 years. There had been no formal process to review clinical staff. There had been no appraisals in place for the previous year. There was no themed analysis of significant events and complaints. The practice was unable to demonstrate any quality improvement programme to patient satisfaction. There had been no oversight or supervision of non-medical clinicians. 	
Examples of continuous learning and improvement	
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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.