

Care Quality Commission

Inspection Evidence Table

Dr N Niranjana's Practice (1-528613695)

Inspection date: 26 October 2020

Date of data download: 20 October 2020

Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Inadequate

- The practice is rated inadequate for providing safe services due to a range of concerns including, safeguarding, recruitment, safe systems and records, health and safety, infection control, risks to patients, information to deliver safe care and treatment, medicines management, emergency procedures, management of safety alerts and significant events.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	Not seen
Policies took account of patients accessing any online services.	Not seen
Policies and procedures were monitored, reviewed and updated.	Not seen
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	N
The Out of Hours service was informed of relevant safeguarding information.	N

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N

Explanation of any answers and additional evidence:

- A GP partner was the lead for safeguarding both adults and children but the arrangements in the practice were inadequate.
- There was no child or adult safeguarding policy presented to the inspection team on request.
- When we looked at safeguarding training records for one lead GP and one locum GP, we found there was no up to date training for the lead GP since 2014 and there were no training records seen for one locum GP. When we looked at training records for the two locum nurses, we found one had completed level three safeguarding training in February 2020 but there was no safeguarding training record for the second nurse.
- There was no evidence of safeguarding training in the personnel file for the healthcare assistant employed at the practice. The practice told us the non-clinical staff had received online safeguarding training but could not provide us with training records to evidence this.
- Locum GPs who attended the practice did not receive a locum induction pack that provided the necessary safeguarding information to enable them to fulfil their role.
- When we asked the lead GP to discuss the process in place if they had safeguarding concerns, they told us there was a folder kept in reception where at risk patients were added to a list. However, the lead GP did not know the location of this folder when accompanied to the reception. When the folder was located and reviewed, we found it contained a print off of child protection meetings which went back a few years, with no evidence of any recent meetings.
- There was no system in place to ensure safeguarding concerns were discussed with the wider practice team and vulnerable adults and children at risk were kept safe. For example, there were no internal meeting minutes provided that showed safeguarding was discussed.
- There was no evidence of active and appropriate engagement in local safeguarding processes, as the practice could not provide details of any safeguarding referrals they had made. When we reviewed patient records, we found two of the GPs had failed to review a child presenting with concerning symptoms and make the necessary referrals to the safeguarding and specialist team. This was despite the parent raising concerns to the two GPs on the two separate occasions. One

Safeguarding	Y/N/Partial
<p>of the GPs told us a referral had been made but there was no evidence of this. The two lead GPs had not discussed this patient due to a poor working relationship.</p> <ul style="list-style-type: none"> The clinicians could not explain how safeguarding concerns, including critically ill patients would be shared with other care givers, despite one of the lead GPs also working for the out of hours GP service. The practice also confirmed they did not have a process in place for sharing this information with the out of hours or ambulance service. There was no vulnerable adults or children at risk register that would ensure patients at risk were monitored on a regular basis. As a result, there was no method of verifying or ensuring all vulnerable adults and children at risk had a clear flag on their notes to make this clear to the clinician seeing them. DBS checks were not up to date. When we reviewed recruitment records, we found one locum GP last had their DBS check carried out in 2013 and another staff member told us they had updated their DBS certificate from 2014 but there was no record of this on file. Practice staff who were designated chaperones told us they received training but there were no training records available to verify. The practice told us no external or virtual multidisciplinary team meetings were currently taking place, due to the Covid-19 pandemic; however, no minutes of meetings that occurred before the pandemic could be provided. They also told us they had meetings with the health visitor but no minutes of such meetings could be provided and the practice manager could not verify this. 	
Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There were significant gaps in the recruitment processes at the practice. One member of staff was recruited under several positions within the practice and was also recruited outside of the practice recruitment policy, last reviewed in September 2020. For example, one of the GP partners was not informed of this appointment despite it being a requirement in the practice recruitment policy that the shortlisting panel should consist of both partners. When we reviewed staff recruitment records, we found this member of staff was initially recruited as a healthcare assistant and at the time of inspection, was recruited as an assistant practice manager and health practitioner. However, we also found practice documentation that 	

Safeguarding	Y/N/Partial
<p>indicated this staff member was being referred to as a doctor, despite not holding a qualification in the United Kingdom. Furthermore, there were gaps in their recruitment records, such as identification which expired in 2014 and no effort had been made by the practice to ensure these records were up to date.</p> <ul style="list-style-type: none"> When we reviewed the Hepatitis B immunity status for five clinicians and one non-clinician, we found only one nursing member of the staff had up to date immunisation records. No one we spoke to could confirm when the Hepatitis B status of clinical staff had last been checked. The practice told us most of the non-clinical staff had declined to have their Hepatitis B immunity status checked but no risk assessments had been carried out. When we reviewed other immunisation records, we found that for one locum nurse, locum GPs and the GP partners, their blood tests to check their measles, mumps and rubella status were out of date. There was no evidence to show how the registration of nursing staff was continuously monitored. The practice had registration records that had expired in 2017 and had no checking system in place to ensure clinicians remained appropriately registered with their professional body. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: October 2020</p>	Partial
<p>There was a record of equipment calibration. Date of last calibration: 22 October 2020</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	N
<p>There was a fire procedure.</p>	Not assessed
<p>There was a record of fire extinguisher checks. Date of last check: not known</p>	N
<p>There was a log of fire drills. Date of last drill: February 2020</p>	N
<p>There was a record of fire alarm checks. Date of last check: 11 July 2019</p>	Y
<p>There was a record of fire training for staff. Date of last training: not known</p>	N
<p>There were fire marshals.</p>	Partial
<p>A fire risk assessment had been completed. Date of completion: 30 September 2020</p>	Partial

Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had not ensured the Portable Appliance Testing (PAT) had covered all the appliances in practice building rooms. For example, some appliances in the staff room received a PAT test in October 2020, whilst electrical appliances inside the boardroom had not been tested. The appliances used in one of the GP's private office such as a television and coffee maker had not been PAT tested because the room was always locked and no one had access to it when the GP was not available. We were not presented with a Control of Substances Hazardous to Health (COSHH) risk assessment on request. The practice told us the last fire drill was carried out in February 2020 but could not provide evidence to support this. The practice manager did not maintain a log of fire drills and was unsure if one was in place. There was no evidence provided to show staff had received any fire support training. There was only one fire marshal in the practice who only worked on one day a week. There were no arrangements made for a second fire marshal in the practice. The practice had carried out an inhouse fire safety risk assessment; however, this was not effective and omitted some key safety aspects. For example, the risk assessment stated all fire extinguishers had been checked but we saw no evidence of this. We observed a fire extinguisher on the ground floor that was not secured and looked outdated, without any recorded date of the last check. There were no visible fire extinguishers on the first floor despite the large size of the building. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: n/a	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> A security risk assessment was carried out in July 2019. Health and safety risk assessments were not been carried out by the practice. We found patients were at risk of harm due to inadequate health and safety arrangements. For example, the premises lift was not working at the time of inspection and this had not been risked assessed and there were no procedures in place to ensure the safe evacuation of patients in the event they collapsed whilst on the first floor. Flu vaccinations were being carried out on the 	

first floor. There was also no consideration of an evacuation chair stored by the stairs to ensure patients with reduced mobility could be safely evacuated in an emergency.

- The upstairs patient toilet has no emergency pull cord for patients to use in the event of an emergency and a hand grab rail was not installed.
- We did not find evidence of a legionella risk assessment but saw evidence from July 2020 where enquiries were being made by the practice to undertake testing but there was no evidence of any follow up.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	N
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 27 January 2020	Partial
The practice had acted on any issues identified in infection prevention and control audits.	N
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	N

Explanation of any answers and additional evidence:

- We found significant gaps in infection control procedures around the practice, including arrangements following the Covid-19 pandemic. For example, although some of the chairs in the patient waiting rooms were taped off to ensure social distancing but there were no posters displayed informing patients of this, neither was there any information displayed around the practice waiting areas relating to the Covid-19 infection. We observed dirty and stained fabric chairs that did not conform to current infection control standards in the first-floor patient waiting room. A risk assessment had not taken place to mitigate this risk.
- The practice was not aware of their responsibilities in relation to managing infection control risk within the practice and they were also not aware of their lead Clinical Commissioning Group (CCG) infection control nurse.
- Not all staff had received up to date infection control training. For example, records showed one locum nurse had last received infection control training in 2018. A second nurse and locum GP did not have any infection control training recorded on file.
- We did not find evidence of an infection control policy but the practice had carried out their own infection control audit. However, when we reviewed this audit, we found it to be sub-standard because it was a 'tick-box' checklist with no clear actions identified or implemented.
- From the entrance into the practice and throughout the building, there were no hand hygiene gel dispensers available. Due to the size of the building and number of doors into the different

areas and floors, there was a risk of cross-contamination with no facilities to adequately ensure good hand hygiene. We observed only one hand gel dispenser available in the first floor waiting room but it was not working during the inspection, further increasing the risk of cross contamination and spreading infection.

- We observed one of the lead GPs was not aware of his responsibilities in relation to Covid-19 secure consulting. For example, he was wearing a three-piece attire against guidelines and was due to see patients face to face on the day of inspection.
- There were inadequate handwashing facilities in both the staff room and one of the patient toilets. One of the patient toilets did not have adequate facilities such as a handwashing soap dispenser or paper towels.
- Clinical room curtains were visibly dirty and as per guidance should therefore have been replaced; however, they simply had a sticker with a replacement date of 20 April 2020. The practice was not clear if this was the date a change was due, or the date they were last changed. When we asked one of the lead GPs about this, they were not aware of who had the lead responsibility for infection control.
- Arrangements in place for managing waste and clinical specimens was not safe. For example, inside the patient waiting rooms, there were no clinical waste bins for patients to dispose of any used masks.
- We found two sharps bins were overfilled and not labelled or dated as per national infection control guidelines.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were inadequate.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Clinicians knew how to identify and manage patients with severe infections including sepsis.	N
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.	N
There was a process in the practice for urgent clinical review of such patients.	N
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N

Explanation of any answers and additional evidence:

- Staffing arrangements in the practice were inadequate and placed patients at risk. We found there was no clinical cover arranged for one of the GP partners when they required annual leave, as the senior GP partner controlled and facilitated the hiring of locum GPs. Consequently, due to their poor working relationship, the GP partner was only able to undertake annual leave absence once in the past year. Furthermore, we were provided with evidence to show when the senior partner took leave of absence, they did not arrange clinical cover for themselves or inform the partner of their absence. We found the practice did not maintain effective oversight of this.
- There was no effective induction system for temporary staff. For example, locum GPs who attended the practice did not receive an induction pack that provided the necessary practice information to enable them to fulfil their role. This information included referrals and emergency procedures, such as locating emergency medicines and equipment.
- There were inadequate risk assessments carried out for patients. For example, we reviewed the care of a patient expressing suicidal ideation and found they were prescribed a significant amount of medicine that had the potential to cause them significant harm without an adequate risk assessment.
- Another patient record we reviewed showed a patient who was at high risk of a fall and fracture was told by the practice they were not eligible for a walking aid. However, the patient had not received a risk assessment and had not been referred to a physiotherapist or occupational therapist as per national guidelines.
- Risk management plans were not developed in line with national guidance. For example, we found patients with asthma had continued to get inhalers without an adequate review. We also found patients commenced on antidepressants were not monitored and risk assessments for these patients were not carried out before being prescribed strong medicines, despite national guidance.
- The practice was not equipped to deal with medical emergencies and staff were not suitably trained in emergency procedures. They told us there was no written medical emergency policy available and although the practice told us staff had undertaken online basic life support training, they were unable to provide evidence of this on inspection. We reviewed six clinical staff records and found four had not received up to date basic life support training.
- The practice was not aware of the emergency call button on their computer screens. They recalled an incident whereby a patient had become violent during their consultation, leaving the lead GP shouting for help, instead of utilising the panic button. There was a risk that due to the large size of the practice, shouts for help would not always be heard. During the inspection, we tested the panic button installed on their computer system but none of the GP's responded to this alarm. The practice told us they were not aware of this button on their computer system.

- We were not assured the practice had systems in place to identify and manage patients with sepsis. We did not see evidence of any sepsis scores or national early warning score guidance displayed in any of the clinical rooms. On review of notes, we did not see any example of a sepsis score template being used and there was no evidence of minutes of meetings where sepsis was discussed. Although the reception staff were able to discuss the signs of sepsis and stated they had received sepsis training, there was no evidence of training records provided.
- The practice did not assess the impact on safety when there were changes to services or staff. During the Covid-19 pandemic, the practice did not review their contingency plan despite a national alert from NHS England to do so.
- There were no steps taken to ensure the patients at risk or those that required regular reviews would be contacted and recalled as necessary, especially as the services provided both at the practice and in secondary care were likely to be impacted. This was in relation to patients prescribed high-risk medicines requiring regular monitoring, as well as at patients diagnosed with mental health conditions.
- When there were changes to staff roles such as their designated healthcare assistant, they did not assess the impact on safety. This particular staff member was delegated to carry out health checks amongst other roles but when they discontinued this role in March 2020, the practice did not ensure patients would not be impacted and would continue to be reviewed when required. No arrangements were made to ensure these changes would not significantly impact patients.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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
Referral letters contained specific information to allow appropriate and timely referrals.	N
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocol.	N
Explanation of any answers and additional evidence:	

- We were not assured there were systems in place to ensure clinical data was managed securely in line with current guidance and legislation. This was in relation to one clinician travelling with the practice laptop abroad without notifying the designated data protection lead at the practice.
- Clinical data was not written in line with current guidance and legislation. For example, prior to carrying out the remote records review, we were provided with evidence to show a significant number of clinical entries were not consistent with the principles of good record keeping, due to several spelling and grammatical errors in 33 of the records. Upon review, we found most of these notes were illegible.
- We also found in the 33 records we looked at as part of our remote clinical records review, there were no management plans recorded. This placed patients at risk of unsafe care through difficulty in follow-up due to substandard consultation records.
- There was unclear documentation in at least eight clinical records we reviewed, placing patients at risk of receiving unsafe care and treatment. These consultations were only recorded as, 'telephone encounter' with no further information provided. When these patients were followed up by one of the lead GPs, the patients confirmed they had spoken to the GP and in some cases they were children whilst in other cases, they had spoken to the GP for serious concerns such as breathing problems which had not been documented.
- We found examples of inconsistent notes where patients experiencing symptoms such as vomiting were then recorded as 'no vomiting' on the same note which themselves were sparse. We also found one patient had been prescribed the same medicine twice on the same day in both tablet and capsule form without any justification recorded in the patient notes.
- We were not assured of a safe system in place to process new patient information. For example, one patient record we reviewed showed a patient registered with the practice in April 2019 but there were no old notes summarized in the patient record and no evidence of an attempt to acquire them. The patient was seen by the GP with a suspected infection but there were no entries prior to April 2019; therefore, no knowledge or evidence recorded of drug allergies.
- There were no safe systems for sharing information with staff to enable delivery of safe care and treatment. For example, we found a patient at high risk of overdose had disclosed this intention to the healthcare assistant who did not to escalate this to the GP immediately. The patient was seen by the GP one week later and prescribed medicines that posed a risk to them. Neither on this occasion or since was mental health discussed with the patient.
- The systems in place to ensure referrals to specialist services were timely and were monitored to avoid delays was not effective or safe. For example, one patient with suicidal ideation required an urgent specialist referral but none was made until two days after the consultation and only sent on the third day. There was no evidence to show how the practice monitored this

referral as there was no response received from the specialist team in the patient record and the patient had still not been reviewed by the GP at the time of inspection, neither was a risk assessment undertaken for the patient.

- We also found a child who had been referred to the secondary care specialist had not been monitored to ensure they had received their appointment following a referral seven months prior. No safety netting advice had been given to this patient.
- There was no process for the management of two-week wait referrals. Two staff we spoke to gave us different accounts of how they managed two-week wait referrals. Administration staff responsible for this task told us this process was recorded on their computer system; however, when we reviewed this process, they were unable to show us an example of a recent two-week wait referral as an audit trail was not maintained. One of the GPs told us they kept a folder which had printed two-week wait appointment requests. Upon reviewing this folder, we found it was haphazard and not systematic and difficult to ascertain the dates of when the referrals were carried out. We found a referral made two weeks prior for a patient with potential cancer symptoms had not been placed in this folder and no clear safety netting had been given to the patient.
- We found the practice manager was acting outside their area of competence by making clinical decisions such as managing test results and there was no clinical oversight of this process. The practice manager told us they filed the normal blood results into the patient records under the practice manager's log-in details despite not being a clinician and without any safety netting in place, such a clinical review prior to doing so.
- The practice manager told us they would print off abnormal test results and give to the GPs to review. In turn, the GPs would instruct the non-clinical staff to contact the patient. When we reviewed this process, we found contact was not made with patients where the plan had been to do so and contact attempts were not recorded on the patient record.
- We also found one patient whose test results indicated potential diabetes diagnosis had their blood test results filed by the practice manager without being sent to a GP to review and action. This led to a month-long delay in the patient receiving the appropriate treatment. This was also corroborated by online patient reviews where they had not been notified of abnormal test results, some only finding out seven months later.
- The practice manager was also responsible for dealing with incoming correspondence and would determine if the letter required further action and if not, it would not be sent to the GP for a review but would be filed into the patient record. There was no evidence of training or supervision from a GP to audit this process. We saw evidence that where a letter was received from the accident and emergency department following admission, it was filed by the practice manager if no direct action was documented but without sending to the GPs for a review first.

- We also found the practice manager would also decide which letters should have an appointment booked with one of the GPs who was not routinely receiving this mail and working from home. The GPs had no system in place to audit this process if delegated to non-clinical staff.
- Information needed for patients ongoing care was not shared appropriately in line with relevant protocol. For example, a patient's urgent referral letter to secondary care was sent via one of the GP's private email, instead of the encrypted email as per protocol. When we reviewed this record, the GPs could not provide evidence that the referral had been received by secondary care.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.85	0.72	0.85	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2019 to 30/06/2020) (NHSBSA)	3.2%	6.9%	8.6%	Significant 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 (01/01/2020 to 30/06/2020) (NHSBSA)	7.62	6.28	5.35	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	0.85	1.79	1.92	Variation (positive)

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

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Not assessed
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Not assessed
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.	N
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was no clinical lead for monitoring medicines safety at the practice. The practice told us they had a Primary Care Network (PCN) pharmacist who attended the practice every week but there was no evidence they were working in collaboration with a partner. • The practice did not ensure emergency medicines were stored safely, as they were kept inside a locked cupboard followed by a locked cabinet. We also found adrenaline in ampules but there was no supplementary equipment such as a syringe, needle, or instructions to assist with delivery of this medicine. The risk was if a patient was to collapse, it would be a lengthy 	

process to open the two locks to access the emergency medicines and further delayed by the lack of supplementary equipment.

- There was no effective monitoring of blank prescriptions at the practice. All blank prescriptions were kept in one of the clinician's private office and there was no process for recording batch numbers if a prescription was removed from the practice to take on a home visit.
- The repeat prescribing system at the practice was not safe and structured reviews of patients on repeat medicines were not taking place. We found examples of where patients continued to be prescribed antidepressants such as citalopram without any evidence of review or attempting to review through recall, for over a year. Another example included an elderly patient diagnosed with type one diabetes on insulin but this patient had not been seen or reviewed by a GP in two years, despite continuing to receive prescriptions for insulin.
- The practice confirmed that they did not record changes to patients' medicines made by other services. This increased the risk of an adverse drug interaction, as a doctor would not necessarily realise a patient was on a medication.
- No medicines audits were being carried out to ensure they were being prescribed safely and effectively. We were not provided with evidence to show there was a review carried out in relation to appropriateness of prescribing and spend, on over the counter items including shower gels and antihistamines such as piriton of at least six patients.
- We saw evidence of unsafe prescribing of new medicines. For example, one newly diagnosed diabetes patient was prescribed medicine to take the maximum dose per day, rather than an uptitration of the doses and no follow-up appointments were arranged.
- We also found evidence where patients were prescribed new medicines that required them to receive counselling due to their potential side effects but this did not take place, despite national guidance. For example, one patient diagnosed with diabetes was also prescribed steroid medicines without counselling, as these medicines could adversely affect their blood sugar levels.
- The practice was not monitoring the prescribing of high-risk medicines and we were not provided with a policy on request. We found three patients prescribed methotrexate (immunosuppressant) were overdue their three-monthly monitoring blood test. One patient continued to be prescribed methotrexate despite the hospital advising a repeat blood test due to deterioration. There was no record to show the practice had contacted the patient to attend for their blood test.
- Two patients prescribed warfarin had two months' supply of warfarin issued repeatedly with no International Normalized Ratio (INR) test, used to measure how much time it takes a patient's blood to clot, ever documented in the notes. There were also no details of when the next test was due, or evidence that the quantity supplied had therefore reflected when the next test

would be required. This lack of monitoring would increase the patient's risk of bleeding and strokes.

- We also reviewed prescribing for rivaroxaban (anticoagulant) and found two out of the three patients prescribed this medicine had no creatinine clearance (to determine kidney function) calculated in the last year as per guidelines.
- We found three examples of patients on hydroxychloroquine (for malaria) with no evidence in the last two years of anyone checking they had attended an eye test, as per guidelines.
- When we reviewed their prescribing and dispensing policy, there was no information on how they would monitor the prescribing of controlled drugs. We found one high-risk patient was prescribed a controlled drug without any risk assessment to ensure this medicine and quantity prescribed was safe for them.
- The practice had not taken steps to ensure appropriate antimicrobial use. We found one patient with a history of prostate enlargement presenting with urinary symptoms was prescribed two antibiotics without justification, instead of one antibiotic as per national guidance.
- The practice did not hold all the recommended emergency medicines, such as Ventolin inhaler for an asthma attack and glucagon used to raise blood sugar levels. A risk assessment had not been carried out to determine the range of medicines held.
- The emergency equipment such as the defibrillator and oxygen were stored in different parts of the building; for example, on the ground and first floor and in locked rooms which required key codes to enter. This was a risk because in the event of a patient collapse, this would cause a delay in the patient receiving life giving treatment due to having to collect the emergency equipment on the different floors and having to use the key-code to enter these rooms. There was no paediatric pulse oximeter, or nasal speculi for infants available with the emergency equipment in the practice. The practice also advised that their nearest emergency department was a 15-minutes' drive away. There were no systems to check the oxygen levels and defibrillator on a regular basis.
- When we reviewed the supplementary equipment that came with the oxygen, there was no essential valve mask required to deliver oxygen therapy to a patient having trouble in breathing. We observed an old nebuliser that had an open used single-use Ventolin nebule inside it that expired in 2016 and a used giving set. There were no other nebulisers or giving sets in stock at the practice. The practice manager was not aware that this equipment was required and assumed the locum nurses were monitoring this.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	N
There was a system for recording and acting on significant events.	N
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:	2

Explanation of any answers and additional evidence:

- We were not assured the practice monitored and reviewed safety using information from a variety of sources. For example, they did not take action when advised by NHS England to ensure their policy was up to date in relation to the Covid-19 pandemic and they were not monitoring or reviewing information received from the MHRA safety alerts.
- The practice did not systematically discuss significant events in meetings and no thematic analysis took place. There was no evidence of closure of the event and we found some significant events that had occurred in the previous week had not been recorded, analysed or effective action taken. This included an incident regarding a patient not having received a home visit as requested, resulting in the ambulance being called by the patient's carer. At the time of inspection, this had not been recorded or discussed as a significant event, despite occurring days prior.
- Although the practice told us significant events were discussed at monthly meetings, there was no evidence any such meetings were taking place, or that there was learning or dissemination of information.
- We were not shown any recorded significant events that occurred in the last 12 months, despite two significant events that the practice had not recognised as such. For example, a second significant event was a coroner related significant event.

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

Event	Specific action taken	
Coroner related significant event not recorded as such by the practice	Patient passed away at home. Incident not discussed as a significant event or discussed under duty of candor with the next of kin. No evidence of an internal investigation was carried out by the practice and there was no evidence of any practice meetings relating to this incident, or evidence of any learning. When a statutory notification was sent to the Care Quality Commission, key areas of the notification had not been completed such as, 'was the patient receiving appropriate care and treatment' and 'date last seen by doctor'.	
Cancer diagnosis	Diagnosis made in hospital after red-flag symptoms were not investigated appropriately by the practice. This was not reviewed or discussed as a significant event by the practice.	
Safety alerts		Y/N/Partial
There was a system for recording and acting on safety alerts.		N
Staff understood how to deal with alerts.		N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was unable to demonstrate a consistent and safe approach to recording and acting on safety alerts. The GP partners were unable to show us evidence of having received safety alerts and this was inconsistent with the practice manager advising us that all incoming safety alerts were received by both partners, printed off and sent to the Primary Care Network (PCN) pharmacist who attended the practice once a week to action. There was a patient safety alert policy in place but staff could not demonstrate they were aware of this. The practice manager told us that they also received safety alerts but did not have a system in place to record them and ensure they were read and acted upon. We found four national patient safety alerts regarding Emerade auto injectors (emergency treatment for anaphylaxis) issued this year advising all autoinjectors to be immediately withdrawn and replaced, had not been actioned by the practice. When asked, both GP partners were not aware of this alert and despite the Primary Care Network pharmacist carrying out searches on patients prescribed Emerade, the two patients affected had not been notified and switched to a safe autoinjector. This placed the patients at risk of a death if their autoinjectors failed to deploy adrenaline when required. A second patient safety alert regarding Carbimazole (anti-thyroid) had not been actioned despite the practice having patients of child bearing age affected by this safety alert. We found key searches in response to this alert were absent. This safety alert had been part of a group of alerts regarding teratogens (medicines that can cause harm to the foetus) for which a discussion of the risks and effective contraception was required with the patient. No discussion of the risks nor of contraception were present in the records of those affected by this alert. 		

Effective

Rating: Inadequate

- The practice is rated Inadequate for providing effective services due to a range of concerns including the patients' needs not being assessed in line with evidence based guidelines, the lack of systems to keep clinicians up to date with current guidance, limited monitoring of outcomes of care and treatment, inadequate staff training and not obtaining consent to care and treatment as per guidelines.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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.	N
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N

Explanation of any answers and additional evidence:

- The practice did not have systems and processes to keep clinicians up to date with current evidence-based practice. There was no lead clinician responsible for this and there was no evidence of clinical meetings taking place between the GPs and locum nurses where current guidelines were disseminated and discussed.
- We found clinicians were not aware of current guidelines. For example, they were not aware of the first line treatment of inhaled corticosteroids for children diagnosed with asthma as per the National Institute of Clinical Excellence (NICE) or British Thoracic Society recommended guidelines. We found three examples of children diagnosed with asthma where their treatment did not follow these guidelines and in one case, the child's condition was deteriorating due to

ineffective treatment. We also found NICE guidelines were not being followed in one case to confirm a diagnosis of diabetes.

- Patients' immediate and ongoing needs were not fully assessed. For example, an elderly patient diagnosed with osteoarthritis and at high risk of a fracture was not assessed for a walking aid and was told they were not eligible for one without undergoing the correct referrals. We also found an example where a patient who had previously expressed suicidal ideation was seen by the healthcare assistant and the GP within the space of one week but their mental wellbeing was not assessed on each occasion.
- Patients presenting with symptoms which could cause serious illness were not followed up in a timely and appropriate way. For example, one patient whose consultation history indicated their condition was rapidly deteriorating, was not followed up in a timely manner or referred to secondary care for further assessment and treatment to ensure their safety, leading to a serious incident. We also found a patient presented to the GP with gastrointestinal symptoms but did not receive an appropriate examination and was not urgently referred to the hospital despite displaying red-flag symptoms. The patient was subsequently rushed to the hospital to undergo emergency surgery which diagnosed cancer.
- There was no recall system in place to ensure patients were reviewed as per national guidelines. For example, we found two patients diagnosed with asthma had continued to get inhalers without an adequate review and two patients were commenced on antidepressants and not monitored. The practice had not attempted to invite these patients to attend an appointment.
- Patient treatment was not regularly reviewed and updated. Prior to the inspection on 26 October 2020, we carried out a remote clinical record review on 7 September 2020 after receiving information of concern. A review of 97 patient records of the practice on both days of the inspection evidenced systemic failures in 90 patient records which exposed patients to a serious risk to their life, health or wellbeing. We found examples of unsafe care and evidently, patients' treatment and care was not regularly reviewed or updated and clinical staff failed to follow up risk to patient health and wellbeing.
- For example, one patient who had a raised average blood sugar level and was to be followed up and reviewed by the practice was not contacted at all and had no follow up since. We also found a patient commenced ACE inhibitors (used to treat high blood pressure or heart failure) should have been told to have a blood test within 14 days of starting this medicine as per guidelines but this did not take place.
- Patients were not told when they needed to seek further help and what to do if their condition deteriorated. We found this was the case in over 10 patient records we reviewed. For example, one patient presenting with worsening spinal red-flag symptoms was not advised of what symptoms to look out for and the action to take to prevent further deterioration. Another patient with suspected diabetes was not asked about the red-flag symptoms that would indicate their risk of going into a life-threatening diabetic ketoacidosis coma.

- The practice did not utilise appropriate referral pathways to make sure that patients' needs were addressed. We found one clinician used his private email to make a safeguarding referral and there was no safeguarding referral detailed in the patient record.
- We were not assured the practice was using their digital services securely and effectively. For example, one of the lead GPs took their practice laptop abroad where they had travelled on holiday. When we spoke to the practice Data Protection Officer (DPO), they told us they were not made aware of this due a lack of communication and poor working relationship in the practice.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small>	0.30	0.82	0.70	Variation (positive)

Older people

Population group rating: Inadequate

Findings

- The practice did not provide enhanced care plans for older patients who were severely frail. None of the clinicians were able to show evidence of where discussions relating to preferred place, power of attorney and 'do not resuscitate' orders were documented.
- The clinicians could not explain how 'do not resuscitate' decisions would be shared with other care givers, despite also working for the out of hours GP service. The practice also confirmed that they did not have a process in place for sharing this information with the out of hours or ambulance service.
- The practice system to follow up on older patients discharged from hospital was not safe. We saw evidence that for the last two years, the practice manager was actioning all incoming correspondence, including that from the hospital and deciding which letters to send to the GPs despite not being a clinician. We also found that the practice did not enter hospital-only medicines on the clinical system, which increased the risk of an adverse drug interaction, as a GP would not necessarily be aware of the changed patient medicine.
- There was no evidence to show health checks were currently taking place for patients over 75 years of age. The designated healthcare assistant who usually carried out these checks was working as the assistant practice manager at the time of inspection since March 2020; therefore, there was no evidence these health checks were still taking place.

Findings

- Patients with long-term conditions were not offered a structured annual review to check their health and medicines needs were being met. We found 10 examples of patients diagnosed with either poorly controlled diabetes or asthma who had not been called in for a review, despite continuing to receive their prescribed medicines.
- We also found evidence that patients with long-term conditions were not being prescribed medicines according to national guidelines. For example, one patient diagnosed with hypertension was not prescribed the recommended medicines and there was no rationale to explain why. Evidence showed the GP had advised the patient to discontinue the medicine as their blood pressure was well controlled but there was no suggestion of follow up to review this. When we reviewed the patient's blood pressure reading, we found they were only just within the accepted range and the blood pressure was likely to rise again without adequate monitoring. The patient was not offered ambulatory blood pressure monitoring.
- Patients with asthma were not offered an asthma management plan. There were no management plans in the notes we reviewed and the clinicians did not have access to blank copies of plans. This was the case in six asthma patient records we looked at.
- This also meant we were not assured if GPs effectively followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice manager would file accident and emergency attendance letters if no direct action was required, despite not being a clinician to make this determination. In addition to this, the GPs confirmed they did not enter medicines prescribed by specialists in hospital into the patient record. Entering such medicines into the record would prevent serious drug interactions.
- The practice could not effectively demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes. We found one patient who was told their blood test results were normal, despite their average blood sugar levels indicating a risk of developing diabetes. No action was taken by the practice to monitor the patient through an annual review to minimise their risk of diabetes.
- We also found one patient did not have confirmatory diagnostic tests for suspected diabetes as per the NICE guidelines. We found when the patient was eventually diagnosed with diabetes, they were prescribed an inappropriate dosage of medicine. For example, guidelines suggested diabetes medicine at one tablet a day with up-titration each week to four tablets a day. There was no mention of this and the patient continued to be prescribed with two-months' supply of diabetes medicine, without any monitoring or follow-up appointments as per guidelines. Consequently, within eight months the patient record showed the patient was diagnosed with congestive cardiac failure.
- The practice did not have a process for reviewing patients on a palliative care register and when we asked one clinician for the name of a patient who was eligible for this register, they could not provide one. There was no evidence of any collaborative working with the Palliative Care Nurse.

- Patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) were not monitored safely and effectively. When we reviewed the records for one patient diagnosed with COPD, we found much of the reviews were carried out by the healthcare assistant, without any clear documentation of discussions with the GP. The same patient was not referred to secondary care when their condition was deteriorating, leading to a serious incident.
- We were not assured GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients with atrial fibrillation were not always assessed for stroke risk and treated appropriately. For example, we found one patient who was diagnosed with atrial fibrillation and previously taking medicine to prevent strokes, stopped requesting this medicine three years prior without any clinical reason. There was no evidence that this patient was being monitored through annual reviews.
- We also found another patient with a history of atrial fibrillation was not considered for further investigations when they presented with red-flag symptoms or given advice on the actions to take if they deteriorated. This patient was on the atrial fibrillation disease register but had not received a review of their need for anticoagulation therapy to prevent strokes.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	87.8%	78.2%	76.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.2% (6)	7.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	97.3%	89.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.4%	12.7%	N/A
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	81.8%	90.7%	91.8%	No statistical variation

Exception rate (number of exceptions).	0.0% (0)	3.6%	4.9%	N/A
--	----------	------	------	-----

Families, children and young people

Population group rating: Inadequate

Findings

- The practice has not met the minimum 90% for four of four childhood immunisation uptake indicators.
- The immunisation targets were low and this was discussed with the practice. They told us patients were contacted three times for immunisations but they did not have arrangements for following up failed attendances.
- There were also no arrangements for following failed attendances of children's appointments following an appointment in secondary care or for immunisation. There was no collaboration or contact with the health visitors when necessary.
- Staff did not demonstrate the appropriate skills and training to carry out reviews for this population group. For example, one child presenting to the GP with increasing symptoms of asthma was not adequately reviewed, as the GP did not offer to examine the patient face to face. The patient was not prescribed the appropriate medicine as per national guidelines and at a second appointment a few months later with exacerbated symptoms, no face to face appointment was offered by the GP to review the patient's breathing, despite the obvious deterioration and the patient requiring more effective treatment. Both GP partners were not aware of the guidelines relating to this when asked on inspection.
- When we reviewed a postnatal consultation with the GPs, we did not find evidence of any discussion made of ongoing contraceptive needs nor of continence as per guidelines.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	74	85	87.1%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	70	94	74.5%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	72	94	76.6%	Below 80% uptake

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	71	94	75.5%	Below 80% uptake
--	----	----	-------	------------------

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

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- Patients did not always have access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Staff responsible for carrying out health checks had last completed their health check training in 2016.
- There was no appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. We found one patient who expressed suicidal ideation to the healthcare assistant was not followed up immediately, or a week after when they were seen by the GP. We also found the healthcare assistant discussing new diagnoses following abnormal test results, with patients newly diagnosed with diabetes, despite this being a clinical role.
- It was also unclear who was undertaking health checks during the Covid-19 pandemic as the healthcare assistant no longer carried out this role from March 2020 but took on the assistant practice manager role. There was no evidence provided to show how health checks for patients aged 40 to 74 continued during this period.
- They used to employ a doctor who on the website was listed as carrying out baby checks women's health and postnatal checks but we did not find evidence that intimate female examinations were being carried out when indicated. For example, two female patients presented with abnormal symptoms but there was no record that an intimate examination was carried out for these patients, or that they were advised to carry out a self-swab. The records did not show any advice being given to these patients on managing these symptoms or consideration given of confirmatory tests.
- The practice was a yellow fever centre; however, no evidence of up to date yellow fever training was shown for any staff. The practice told us that no yellow fever vaccines had been given for the past year to any patients.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England)	62.4%	N/A	80% Target	Below 70% uptake

Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	59.8%	63.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	40.2%	42.1%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2019 to 31/03/2020) (PHE)	100.00%	95.5%		N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	50.0%	57.8%	53.8%	No statistical variation

Any additional evidence or comments

- The practice told us they had a recall system in place for cervical screening where a patient was contacted three times to attend an appointment.
- There was no fail-safe system in place for cervical smears. Patients with abnormal smear results were not followed up; therefore, there was a risk of harm to the patient due to undetected cervical cancer. The practice told us the two locum nurses who attended the practice twice a week were responsible for checking that smear results were received but no evidence was seen and there was no oversight maintained over this process. There was no evidence of audits taking place and the practice did not know what their inadequate rate was.
- We did not find evidence the practice was proactively recalling patients to attend cervical screening. For example, one patient was due for a smear test in 2013 but no action had been taken on this alert.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- Due to the Covid-19 pandemic, patients were often seen remotely. There was evidence to show patients did not always receive same day appointments and this was consistent with online patient reviews where they reported experiencing difficulties with access to urgent appointments.
- We saw evidence where one annual health check for a patient diagnosed with learning disability had been coded as such by the healthcare assistant; however, there was no evidence of what was discussed during the review in the patient notes.
- When we asked the safeguarding lead about learning disability checks, we were told they were delegated to the healthcare assistant and not the GPs as per national guidance and contractual requirement. The healthcare assistant had discontinued the role of healthcare assistant in March 2020 and was currently working at the practice for one day a week as an assistant

practice manager. Therefore, there was no evidence provided to show who was carrying out the checks without a healthcare assistant currently in place.

- The practice could not demonstrate how they identified people who misused substances. For example, a patient with suicidal ideation was prescribed 56 strong painkillers without a risk assessment to ensure their safety and prevent them misusing this medicine which could be fatal.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Although the practice had a dementia register in place, we were not assured that effective holistic dementia reviews were taking place. For example, one elderly patient who was due a dementia review had it recorded in their notes that a review was carried out by the healthcare assistant, instead of a GP and there were no comments made about their dementia in their care plan. We found this patient's physical health needs had not been monitored at this review. For example, the patient was an insulin dependent diabetes patient but had not been reviewed or spoken to by the GP in two years, despite continuously being prescribed insulin throughout the two-year period.
- When patients were assessed to be at risk of suicide or self-harm the practice did not have arrangements in place to help them to remain safe. For example, one patient expressed suicidal thoughts to the healthcare assistant but the GP was not informed of this immediately or at any point during that day. We also found the same patient saw the GP for other related conditions without a discussion of their mental health, or an adequate risk assessment to ensure they would remain safe.
- There were inadequate recalls for patients newly diagnosed with depression and commenced on antidepressants. We found these patients were not recalled for an annual review.
- Patients with poor mental health were not referred to appropriate services. For example, a patient presented to the GP with low mood and mixed feelings and thoughts but no record was made of whether the patient was safe to leave the building, nor was there action taken to ensure an urgent referral was made to the crisis team.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive,	100.0%	93.1%	85.4%	Variation (positive)

agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)				
Exception rate (number of exceptions).	3.6% (1)	4.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)	100.0%	85.8%	81.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.0% (0)	5.1%	8.0%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	531.9	Not Available	533.9
Overall QOF score (as a percentage of maximum)	95.2%	Not Available	95.5%
Overall QOF exception reporting (all domains)	6.6%	Not Available	5.9%

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

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was a part of the Primary Care Network and there was evidence of communication with them. Due to poor working relationships within the practice, collaborative working with the PCN was not being effectively managed. The practice did not have a comprehensive programme of quality improvement. We found infection control audits were not taking place and the practice did not monitor or respond to online patient reviews in order to improve their service and target areas where there were concerns. There was no evidence of improvement activity carried out in the last two years. When we requested evidence of a clinical audit, the lead GP provided us with a medicines audit dated

March 2020 but the information contained in this audit was dated between 2005 and 2006. There was no evidence of any recent quality improvement audits carried out.

- The practice could not demonstrate how they regularly reviewed unplanned admissions and readmissions. For example, one patient admitted into hospital and diagnosed with cancer was coded in the patient record as having this condition; however, there was no review of this admission and no action was taken to review the patient following this diagnosis.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	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.	N
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	N
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.	N

Explanation of any answers and additional evidence:

- Staff did not have the skills, knowledge and experience to deliver effective care, support and treatment. For example, the practice recruited a staff member as a healthcare assistant but practice documentation on the computer system referred to this staff member as a doctor, despite not being registered as one in the United Kingdom. This staff member was also later recruited as an assistant practice manager during the Covid-19 pandemic.
- There were significant knowledge gaps found in the leadership of the practice. For example, both the practice manager and GP partners did not appear to understand their responsibilities and requirements in relation to all aspects of emergency procedures around the practice. The inspection team had to advise the practice manager what emergency medicines and

equipment was required as they were not aware of what exactly was required. This left the practice grossly unprepared for any medical emergencies at the practice.

- We were not presented with evidence of a programme of learning and development. There were gaps in training such as information governance, infection control, fire and health and safety, basic life support, and in some cases, there were no training record in staff files.
- We saw evidence the healthcare assistant had completed their health checks training in 2016 and their care certificate training in February 2018 but the practice manager was not aware of this when asked. There was no evidence of chronic disease training for the healthcare assistant, such as for diabetes but they were carrying out these reviews and making clinical judgements, instead of the GP. For example, we found they carried out reviews on diabetes patients which was outside their area of competence. We also found evidence of poor coding and record-keeping such as recording patients as being on the Macmillan gold star cancer pathway despite the patients not having any previous or history of malignancy.
- The practice also informed us that the healthcare assistant was accredited as a Health Associate with a national body; however, when we made enquiries with this body to verify this information, they advised that this was not an accreditation but a membership with them as a trade union body. They advised this registration was only valid if the staff member was under nurse supervision. We found this was not the case and the healthcare assistant was working independently without any clinical supervision from either a nurse or GP. For example, the practice could not provide any evidence that the healthcare assistant was qualified to talk to a newly diagnosed diabetes patient about their blood test results which would be outside the scope of a healthcare assistant's competence. Such a blood result should have been booked to see a GP, given this appointment would involve the breaking of bad news with life-changing consequences.
- We also found some of the healthcare assistant's sessions had been recorded as 'doctor' despite not holding this qualification in the United Kingdom. Additionally, we found this staff member was allowed to conduct a tutorial with medical students which prompted a complaint from the medical school about inappropriate conduct towards the medical students. It was not clear why the practice had allowed the healthcare assistant to undertake this GP tutorial role.
- We found the practice manager was acting outside their area of competence by making clinical decisions. For example, we found they were receiving all hospital test results, instead of a GP and which they would file before sending to a GP to review. As a result, we found one patient whose test results indicated potential diabetes diagnosis had their blood test results filed by the practice manager without being sent to a GP to review and action. This patient was later seen by the healthcare assistant almost one month later where the GP also initiated them on diabetes medicines.
- The practice manager was also responsible for dealing with incoming correspondence and would determine if the letter required further action and if not, it would not be sent to the GP for a review but would be filed into the patient record. There was no evidence of training or supervision from a GP to audit this process. We saw evidence where a letter from accident and emergency following

admission was filed if no direct action was documented without sending to the GPs for a review first.

- The GP partners could not explain what steps they took to provide adequate clinical supervision for staff acting under their authority. There was no evidence the patient care provided locum GPs and nurses was being reviewed and monitored. For example, the practice manager assumed the locum nurses were carrying out emergency medicines and equipment checks but there was no process to maintain this. We found these checks were not carried out.
- There was no evidence of documented induction records in place, or a programme of learning and development and no evidence of appraisals taking place. We were not presented with evidence of staff training and in some cases, staff had no training records kept on file.
- There was no evidence of an induction programme for locum staff or a programme of learning and development. For example, there was no induction pack for locum GPs that provided information such as safeguarding and emergency procedures within the practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	N
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
For patients who accessed the practice’s digital service there were clear and effective processes to make referrals to other services.	Not assessed

Explanation of any answers and additional evidence:

- The practice told us multidisciplinary team meetings were not presently taking place and we did not find evidence to the contrary.
- There was no evidence of collaborative working with other teams such as the health visitors or the palliative care team. The practice had not made arrangements with the out of hours service regarding their at risk or palliative care patients.
- The practice told us they did not use advanced care plans such as coordinate my care and we found no evidence to the contrary.
- There were no arrangements made between the out of hours service and the practice regarding their at risk or palliative care patients.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	N
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
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, tackling obesity.	Y

Explanation of any answers and additional evidence:

- The practice could not identify patients in the last 12 months of their lives. They told us there was no process for reviewing patients on a palliative care register and when we asked the lead GP, they did not know which patients were eligible to be placed on this register.
- Patients were not always given advice in managing their own health and recognising red-flag symptoms and when to seek help.
- Patients were not signposted to relevant services such as the Diabetes Education Programme when they were at risk of developing diabetes.
- We were not assured appropriate health assessments and checks were currently being undertaken. The designated healthcare assistant who usually carried out these checks was working as the assistant practice manager at the time of inspection since March 2020; therefore, there was no evidence provided to show these health checks were still taking place and who was undertaking them.
- The practice told us they had access to a physiotherapist and wellbeing coach through their Primary Care Network. However, we did not find any records pertaining to this during the inspection.
- When we looked at the practice website, we found links to local stop smoking and obesity management services.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or	97.8%	96.6%	94.5%	Tending towards variation (positive)

other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.4% (3)	0.4%	0.8%	N/A

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.	N
The practice monitored the process for seeking consent appropriately.	N
Policies for any online services offered were in line with national guidance.	Not assessed

Explanation of any answers and additional evidence:

- One of the clinicians was an approved GP trainer; however, they told us consent was not obtained from patients when medical students observed the consultations.
- The practice does not use advanced care plans for patients. Both GPs could not provide evidence to show where discussions had occurred regarding lasting power of attorney, 'do not resuscitate orders', nor documentation of where the patient would prefer to die when the time came. This was a critical part of palliative care to ensure patients were supported in making decisions and treated with dignity and respect.
- We were not assured clinicians assessed patients' mental capacity in line with guidance. For example, one patient was recorded as, 'does not say words' but there was no attempt to assess their mental capacity using gillick competency.

Caring

Rating: Inadequate

- The practice is rated requires improvement due to concerns regarding the way staff treated patients, lack of action to improve patient feedback and lack of interpretation services.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was mixed online patient feedback regarding staff attitude towards patients and this was consistent with the national GP patient survey. Some patients highlighted lack of compassion and constructive advice, whereas other patients were happy with staff attitude. We did not observe staff interaction with patients on the day of inspection. Evidence we reviewed showed patients were not given appropriate and timely information to cope emotionally with their care. This was in relation to ensuring patients received advice on how to recognise red-flag symptoms once they returned home in relation to their conditions. We also found patients who visited the practice experiencing a deterioration in their mental health were not given appropriate advice or intervention to help them cope with their current condition and the necessary steps were not always taken to keep them. 	

CQC comments cards	
Total comments cards received.	Not assessed
Number of CQC comments received which were positive about the service.	Not assessed
Number of comments cards received which were mixed about the service.	Not assessed
Number of CQC comments received which were negative about the service.	Not assessed
Source	Feedback
Google reviews	The practice had a rating of 2.3 out of 30 reviews and 18 of those reviews were recorded in the past year. Mostly negative reviews where patients complained of poor patient care and medicines being prescribed easily without an adequate assessment of symptoms. Some patients wrote they were not informed of abnormal

	test results until seven months later and some patients felt there was a lack of compassion from the GPs and practice management.
NHS reviews	We saw six mostly positive reviews and one review which raised issues with some reception staff attitude.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	72.5%	79.7%	88.5%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	65.3%	77.2%	87.0%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	89.4%	90.8%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	64.1%	70.9%	81.8%	Tending towards variation (negative)

Any additional evidence or comments

- The practice did not respond to any online patient reviews and no action was taken to improve patient experience at the practice.
- There was no Friends and Family Test, or any survey results displayed on the practice website.

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

Involvement 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.	N
Staff helped patients and their carers find further information and access community and advocacy services.	Partial

Explanation of any answers and additional evidence:

- We found in several cases, patients were not provided with information to understand their care and in some cases, advice relating to recognising deterioration in their condition was not given.
- The practice website had access to information regarding community and advocacy services. However, in other cases, the practice did not help patients access community services such as the Diabetes Education Programme.

Source	Feedback
Interviews with patients.	No patient interviews were carried out on the day of inspection.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	87.9%	88.2%	93.0%	No statistical variation
				Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.				N
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Partial
Information leaflets were available in other languages and in easy read format.				Partial
Information about support groups was available on the practice website.				Y

Explanation of any answers and additional evidence:

- Interpretation services were not available for patients. The practice told us patients who required an interpreter were usually assisted by a friend or relative, despite potential safeguarding and confidentiality issues.
- There were some patient information leaflets and notices available. However, there were no information leaflets or posters relating to the current Covid-19 pandemic, or leaflets displayed in the practice waiting rooms on how patients could access bereavement or mental health services.
- There were no information leaflets in other languages but there was a translate option on the practice website. However, when we viewed this we found not all languages were available as there only 65 languages out of a potential 108 languages.

Carers	Narrative
Percentage and number of carers identified.	Not assessed
How the practice supported carers (including young carers).	There was a section for carers on the practice website but this area was left blank with no information provided.
How the practice supported recently bereaved patients.	We were not assured recently bereaved patients were supported. For example, we found one next of kin was not contacted by the practice after a patient passed away and it was not clear what support would be offered.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Not assessed
The practice ensured patients were informed how their records were stored and managed.	Not assessed
Patients were made aware of the information sharing protocol before online services were delivered.	Not assessed
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Not assessed
Online consultations took place in appropriate environments to ensure confidentiality.	Not assessed
The practice advised patients on how to protect their online information.	Not assessed

Responsive

Rating: Inadequate

- The practice is rated inadequate because the service did not meet patients needs, patients could not access care in a timely way and complaints were not reviewed.

Responding to and meeting people's needs

Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
There were arrangements in place for people who need translation services.	N
The practice complied with the Accessible Information Standard.	Not assessed

Explanation of any answers and additional evidence:

- The practice could not demonstrate they understood the needs of its local population. One of the lead GPs only worked at the practice one day a week and worked remotely the rest of the week. He advised this was due to poor working relationships within the practice. This had a significant impact on patient access to care because when we reviewed two weeks' worth of their appointments system, we found the appointments they were offering were significantly below their contractual obligations. This was consistent with online patient reviews where they raised concerns about accessing urgent or routine care.
- The practice facilities were not appropriate for the current Covid-19 pandemic. For example, there was no signage visible explaining the social distancing arrangements within the practice or any warnings for patients not to attend if symptomatic. Facilities such as bins to clinical bins to dispose of used face masks and alcohol hand gel was not readily available for patients around the practice.
- Although the practice told us patients with mobility issues could be seen downstairs by the nurses who were based upstairs, there were no reasonable adjustments noted upstairs such as, a hand grab rail and emergency pull cord in the patient toilet.
- There were no arrangements in place for people who need translation services. Patients were often advised to bring a family member or friend, despite the confidentiality and safeguarding issues.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am – 6.30pm
Tuesday	8:00am – 6.30pm
Wednesday	8:00am – 6.30pm
Thursday	8:00am – 6.30pm
Friday	8:00am – 6.30pm
Extended hours:	
Monday	6:30pm – 7:30pm
Thursday	6:30pm – 8:00pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	91.3%	89.5%	94.2%	No statistical variation

Older people

Population group rating: Inadequate

Findings

- When we reviewed the patient list, we found over 95% of the patients were registered with the lead GP. However, no attempts had been made by the practice to assign a usual GP to take responsibility for their care.
- We found evidence that a few patients who were very frail were deemed high risk for covid-19 infection. There was no evidence these patients had been spoken to by the practice to ensure they understood shielding. There was no evidence of such as process visible in their notes.
- The practice did not carry out structured annual medication reviews for older patients. We did not see any examples of a structured medication review and the practice verified no active recalls occur.
- The practice was not always responsive to the needs of older patients requiring home visits and urgent appointments. For example, they told us of an incident whereby a locum GP had not undertaken a home visit but instead had spoken to the patient over the telephone who later called an ambulance. The patient was then seen by the practice only after the ambulance made the arrangement for the patient to be seen by the GPs later that day.

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients were not always able to access care in a timely manner. When we reviewed their appointment system, we found double slots were booked for patients with just one condition and without justification. This affected patients being able to access appointments.
- The practice did not provide effective care coordination to enable patients with long-term conditions to access appropriate services. We found newly diagnosed diabetes patients were not appropriately referred to the Diabetes Education Programme, or were signposted to online resources or given verbal advice.
- The practice did not liaise with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- The practice did not use advanced care plans. Care and treatment for people with long-term conditions approaching the end of life was not coordinated with other services. There was no evidence of any collaborative working with the Palliative Care Nurse. There was also no process for reviewing patients on a palliative care register and when we asked the lead GP, they did not know which patients were eligible to be placed on this register

Families, children and young people

Population group rating: Inadequate

Findings

- The practice employed two locum nurses who worked twice a week but there were no additional nurse appointments available for school age children.
- There were no systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. There was no child at risk register kept at the practice.
- The practice did not review newly pregnant women on long-term medicines.
- There was evidence to show patients were not always given same day appointments and were signposted to the out of hours service when the practice ran out of urgent appointments.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The needs of this population group had not been effectively identified. For example, We did not find evidence the practice was proactively recalling patients to attend cervical screening. For example, one patient was due for a smear test in 2013 but no action had been taken on this alert.
- Patients did not always have access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Staff responsible for carrying out health checks had last completed their health check training in 2016.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice held a register of patients living in vulnerable circumstances.
- Due to the Covid-19 pandemic, patients were often seen remotely. There was evidence to show patients did not always receive same day appointments and this was consistent with online patient reviews where they reported experiencing difficulties with access to urgent appointments.
- The practice did not provide effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice did not adjust the delivery of its services to meet the needs of patients with a learning disability. Health checks had not been carried out on these patients since the start of the Covid-19 pandemic and there was no recall system in place for them.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- Staff interviewed did not have a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients on the dementia register were not reviewed even on an annual basis. For example, we found a patient with type one diabetes and dementia had not spoken to a GP in over two years, yet continued to receive their diabetes medicines.

Timely access to the service

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

National GP Survey results

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

Explanation of any answers and additional evidence:

- Not all patients with urgent needs had their care prioritised. One of the lead GPs only worked at the practice one day a week and worked remotely the rest of the week. He advised this was due to poor working relationships within the practice. This had a significant impact on patient access to care because when we analysed the practice appointments system over a two-week period, we found the practice offered significantly fewer appointments than what is considered the minimum by NHS England. For example, due to the practice population size, the practice would

need to offer 300 appointments of any kind but we found a maximum of 220 appointments had been offered over that two-week period.

- When we spoke to practice staff regarding how many routine appointments they offered in a week for their list size of approximately 4800 patients, they were not aware of how many they ought to offer and had not discussed this as a practice.
- We found evidence that some patients with a single condition were booked double appointment slots by one of the GPs without any justification.
- When we reviewed the appointments offered, we found the practice only offered four urgent calls per session and when we asked what the process would be if a patient required an urgent appointment and all were used up on the day, they advised the patient would be redirected to their Out of hours provider. There was a risk that a patient with an urgent need might be turned away due to this strict limit and not be triaged by the GP. This was consistent with online patient reviews.
- Although the practice did carry out home visits, we found they were not always as responsive. For example, they told us of an incident whereby a locum GP had not undertaken a home visit but instead had spoken to the patient over the telephone who later called an ambulance. The patient was then seen by the practice only after the ambulance made the arrangement for the patient to be seen by the GPs later that day.
- We found evidence to show care and treatment was delayed most of the time. For example, a young child was booked to see the GP for a face to face appointment at 10.30am but was only seen by the GP at 11.42am, with no justification provided as to why the appointment was late. We found this to be consistent with google reviews where patients complained of long appointment waiting times.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	61.2%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	50.4%	55.5%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	53.8%	57.5%	63.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	56.5%	61.5%	72.7%	No statistical variation

Any additional evidence or comments

- There had been no action taken by the practice to improve patient access to care. On the day of inspection, both GPs advised the inspection team that they did not have any appointments booked when asked if they had any clinical commitments that day; however, when we looked at the appointment screen, we found patients had indeed been booked to see the GPs earlier but no attempt had been made to contact the patients.

Source	Feedback
For example, NHS Choices or google reviews	Several online patient reviews whose theme was mostly around access and delay in appointment waiting times. We found one example where a patient reviewer said they made it clear to reception staff that the matter was urgent but the receptionist found no solution at all. The practice had not responded to any of this feedback.

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.	Not assessed
Number of complaints we examined.	Not assessed
Number of complaints we examined that were satisfactorily handled in a timely way.	Not assessed
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Not assessed

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

Explanation of any answers and additional evidence:

- Although we were unable to view patient complaints on the day of inspection, the practice told us they do not systematically discuss complaints or carry out thematic analysis of any received.

Well-Led

Rating: Inadequate

- The practice was rated inadequate for well-led because leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care, there was no clear vision or credible strategy, the overall governance arrangements were ineffective and no clear and effective processes for managing risks, issues and performance. The practice did not always act on appropriate and accurate information and there was little evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	N

Explanation of any answers and additional evidence:

- The leaders could not demonstrate that they understood the challenges to quality and sustainability. There was a complete relationship breakdown between the two GP partners and action had been taken by external stakeholders to try and resolve the fractured relationship through mediation but to no avail. One of the GP partners told us mediation would not work as the relationship was now untenable. We observed a complete lack of communication between both partners and consequently, this placed patients at risk of harm. For example, one child required a safeguarding referral but none had been sent and both partners had not discussed this patient despite being seen by both GPs and repeated requests from the child's parent.
- During the day of inspection, both lead GPs indicated complaints they had with each other and previous conduct and staff felt stuck in the middle. In several conversations during the inspection the GP partners blamed their breakdown in relationship for these shortcomings. However, many failings occurred prior to this and did not explain the failure to take responsibility for the safe care of patients. However, the broken relationship between the GP partners had a significant impact on them providing safe care and treatment to patients.
- Apart from safeguarding lead roles, there was no clinical lead in all the clinical areas and there was no oversight of each other's work.
- At the time of inspection, there was only one full time equivalent GP which the GP partners covered between them as one GP only provided one session and worked from home the rest of the time. The GPs agreed this was insufficient for the list population and size of approximately

4,800 patients. However, due to the poor working relationships, the GP partners had failed to agree a solution to address this, resulting in some patients with urgent needs not being seen and referred to their Out of hours provider. It was also not clear how the GP partner working remotely would handle inviting patients into the practice who required an urgent examination when he himself was working from home and not communicating with the other GP partner.

- When we raised our concerns at the end of the inspection, the management team did not satisfy that anyone with the appropriate clinical skills would deal with the emergency medicines and equipment issues. The management were not aware of what they needed to rectify to ensure they were adequately equipped for emergencies when they held their flu clinic two days after the inspection.
- There was no leadership development programme, including a succession plan. Partnership meetings were not taking place.

Vision and strategy

The practice did not have a clear vision and there was no credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

- The partnership had no clear vision, and no strategy or business plan. Staff we spoke to did not know of a practice mission statement or practice values although they told us patient care was their priority.
- There was no practice vision, values or strategy that were developed in collaboration with staff, patients and external partners. Despite the involvement of a Primary Care Network (PCN) manager, their role was not clear at the practice. There was no engagement between the PCN manager and a GP partner due to a poor working relationship.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	N
There was a strong emphasis on the safety and well-being of staff.	N
There were systems to ensure compliance with the requirements of the duty of candour.	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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Not assessed
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	N

Explanation of any answers and additional evidence

- The poor working relationships within the practice meant that any behavior issues were not effectively managed by the two partners. For example, a complaint was received by the medical student's tutors about an incident of inappropriate conduct by the healthcare assistant towards their medical student. However, it was not clear what action had been taken by the practice to deal with this complaint as no return correspondence to the medical school was provided. On examining this complaint, it was also not clear why the healthcare assistant was providing GP tutoring instead of the approved GP trainer.
- We also found arrangements to deal with disputes within the practice were not handled appropriately. For example, there was a situation whereby one of the partners had followed the disciplinary policy to activate disciplinary procedures against a member of the administration staff following improper conduct. Following this, we saw evidence this matter was then inappropriately discussed on the practice's social media platform by the practice manager, resulting in other members of staff getting involved in the dispute. A junior member of staff was the one to suggest a meeting was held instead of disputes being discussed on the platform.
- Despite some staff in the practice telling us they worked well as a team, the divided leadership and poor working relationships in the practice both recorded and observed, showed the environment was not conducive to raising concerns without fear of retribution. Staff were also aware of difficulties in relations between the partners and were unhappy with one or other of the GP partners leadership and management style and approach. Consequently, we saw evidence that this led to a split between staff supporting either of the

partners. There was no evidence the partners had considered the impact their fractured relationship had on all the staff mental health, wellbeing and patient care.

- We were also not assured that there was a strong emphasis on staff safety and wellbeing. For example, one of the staff had experienced a traumatic event but there was no evidence the practice had sought advice from the occupational health department to ensure the staff member was fit to work and if so, what reasonable adjustments could be considered to assist them whilst at work.
- The practice did not have systems in place to comply with the requirements of the duty of candour. We found a coroner related significant event was not raised as a duty of candour and no discussion took place with the next of kin, or any apologies made. This event was not recorded as a significant event and there was no learning from it.
- Staff were aware of the whistleblowing procedures and was a factor in the inspection taking place.
- We did not see training records to show staff had received equality and diversity training.

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

Source	Feedback
Clinical and Non-clinical staff.	Staff told us they worked well as a team and felt supported. Some of the staff discussed the difficulties in relations between the GP partners and how it affected them as well as the practice. They discussed the division and how it led to a divided team structure.

Governance arrangements

The overall governance arrangements were inadequate

	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

Explanation of any answers and additional evidence:

- There were no structures, processes and systems for the practice to review its own governance structures and systems. We found multiple and significant areas of weakness or insufficiency that placed patients at immediate risk of harm. Inadequate governance arrangements were found in relation to safeguarding, recruitment checks and induction, monitoring of professional registration and appraisals, consent and decision making.
- There were no arrangements in place to ensure mandatory training was adequately monitored. Training records we viewed were mostly from 2016 and there were gaps in several areas such

as safeguarding, infection control, fire safety, information governance and long-term condition reviews.

- With the exception of safeguarding, there were no delegated clinical leads in other areas such as, Quality Outcome Framework patient reviews, staff training and clinical supervision and governance medicines and quality improvement, complaints, infection control, recruitment, and emergency procedures. There was no set arrangement to ensure effective dissemination of information such as practice meetings and when they did occur, they were not recorded and one of the GP partners would not attend due to the broken relationships in the practice.
- There was evidence that some staff were not always clear about their role and some staff such as the practice manager and healthcare assistant were working roles outside their area of competence.

Managing risks, issues and performance

The practice did not have any 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.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	N
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N

Explanation of any answers and additional evidence:

- There were no comprehensive assurance systems in place to underpin essential standards to identify, manage and mitigate risk. Risk assessments could not be evidenced such as fire and health and safety, legionella and emergency medicines. There was no process of oversight to ensure staff training or required recruitment checks. There was no assurance of competence of non-clinical staff in carrying out clinical roles. There were gaps in cervical screening fail safes and two week wait referral, and other referral monitoring. Staff had not ensured readiness for a medical emergency as there were gaps relating to staff receiving annual basic life support training and there was no evidence provided to show non-clinical staff had sepsis awareness training.
- There were systems or processes to manage performance and no assurance systems in the monitoring of unplanned admissions, cervical screening and at-risk patients. Appropriate arrangements for dealing with patient blood test results could not be assured because systems

showed a significant number had been dealt with by an unqualified and untrained staff member, and there was no verification this was done safely under appropriate clinical supervision, such as with a GP.

- The practice did not have a business continuity plan in place despite clear communications from NHS England at the start of the Covid-19 pandemic advising all providers to ensure these plans were in place and were updated. Therefore, there were no arrangements put in place for key staff to work from home in the event that they were forced to self-isolate, despite clear instructions for staff to have this system in place.
- The practice experienced an incident whereby the practice servers lost data but this incident was not recorded or analysed and plans were not put in place to minimize risk. At the time of inspection, some of the data had still not been restored.
- There were no comprehensive assurance systems to underpin essential standards of quality and safety. There was no evidence of annual staff appraisals to help manage performance. Performance and recruitment issues could not be sufficiently addressed because of divides between the GP partners. Quality improvement activity was limited; for example, there was no action taken to address below average clinical performance scores and patient satisfaction. The healthcare assistant was also being referred to as a 'doctor' in some practice paperwork and carrying out GP roles such as tutoring medical students without any justification or monitoring from the GP partners.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N

Explanation of any answers and additional evidence:

- Performance information was not used to improve performance or hold staff and management to account. This was in relation to low Quality Outcomes Performance (QOF) scores, prescribing, childhood immunisations, patient satisfaction surveys. Indicators were not analysed to identify areas for improvement.
- Information was not always accurate, reliable or timely. This was in relation to incomplete patient care records and the lack of recorded clinical meeting minutes. There were several instances of grammatical and spelling errors in all notes including spelling mistakes for medicines such as sertraline vs sertarlin and this placed patients at risk of incorrect prescribing due to inaccurate information. Some patient notes did not have any management plans in place

and information received from the hospital such as medicines changes were not recorded inside the patient notes.

- The practice had not update their yellow fever vaccination registration with the designated body. We found a previous GP no longer working at the practice was the registered individual on the website.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Not assessed
Patient records were held in line with guidance and requirements.	Not assessed
Any unusual access was identified and followed up.	Not assessed

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.	N
The practice had an active Patient Participation Group.	Not assessed
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.	Y

Explanation of any answers and additional evidence:

- Practice views were not acted upon. The practice did not read or respond to patient online reviews on Google or NHS choices. There was no evidence the practice was collecting patient views before or during the Covid-19 pandemic.
- We did not assess how the practice collaborated with the Patient Participation Group (PPG); however, the website last recorded information on the PPG in 2018.
- We did not see evidence where staff views were reflected in the planning and delivery of services. We found the poor working relationships within the practice had an impact on staff views being sought and applied.

Continuous improvement and innovation

There was no 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">• There were significant gaps and weaknesses in processes and arrangements intended to identify and deliver learning, continuous improvement in areas such as safeguarding, significant events, complaints and practice meetings.	

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.