

Care Quality Commission

Inspection Evidence Table

Drs Pearce and Trenholm (1-548093087)

Inspection date: 12 and 17 January 2023

Date of data download: 06 January 2023

Overall rating: Inadequate

We rated the practice as inadequate overall because:

- Governance systems overall were ineffective, in particular but not limited to medicines management; health and safety; staff training and recruitment; and monitoring of care and treatment provided to patients,
- There was a lack of leadership and staff were not appropriately supported to ensure care and treatment for patients was effective.
- There was limited oversight to ensure patients needs were assessed and reviewed appropriately and monitored in accordance with guidance where needed.
- Staff did not benefit from regular supervisions and appraisals to ensure they were provided with opportunities to develop and had not received necessary training to carry out their role.
- Patients were unable to access care and treatment in a timely manner, in particular access to face to face appointments; and there were no procedures to promote continuity of care.

Safe

Rating: Inadequate

We rated the practice as inadequate for safe because:

- The practice did not have clear systems and processes to keep people safe and safeguarded from abuse.
- Recruitment processes did not consistently demonstrate that all required checks had been carried out.
- Concerns identified from health and safety audits, in particular fire safety, were not effectively managed to ensure the premises was safe to use and risks were minimised.
- Not all patients on high risk medicines were appropriately monitored or recalled.
- Patient specific directions were not always managed in line with legal requirements.
- Medicine reviews were overdue.
- Shortfalls in coding and summarising patient records meant that staff did not have all the necessary information to provide care and treatment to meet patients' needs.
- Suitable arrangements were not in place to ensure staff were appropriately trained and knew how to respond to medical emergencies.
- The practice did not have a system to learn and make improvements when things went wrong. The practice could not demonstrate that they could effectively and consistently identify what constituted a significant event.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
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
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N
<p>Explanation of any answers and additional evidence:</p> <p>Safeguarding processes were not effective:</p> <ul style="list-style-type: none"> The practice's safeguarding lead was on long term absence and a deputy had not been identified in the interim. The practice's safeguarding policy identified the two practice partners as separate leads for safeguarding adults and children. The policy stated that in the event that one of the leads was absent from work, the other would fulfil that role. However, this was not in place at the time of our inspection. In the absence of a safeguarding lead, the practice manager was a point of contact for the practice; but had not received the relevant training in line with national guidance in order to effectively fulfill the responsibility that is associated with this role. Safeguarding training was not up to date. There was no evidence of up to date safeguarding training for all staff including both GP partners and other clinicians. The practice told us that staff had been provided with a one-page document which set out safeguarding process and relevant contact information. However, some members of staff told us they had not received or were aware of this document. There was insufficient attention to safeguarding children and adults. We were told of situations where staff did not recognise or respond appropriately to safeguarding concerns raised to them. No action was taken by the provider after the inspection to address this issue. Necessary action to safeguard a child following disclosure of abuse had also not been taken in an appropriate time frame. We identified that allegations of child abuse had been disclosed by the child's guardian to a locum GP working from the practice. No action had been taken to raise this internally or notify local safeguarding services to take immediate and necessary action to safeguard the child. The patient's guardian later disclosed their concerns again to another clinician in practice who made the required referrals. The follow up information request was unable to be fulfilled by the appropriate grade of staff due to a lack of resource and was inappropriately allocated to a staff member who felt this was not within their competency to action. We were informed that staff felt pressured to act outside of their competencies due to lack of appropriate clinicians. At the time of inspection, the requested information had not been submitted. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> During inspection, we were shown a filing cabinet which contained safeguarding documentation. The practice was unable to give assurances that this information had been entered onto patient records; coded and actioned. Examples we identified included: a report on a child on a protection plan who lived in a situation where there was police involvement due to domestic abuse; an assessment of a child's health needs; and coding and linking of records for the family of a patient who was a suicide risk. Minutes from safeguarding meetings did not always contain necessary information. A multi-agency child safeguarding meeting was held in November 2022. However, the minutes did not contain details of who attended, who should take the required action and by what date. The practice was also unable to provide assurances if the required actions had been completed. The practice was unable to evidence that they discussed adults at risk. They told us that adult safeguarding concerns were discussed at weekly clinical meetings. However, these had not been minuted. <p>The practice did not have effective systems to ensure disclosure and barring service (DBS) checks were conducted as required or that staff had received necessary checks before they had unsupervised contact with patients. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</p> <ul style="list-style-type: none"> The practice did not have a DBS policy to give guidance to staff. We looked at 4 recruitment files and found that 1 member of non-clinical staff had not had a DBS check. The practice had not undertaken a risk assessment to demonstrate why a DBS check was not required or identify actions to mitigate potential risk. An email from the Local Medical Committee stated that a historical DBS check had been carried out for this member of staff in another area. During our inspection we observed young children left unsupervised in the reception area. A member of staff was identified to accompany the children did not have a DBS completed when they were employed at the practice. The provider could not assure themselves that staff were suitable for the role and of good character in the absence of a DBS being completed. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 4 recruitment files and found that not all information as required in the regulations was in place.</p> <ul style="list-style-type: none"> The practice usually obtained 2 references to show satisfactory conduct in previous employment in health and social care. One file did not have any references. Another staff file only had 1 reference. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates	Partial
There was a fire procedure.	Partial
Date of fire risk assessment: 23/10/22 Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have effective systems to identify and act on risk identified on their fire risk assessments. For example:</p> <ul style="list-style-type: none"> • A risk assessment conducted in 2013 identified that the practice's fire system was not compliant with safety standards and that extensive remedial works were required in order to bring the system up to a safe standard. The required action had not been completed by the practice and their fire system was not brought up to standard. However, fire safety audits completed annually by the practice incorrectly identified that the fire system met the required standard. We also received information from external stakeholders that the practice had reported in their annual information return, that their fire system was compliant. • Concerns identified in the fire risk assessment in 2013 included emergency lighting and smoke detectors not operating effectively. Limited mitigation had been put in place as there were delays in getting equipment. For example, domestic smoke alarms were going to be installed, but at the time of the second site visit on 17 January 2023, they had been ordered but had not been received. • Fire evacuation drills had not been carried out 6 monthly in line with fire regulations. There were no records of boiler temperatures, daily fire checks or weekly fire alarm checks as recommended in the fire risk assessment. • Records of emergency lighting and smoke detector checks were incomplete. Records showed that the emergency lighting was last tested by the practice in March 2012. • Room temperature recording of high-risk areas such as the boiler room and server room had not been carried out as recommended in the fire risk assessment carried out in 2021 and had not been identified on the latest risk assessment in 2022. • There were 2 fire marshals who had received training. <p>On the first day of the site visit staff reported the gas isolation lever was seized, which meant that the gas supply could not be isolated if there was a leak. There had been an incident a few weeks before the inspection when there was a suspected gas leak. We requested that this issue was looked into on the day to ensure the safety of staff and patients. Due to lack of available leadership on the day for the issue to be fixed employed staff had address this to ensure that an engineer was booked and paid for urgently. The gas lever issue had been resolved by the following day.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: requested but not provided	

The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was unable to evidence if staff had received infection prevention and control training. The practice lead for infection control, started employment in March 2022. They told us that at that time there were no infection control measures in place. Following their appointment, they implemented a new policy based on CQC guidance and introduced regular checks and audits of infection control processes. We saw that the practice premises was visibly clean and tidy. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have an effective system to ensure appropriate cover for staff absences. For example:</p> <ul style="list-style-type: none"> Staff told us that there were instances where the practice was unable to open due to insufficient numbers of clinical staff. The practice was reliant on locum GPs to provide a service however, appropriate cover was not always secured to ensure a safe service for patients. The provider did not inform us of the absence of registered persons or interruptions to service provision. Staff told us they had not been able to take annual leave, some for 6 months, as there were inadequate numbers of staff. One clinician told us they had worked a day of their annual leave when another clinician had gone off sick. Staff told us they routinely worked beyond their contracted hours as there were not the staff to ensure the work was completed in their absence. <p>Systems to ensure temporary staff had necessary information, were not effective. GP locums who worked on site and remotely, were given information on what tasks they would need to carry out but were not provided with information on practice policies and procedures.</p> <p>The practice was unable to demonstrate that all staff received training in emergency procedures. For example:</p> <ul style="list-style-type: none"> The practice manager told us that all clinical staff had received basic life support training (BLS), but there was no evidence to support this. Non-clinical staff had not received BLS training. 	

- Non-clinical staff were unable to describe the actions they should take should a patient become unwell. For medical emergencies, staff told us they would not use the emergency button provided on their system but would instead send an instant message or call a clinician.
- Staff told us that they had not received training to identify deteriorating patients.
- Not all patient facing members of staff were aware of the symptoms of sepsis.

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. ¹	Partial
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.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <p>Prior to inspection we conducted a remote review of patient records and identified that they were not consistently managed in a way to protect patients. For example, patient history, examination, management plans, safety netting and follow up were not adequately documented in the patient record.</p> <p>The practice did not have a system to ensure information relating to new patients was processed appropriately and were unable to provide assurances that patient records were accurate and up to date to enable staff to provide effective care and treatment. We identified a significant backlog of new patient notes which required summarisation. For example:</p> <ul style="list-style-type: none"> • Staff showed us 17 filing cabinet drawers which contained patient notes. They told us that the notes had not been summarised. One example taken from this backlog included in the patient history safeguarding concerns raised in 2018. The practice was unable to provide assurances that this information had been included on the practice's electronic clinical record ensuring that the appropriate support was available to the patient. The practice manager told us that they believed relevant information had been added to records but was unable to confirm this. • Staff told us that there was no-one to undertake the summarising of patient notes. When patient information was received GP to GP, it was filed without being coded as there was no-one available to apply the relevant codes. <p>The practice did not have a system for clinical coding and workflow management or a system to ensure that referrals were made in a timely way. Staff had not received necessary training to apply clinical</p>	

codes on patient records. We found all tasks requiring clinical oversight by a GP were assigned to the GP partner who was absent and locum GPs worked through the list. However, there was no oversight of this to ensure that risk was prioritised, and actions were completed when needed. There were approximately 700 records which required scanning onto patient records, and we found a request for an urgent cancer referral from December 2022, that had not been actioned.

When we inspected on 12 January 2023 there was a total 320 tasks outstanding. Of these, 81 were marked as urgent. Routine tasks dated back to 17 November 2022 and the urgent tasks dated back to 23 December 2022. No action had been taken by the provider to address the tasks. Examples included:

- Routine task dated 17 November 2022 following a consultation, a follow up blood test and appointment were requested. This had not been actioned.
- The first six urgent tasks were sent by a pharmacy technician to prescribers working from the practice advising them of a change in prescribing practice.
- Other urgent tasks which had not been completed included a referral to mental health services; a patient who required a specific injection in August 2022 to protect their bones, required a blood test before this treatment could be received; and an information request to a locum GP regarding a potential error in issuing antibiotics.

When we inspected on 17 January 2023 there were 332 tasks outstanding; 61 were urgent, the oldest of these dating from 30 December 2022.

- Examples included an urgent task where a patient needed an alternative medicine prescribed. A routine task where a test result was inconclusive information that the patient should speak with a duty GP the same day if the patient was concerned.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.77	0.78	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	4.5%	4.5%	8.5%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	3.36	3.81	5.28	Significant Variation (positive)

Indicator	Practice	SICBL average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	128.7‰	117.2‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.67	0.51	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	6.5‰	6.2‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Partial

Medicines management	Y/N/Partial
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Patient group directions (PGDs) had not been signed and authorised in line with guidance. For example, clinical staff signed the PGD after it had been authorised. This meant that those staff who signed after the PGD had been authorised were not covered to administer the medicines. (PGDs allow specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber).</p> <p>The practice did not have any effective systems in place to monitor the prescribing of controlled drugs, raising concerns or effective protocols to verifying patients identity.</p> <p>The practice could not be assured of the competencies of non-medical prescribers as this had not been monitored. Non-medical prescribers did not have access to regular formal clinical supervisions and the provider had not monitored their prescribing practices to ensure they acted in their own competencies and that prescribing decision had been appropriate.</p> <p>Systems for managing repeat prescriptions to ensure patient safety were ineffective. For example:</p> <ul style="list-style-type: none"> • The practice did not have a prescribing policy and our remote clinical searches on 10 January 2023 identified a total of 1796 patients medicine reviews were overdue by 1 month. • Staff told us that they were only able to get prescriptions signed by a GP on Mondays and Fridays even if there was a GP on site on additional days. We raised this with them, and they advised that they had been told by practice management that prescriptions could only be signed on the specified days. For urgent prescriptions staff told us they were reliant on an appropriate clinician being at the practice to authorise them. However, there had been occasions when there had not been a clinician on site to authorise the urgent prescription requests. • When we inspected on 17 January 2023 there were 160 prescriptions waiting to be authorised by a GP dated from the day before. • The practice's prescription team consisted of one member of staff who was responsible for all aspects of prescription management. They told us they had not received formal training for the role and that they routinely worked additional hours to keep on top of the workload. When they were absent from work, prescriptions were managed by a member of the reception team who had not been provided with formal training. • Due to workload, the practice closed the specific prescriptions phone line and diverted all prescription queries and requests to the reception team. However, no additional training was provided to staff to ensure they were able to give patients appropriate information. There was no risk assessment in place to evidence that the safety or impact of this had been considered. • Due to a lack of appointments, patients were not always able to receive required monitoring in an appropriate time frame to ensure medicines remained appropriate and safe. Clinicians who authorised prescriptions would identify patients who were overdue monitoring and medicine 	

Medicines management	Y/N/Partial
<p>reviews. However, due to a lack of appointments these could not always be actioned. We identified 96 tasks dating back to 4 November 2022 which identified patients who were overdue monitoring and required a blood test. These tasks had been closed which indicated they had been actioned; however, they had been closed by staff without the patient receiving the necessary monitoring as they did not have the appointment availability to bring them into practice.</p> <ul style="list-style-type: none"> • Blood monitoring tests on tasks for medicines were not always specified so staff had to check with the prescribing clinician what tests were required, which delayed prescription requests being fulfilled. • A review of a sample of patient records showed they have been coded as having a medicine review but there was no information contained in the records of what has been discussed. • There was no protocol in place to ensure uncollected prescriptions were appropriately managed. We found examples of prescriptions which had not been collected, included for diazepam, (used to treat anxiety, muscle spasms and seizures) which was dated 2 September 2022; and nitrofurantoin (used to treat urine infections) dated 15 August 2022. <p>The practice did not have an effective system to ensure medicine reviews were conducted when required and that they contained necessary information. For example:</p> <ul style="list-style-type: none"> • Our remote searches identified that medicine reviews had been coded on patient records, however there was not always additional information including a rationale for continued prescribing. • A total of 44 patients were prescribed gabapentinoids (used to treat epilepsy and nerve pain) had not received monitoring in the preceding 12 months. We reviewed the records of 5 of these patients and found all were overdue a review; and for 2 of the patients there was no evidence of discussions around risks associated with these medicines. • Two of the 4 patients prescribed Leflunomide had not received required monitoring. (Leflunomide is used to relieve symptoms caused by active rheumatoid arthritis). • One of the 5 patients prescribed Lithium had not received required monitoring. (Lithium is used to treat mood disorders). • We identified 14 out of 44 patients prescribed potassium sparing diuretics (sometimes called water pills, used to help rid your body of salt (sodium) and water) had not received required monitoring. • A total of 797 patients were prescribed ACE inhibitors or Angiotensin receptor blocking medicines (used to help lower blood pressure). Of these 37 had not received the recommended monitoring. • One patient was prescribed Amiodarone (used to treat abnormal heart rhythms) and had not received the necessary monitoring. We did note from the records that a blood test had been booked for a few days post inspection. • A total of 224 patients were prescribed direct oral anticoagulants (used to prevent blood clots, which could cause strokes or heart attacks) 69 of these patients did not have the required monitoring. • Twenty-nine patients were prescribed warfarin (used to prevent blood clots, which could cause strokes or heart attacks), of these 5 had not had the necessary monitoring within the previous 56 days. • We sampled 5 patient records and found that their medicine reviews had been conducted without documenting the outcomes from the review; and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review. 	

Medicines management	Y/N/Partial
<p>We asked for an action plan to address the concerns regarding the findings from our searches. An action plan was returned but it did not specify in detail what action would be taken, by whom and a date for completion.</p> <p>Emergency medicines held at the practice were in line with guidance and are regularly checked and this was documented.</p>	

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.	Partial
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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have a system to identify and investigate significant events. The practice did not have a protocol in place to give guidance to staff. Staff we spoke with were unable to demonstrate they understood what would constitute a significant event or were aware of internal processes to escalate concerns should they be identified. Practice records demonstrated they had begun identifying significant events in December 2022 and by the time of inspection they had recorded 4 events. However, there were no records available of significant events which occurred prior to December 2022.</p> <p>The practice was unable to demonstrate that they could identify significant events through alternative avenues. For example, we reviewed formal complaints received by the practice and identified incidents which should have been investigated as significant events.</p> <p>Examples included:</p> <ul style="list-style-type: none"> An urgent referral not being sent and there was no follow up by the practice to check the referral had been made. Two complaints were made about not receiving timely care and treatment, which resulted in patients attending secondary care for diagnosis and treatment. The main factor in not being able to access treatment was the lack of appointments with clinicians. The practice had not raised these as significant events. We also found that investigations were not commenced until consent had been obtained from patients which caused a delay in starting an investigation. For 1 of the complaints even though consent had been obtained no further action had been taken. 	

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

Event	Specific action taken
A letter was printed out for a patient and given to them, but there was also documentation belonging to another patient which had not been removed from the printer, which was given to the patient.	<ul style="list-style-type: none"> • Patient returned documentation containing details of another patient. • The practice investigated and notes showed that reception was busy and short staffed. • Actions recommended were for reception staff to have a second person to confirm patient identity before handing over documents. However, there was no information to show that staff had been made aware of this. • The incident was logged as a data breach. • The patient whose details were given to was to be contacted under Duty of Candour requirements and provided with an apology. At the time of the inspection this action had not been taken.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff were not clear on the process for managing safety alerts and said that emails were received, but they were not clear what actions were taken in response to safety alerts.</p> <p>During our clinical searches we checked actions taken in response to a safety alert on patients who were prescribed a combination of diuretics and heart medicines. Seven patients were identified by our searches who were prescribed this combination of medicine. We looked at the records of 5 patients and found that 1 patient was overdue blood tests. There was an entry in the patient record which indicated the practice were aware of this, but no action had been taken to arrange the blood tests.</p>	

Effective

Rating: Inadequate

We rated the practice inadequate for effective because:

- 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.
- The practice did not have a comprehensive programme of quality improvement activity. There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- Staff did not work together and with other organisations effectively to deliver care and treatment.
- Staff were not consistent and proactive in helping patients to live healthier lives.
- The practice always obtained consent to care and treatment in line with legislation and guidance.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
The practice prioritised care for their most clinically vulnerable patients.	Partial
Explanation of any answers and additional evidence: The practice's computer system had templates which linked to current national guidance and evidence-based practice. Clinicians were able to use these when carrying out patient consultations. However, the practice had not made sure that all clinicians used the templates consistently.	

The practice was unable to provide assurance that patient records contained up to date information. There was a back log of documents which required scanning on to patient records, dating back to July 2022. This meant that clinicians did not always have necessary information to provide effective care and treatment.

- A document was kept of referrals that had been made, this showed that these referrals were made on the day the task was raised. Staff said they regularly worked over their contracted hours to ensure referrals were made promptly. We found 1 example of a 2 week wait referral that had not been made, but at the time of the site visits there were no outstanding 2 week wait referrals.

There were examples of appointments not being available and staff not knowing what patients' needs were as information was missing, for example:

- One request related to blood tests for a patient who had attended for an appointment. The blood taker did not have information on what blood tests were needed, as the locum GP had not specified them on the system and the patient did not know what blood tests were needed. The practice nurse advised the blood taker to try and contact the referring GP for more information and rebook the appointment for the patient.

Effective care for the practice population

Findings

- There was no process in place to prioritise end of life care for patients to ensure suitable care and treatment was provided.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. However, appropriate, and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified was not demonstrated by the practice.
- The practice did not have an effective system in place to ensure that all patients with a learning disability were offered an annual health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

Management of people with long term conditions

Findings

- We found there were shortfalls in the system used to identify when a review was due. We found that specific templates were in place, but these were not used by all staff to ensure that relevant areas were covered. The practice said they planned to move all patients onto a new system when they would be recalled for review during their birthday month. This had yet to be put into place and therefore staff were reliant on the use of diary entries on patient records and reception staff collating the information manually.
- Patients with long term conditions were reviewed to ensure their treatment was optimised in line with national guidance. We sampled records of patients with long term conditions such as asthma and diabetes and found that routine monitoring and reviews had been carried out in the recommended timeframes. However, a member of staff responsible for this work said although they had received training on this, they did not always have a GP to go to for advice if required.
- In addition, there was a lack of coordinating care to ensure that all necessary tests had been carried out prior to a review being undertaken. For example, a patient had been sent a text

message to book an appointment for a long term condition review, but there was no reference to the need for blood test tests to be taken before they attended the appointment.

- Patients who had received treatment in hospital or through out of hours services were not consistently followed up due to the lack of GPs.
- We identified 16 patients with a potential missed diagnosis of diabetes. We reviewed the records of 5 of these patients, of which 1 patient had not reviewed in line with national guidance. which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	49	93.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	55	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	55	92.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	55	92.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	46	89.1%	Below 90% minimum

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

Any additional evidence or comments

The practice had not identified actions to improve immunisation uptake.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	71.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	76.3%	59.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	71.7%	70.9%	66.8%	N/A
		-		-

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

Any additional evidence or comments
The practice had not identified actions to improve cervical screening uptake.

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity. There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial

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

<ul style="list-style-type: none"> There was no involvement by the practice in quality improvement activity. Patients were not provided with consistent care and treatment due to a lack of consistency in GP locums employed. Information on unplanned admissions was received by the practice, but systems to monitor these were not effective, as there was a backlog in tasks and a lack of clinical oversight to ensure this work was carried out and appropriate actions taken.
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Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	N
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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:	
<p>The practice was unable to demonstrate if all staff were up to date with training or that they had received training appropriate to their role. For example:</p> <ul style="list-style-type: none"> We were able to review limited training records for clinical and non-clinical staff. These records had not been completed and demonstrated significant gaps in staff training. We identified staff had not received fire safety training or safeguarding training in line with national guidance. We requested evidence demonstrating training records for all members of staff working from the practice, however this was not provided. The practice did not have guidance demonstrating what training they identified as necessary for staff and systems to ensure staff completed training were ineffective. Staff told us that they had received no training for summarising and coding records. <p>The practice was unable to provide assurance that all staff had the knowledge and experience to deliver effective care and treatment. For example:</p> <ul style="list-style-type: none"> There was no formal appraisal system or supervision system in place or overall governance of clinical activities in the practice. Non-medical prescribers had not had their prescribing practice monitored or audited to ensure decisions and patient outcomes were appropriate. Clinicians had not received formal supervision and were not provided with appropriate clinical support on site. <p>The practice's processes for inducting new staff did not ensure they received all necessary information. For example, inductions for new staff consisted of a walk around the premises and an introduction to fire and health and safety.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	N
Explanation of any answers and additional evidence: The practice was unable to demonstrate that they provided care in a coordinated way. <ul style="list-style-type: none">• We found examples of events where patients had not received appropriate care and treatment. For example, 1 patient required medicine to protect their bones. They had requested a repeat prescription in August 2022. However, before the prescription could be issued blood tests were needed. The practice did not identify this until January 2023, when a request was made to the district nurses for the blood tests to be taken. In addition, there was a missed opportunity for the required bloods to be taken when a clinician visited the care home where the patient lived and did not take blood for testing.• Another example related to a delay in requesting a referral to secondary care services. Consent was needed from the patient but there was a delay of over a month before a medical secretary was asked whether consent still needed to be gained. It was not clear from the patient record whether the necessary consent had been obtained to enable the referral to be made.	

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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice did not have effective systems to ensure that patients' needs were assessed, and care and treatment was provided to meet their needs. There were shortfalls in the provision of care for patients who were receiving end of life care. We received reports that end of life 'just in case' medicines had not been prescribed and home visits were not being undertaken to make sure patients were receiving appropriate care.	

- There were insufficient numbers of clinicians available to provide routine health checks and monitor patients at risk of developing long term conditions. This meant that there was a risk of patients not receiving appropriate care and treatment.
- There was a link on the practice website to the NHS website with information on mental health services and an A to Z of conditions.
- The practice waiting room had information on healthy living such as stop smoking services.

Consent to care and treatment

The practice 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence, including from clinical searches: Our clinical review of notes where a DNACPR decision had been recorded identified that where possible the patients' views had been sought and respected. We saw that information had been shared with relevant agencies.	

Caring

Rating: Requires Improvement

We rated the practice requires improvement for caring because:

- Staff were inconsistent with treating patients with kindness, respect, and compassion. Feedback from patients was negative about the way staff treated people.
- Staff helped patients to be involved in decisions about care and treatment, but this was not consistent.
- The practice did not consistently respect patients' privacy and dignity.

Kindness, respect, and compassion

Staff were inconsistent with treating patients with kindness, respect, and compassion. Feedback from patients was negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: Staff we spoke with were committed to providing appropriate care and treatment for their patients. However, staff shortages and high workload had left them feeling frustrated that they could not do this. They acknowledged that at times this resulted in these stresses becoming apparent to patients.	

Patient feedback	
Source	Feedback
The NHS website	Feedback from patients who posted reviews voiced concerns about poor staff attitude. There were also comments that staff were polite and kind.
Complaints received by the practice.	Themes of complaints received by the practice in the past year included poor staff attitude.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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	88.0%	88.4%	84.7%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
good at listening to them (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	86.0%	87.6%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	91.1%	95.1%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	65.2%	76.4%	72.4%	No statistical variation

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

Any additional evidence
There had been a total change in the practice management team in the past 12 months. They planned to carry out patient surveys however there were no clear timescales for this to occur.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment, but this was not consistent.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
Explanation of any answers and additional evidence: Easy read and pictorial materials were available on request, but not all staff were aware of this. There was some information on the practice website which directed carers to organisations which could provide support.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	90.7%	92.7%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Partial
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Partial
Explanation of any answers and additional evidence:	
The practice had access to translation services and facilities to provide information in other languages and easy read format, however not all staff were aware of how to access these services.	
The practice website had limited information on support groups available.	

Carers	Narrative
Percentage and number of carers identified.	The practice had not identified patients who had caring responsibilities
How the practice supported carers (including young carers).	There was no information available in the practice or on their website which provided information on services available to support carers.
How the practice supported recently bereaved patients.	Due to the reliance on GP locums to provide a service, no additional support was provided to bereaved patients. Apart from once a month when a village agent visited the practice to support patients who had been bereaved, but no specific patients were contacted.

Privacy and dignity

The practice did not consistently respect patients' privacy and dignity.

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

Explanation of any answers and additional evidence:

Conversations held at the reception desk could be easily overheard and staff did not always consider taking patients to a private area to discuss their needs. For example, on the day of the inspection site visit CQC inspectors overheard conversations in the reception area that could be considered confidential.

Responsive

Rating: Inadequate

Responding to and meeting people's needs

We rated the practice as inadequate for responsive because:

- No analysis had been carried out of local population needs. Services had not been developed to meet patients' needs.
- Patients were not able to access care and treatment in a timely way.
- Results from the National GP patients survey were below local and national averages and there were no plans in place to address the shortfalls.
- There was a lack of appointment availability to enable patients to book ahead and face to face appointments were not always available, as the practice did not always have a GP on site.
- Patients' accessibility needs were not fully considered in the provision of the service.
- Complaints were not used to improve the quality of care.

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.	Partial
The practice complied with the Accessible Information Standard.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice premises were not appropriately maintained for services to be delivered from. It needed remedial works to ensure it was safe for use, in particular in relation to the fire safety system. The practice had not undertaken any work on assessing the needs of the local population and there was limited continuity of care for patients.• There was information on the practice website about requesting an interpreter however, not all staff who worked at the practice were aware of these services and therefore we could not be assured that translation services would be available or accessible should a patient require it.• The practice did not have any aids in place for patients who were hard of hearing, such as a portable hearing loop, which is used to cut out background noise for hearing aid users.• The practice were not aware that patients of no fixed abode could register at the practice and use the practice address for correspondence.	

Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm

Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Telephone lines were open from 8:30am till 6:00pm	

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

- No analysis had been carried out of local population needs. Services had not been developed to meet patients' needs.
- Reception staff had limited information on what conditions different clinicians were able to review. There was a checklist in place for triaging calls and referral to community pharmacy services, but staff told us they had not received training on this.
- Staff considered there were insufficient appointments available to meet patients' needs and patients were unable to get through on the telephone easily, due to staff shortages and wait times.
- Feedback from patients who posted reviews on the NHS website voiced concerns about inability to get appointments; and call waiting times when telephoning the practice.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	N
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Partial
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Partial
Patients with most urgent needs had their care and treatment prioritised	Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have an effective system to identify and prioritise patients requiring a home visit.</p> <ul style="list-style-type: none"> • Staff told us that patients were only considered for a home visit if the relevant code had been applied to their record. However, coding in practice was inconsistent and the practice was unable to provide assurances that all patients who were housebound or would be eligible for a home visit, had been coded appropriately. • There was no protocol in place for triaging home visit requests, and there was a reliance on reception staff deciding whether a home visit was needed. <p>Patients were not able to access appointments easily and there was limited support in place for those patients who were digitally excluded. The practice did not have sufficient staff to offer advance appointments in advance of 2 weeks. Therefore, the majority of appointments were on the day.</p>	

- On the first day of the site visit we checked appointment availability for the following 2 weeks and found:
- One GP appointment on the 18/01/23 Two GP appointments on the 23/01/23
- Five GP appointments on the 4/01/23
- No nurse appointments were available until three weeks later on 9/2/23
- There was no facility to book longer appointments and no routine appointments were available outside of core hours for those who may not be able to attend during working hours.
- Telephone lines were not open when the practice was closed for lunch, and it was not clear where these calls were redirected to enable patient access.

We identified that patients were inappropriately turned away from the practice as the appointment system had not been managed effectively. Staff told us that between Christmas and New Year staff were instructed to refer patients to NHS 111 as there were no appointments available. However, a clinical member of staff told us that appointments were available but had been embargoed. On 29 December 2022, they had availability for 5 face to face appointment available however these were not used, and patients continued to be turned away. This had been raised with a manager at the time, but no action was taken.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	44.6%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	50.5%	61.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	42.5%	58.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	59.7%	76.6%	71.9%	No statistical variation

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.	51
Number of complaints we examined.	9
Number of complaints we examined that were satisfactorily handled in a timely way.	Evidence was incomplete due to a backlog in responding to concerns
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> On 12 January 2023 we requested a complaint procedure, but this could not be located. When we returned onsite on 17 January 2023, a policy had been identified. There were no systems and processes to use information from complaints to drive improvement and ensure action had been taken when needed. The practice had received 51 complaints since April 2022. Themes we identified included inability to make appointments, delayed prescription requests and staff being rude to patients. Themes and trends had not been identified by the practice. None of the complaints had been fully responded to; there was no indication of learning and next steps. Action in response to complaints did not demonstrate that there was a full understanding of the concerns raised as there was limited or no clinical input into complaint investigations. We reviewed complaints in detail dating back to October 2022 and identified 7 that potentially were significant events. Examples of complaints which could have been significant events included: A third party needed to book blood tests for a patient at the start of October 2022. No information was provided by the practice on what blood tests were required, so when the third party tried to book the blood test at the local hospital it could not be done. Eventually, an appointment was made for the 15 November 2022, with the understanding that information on the blood tests needed would be provided. The forms for the blood test were not made available until the practice met with the complainant on 21 October 2022. In between the time of the complaint being made and action being taken, staff at the practice had promised to look into the situation but nothing was actioned. 	

Well-led

Rating: Inadequate

We rated the practice inadequate for well-led because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice did not have a clear vision. There was no credible strategy to provide high quality sustainable care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues, and performance. The practice did not involve the public, staff, and external partners to sustain high quality and sustainable care.
- There was no 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: <ul style="list-style-type: none">• One of the GP partners was on long term absence at the time of the inspection and the other GP partner worked at the practice for two days a week. Neither partner had ensured there was appropriate oversight in their absence to ensure high quality sustainable care could continue to be delivered• Staff reported that there have been no routine or regular updates or communication from either of the partners regarding the running of the service.• Neither GP partner engaged with the inspection site visits or provided support to practice staff during the process.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was unable to demonstrate that there was a clear vision in place with a supporting strategy to provide sustainable care for patients. The leaders were absent from the business for the majority of the time and so were unable to monitor delivery. 	

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.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
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.	Partial
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The GP partners were not engaged with the daily running of the practice and the management team were not experienced in primary care and were still learning about the sector. Staff told us they had tried to highlight to the GP partners areas they were concerned with, such as inadequate staff numbers, workload, and inability to provide appointments for patients. However, no action had been taken regarding their concerns. Feedback from staff included: there was a lack of oversight of how the practice was operating; information was not readily available, such as documentation relating to health and safety; and high workloads. The complaints processes was not effective, and we found examples of complaints which had not been fully investigated and responded to. Some complaints noted that duty of candour needed to be followed, but this had not been actioned. The practice was unable to demonstrate that equality and diversity training had been provided for staff. 	

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

Source	Feedback
Staff	"It is like being in a boat with no-one steering"
Staff	"There is scope to make changes, but only when these are within the member of staff remit. If this is not the case, then changes cannot be made as they need sign off by the GP partners."
Staff	Staff reported working during their annual leave or not being able to take leave; taking laptops home to complete work; and coming in on non-working days to see patients, as they did not want the let patients down.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were no overarching governance arrangements in place. • Regular meetings were not in place for areas such as complaints, significant events and safeguarding adults. We were informed that these were discussed at weekly clinical meetings, but these meetings were not minuted to demonstrate this. • There were no protocols for coding or workflow management. There were no governance checks to ensure that referrals, summarising, or coding were appropriate. • The practice had a new employee starter checklist, but there was no induction programme for staff. There was no supervision or appraisal system in place and staff reported that they rarely received formal supervision or appraisal. • The practice did not have arrangements to ensure that staff had received effective training to carry out their role. Training records were incomplete and there was no information detailing what training the practice was considered necessary for staff. • Staff reported not being clear about their role, examples were given of attending for interview and then being asked which vacancy they would like to take. • There were occasions where staff felt pressured to act outside of their competencies. • Arrangements to ensure that safe systems and processes were in place for minimising the risk of harm to patients were limited. • Policies and procedures were not routinely reviewed and updated to ensure they contained relevant information and guidance for staff. • Significant remedial works were required to bring the premises up to safe standards. This included renewal of the fire alarm system and work to stop water leaking into the building from gutters. With the leaders absent staff did not have the appropriate authority to action the remedial work required. • The practice was unable to demonstrate that there was appropriate medical indemnity cover for clinical staff. We requested to review evidence demonstrating that they had the required cover, however this could not be found. The practice manager provided us with an insurance document which did not detail professional indemnity. 	

- Statutory notifications were not made to CQC to advise whom would be covering the responsibility of delivering the regulatory activities and governance in the absence of the registered person.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	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: Systems and processes in place were not effective and staff were not able identify any concerns with risk, issues and performance. There were inconsistencies in identifying incidents which could be classed as significant events; and information from concerns received was not used to monitor service performance and drive improvement. The practice did not have a major incident plan and staff had not received guidance on what actions to take should a major incident occur.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	N
Explanation of any answers and additional evidence: There was no overall day to day clinical oversight at the practice and governance systems were not in place to ensure audits of care and treatment were carried out to ensure safe patient care. The provider did not formally notify us of the long term absence of the main GP partner, as required by the regulations. No systems or processes were put into place to ensure there was effective governance whilst the main GP was absent.	

Governance and oversight of remote services

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

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.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: Lack of leadership by the GP partners meant that there were no arrangements to consult others in the planning and delivery of services. Staff feedback indicated that they felt their feedback was not listened to or acted upon which would have led to improvements to patient safety and delivery.	

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: There were no systems and processes in place for learning, continuous improvement and innovation.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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