

Care Quality Commission

Inspection Evidence Table

Dr Touseef Safdar (1-548913045)

Inspection date: 9 and 11 June 2021

Date of data download: 03 June 2021

Overall rating: Inadequate

During our last inspection in December 2019 we rated the practice as Requires Improvement overall.

At this inspection we have rated the practice as inadequate overall because:

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

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

Safe

Rating: Requires Improvement

At our previous inspection in December 2019 we rated the practice as requires improvement for providing safe services as some non-clinical staff in patient facing roles had not been appropriately risk assessed or had a review of their immunisation needs against possible infections.

At this inspection we have rated the practice as requires improvement for providing safe services because:

- We identified issues with recruitment processes and ongoing employment checks.
- We found concerns in relation to the monitoring of high-risk medicines.
- There was a lack of systems and processes for oversight of clinicians working in the practice.

Safety systems and processes

The practice systems, practices and processes to keep people safe and safeguarded from abuse were mostly in place.

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.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was limited evidence which showed that the practice had regular contact with health and social care professionals. Multi-disciplinary meetings (MDT) were being held through the primary care network (PCN) on a monthly basis, however there had been no engagement by the practice in attending these meetings in the last 12 months. We saw an example that a meeting due to be held with the practice on 10 March 2021 had been cancelled by other professionals. We were told that the frequency of some meetings and the availability of staff from external agencies to attend meetings had been impacted upon by COVID-19. The practice told us that they raised concerns directly with agencies in the absence of attendance to MDT meetings. 	

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 Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We examined several staff personnel files, including staff members recruited during the last twelve months and found that there were gaps in the recruitment checks undertaken prior to employment for two members of staff. We found that interview schedules were missing and 	

there was no evidence in staff files that references had been undertaken.

- The personnel files of most staff members had evidence of their vaccination and immunity status. However, for one clinician who had worked at the practice for twelve months there was no record of their immunisation record in their personnel file.
- After the inspection, the practice sent us evidence of staff immunisation, references and interviews schedules in line with safer recruitment, however, we noted that one staff member's reference check contained no signed date of completion. The practice told us that some of the information was not held in staff personnel files and was held electronically.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 27 May 2021	Y
There was a record of equipment calibration. Date of last calibration: 27 May 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 19 October 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The building was managed by NHS property services who conducted a fire risk assessment every two years. Actions from the fire risk assessment were identified and actioned appropriately for all staff, for example, the replacement of fire action safety signs and relocating the photocopier to another area in the building. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 6 January 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16 October 2019	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The building was managed by NHS property services who carried out all out all health and safety, premise, security checks and maintenance of the building. Relevant environment risk assessments such as legionella, COSHH and health and safety assessments were carried out and all actions 	

had been identified and completed. In addition, the practice had carried out their own premise's security audit in January 2021.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21 May 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
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.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was a locum lead nurse for infection prevention and control (IPC). An IPC policy had been updated and the practice had undertaken an IPC audit in the past 12 months. The audit in May 2021 had achieved an overall score of 99%. Actions identified had been completed for example, to remove the nurses dressing trolley. 	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was a heavy reliance on locum staff for the delivery of clinical services in the practice. Long term locum arrangements were in place and a locum induction pack was available. However, non-clinical staff were not always provided with an induction. For example, a receptionist who had been appointed in the last 12 months had not received a formal induction, however informal buddy arrangements were in place. 	

- Staff were able to describe how they would identify and deal with a rapidly deteriorating patient. However, non-clinical staff reported that they had not received specific sepsis identification training, and this was an area that was identified during our last inspection for improvement.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a system in place to monitor test results, however these were not always actioned in a timely manner. For example, we found evidence that there had been a three month delay in recording the blood results of a patient who was prescribed a high-risk medicine that required regular monitoring. • During our inspection we found that patient information was not always recorded. For example, we found examples where patient records had been coded as having had a medicine review, however there was no information recorded in the patient records and we could not be assured that individual medicines had been reviewed. • Support and advice to staff, such as members of the nursing team, was ad hoc. We saw no evidence of oversight or clinical meetings between the GPs and the nursing team. We were told that the nursing team would send a message to the locum GP's through the computer to action, however at the time of our inspection there was no formalised system in place. 	

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.46	0.69	0.70	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	4.1%	6.9%	10.2%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	4.75	5.13	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	61.7‰	131.9‰	126.9‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.35	0.70	0.66	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	7.2‰	8.4‰	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

Medicines management	Y/N/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 structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	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 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"> The practice relied on locum staff to carry out all clinical work in the practice, A long term locum GP was responsible for clinical oversight, however there was a lack of systems and procedures for supervision, peer reviews or clinical oversight of clinicians working in the practice. Patients registered at the practice were able to request repeat medicines through a prescription ordering service (POD). This is a service where patients can order prescriptions through a centralised telephone system. However, during our inspection we found that this was not being effectively monitored and systems needed to be embedded further to ensure the practice had oversight and processes in place to review medicine reviews taking place. After the inspection, the practice sent us evidence of a monthly monitoring process they would undertake to ensure the practice were monitoring and had oversight of medicines being issued to their patients. Our review of clinical records found that some patients had not received appropriate reviews or monitoring of their medicines. We were told that monthly searches were carried out to identify 	

patients who required monitoring and these patients were contacted and reviewed appropriately. However, a random sample of clinical records showed high-risk medicines were not consistently being monitored appropriately, which meant that monitoring was not always managed in a way that kept patients safe.

In particular:

- During the inspection we found that there was a delay in entering blood results onto the system for one patient taking methotrexate (a medicine used to suppress the immune system). A further patient did not have the required monitoring in place and we were unable to evidence that the monitoring was up to date prior to issuing a prescription.
- During the inspection we reviewed three patients prescribed lithium (a medicine used to treat mood disorders) and found that for two patients there was no documentation in the clinical records to confirm that their monitoring had been checked and therefore, we were not assured that staff members had satisfied themselves it was safe to prescribe.
- During the inspection we were not assured that five of the patients prescribed spironolactone (a medicine used to treat heart failure) had the required monitoring. We found that these patients had been coded as having a medicine review undertaken but were unable to evidence that individual drugs had been reviewed appropriately.
- During our inspection we reviewed patients prescribed simvastatin and amlodipine. A drug alert was issued in 2014 which outlined the increased risk of myopathy (clinical disorder of the skeletal muscles). The alert advised that patients on both medicines should be reviewed and one of the medicines should be replaced with an alternative. If there is no alternative, then as a minimum the simvastatin should be reduced from 40mg to 20mg. We found that four patients were being prescribed amlodipine and more than 20mg simvastatin together. However, we found no evidence of this being reviewed in accordance with the drug safety alert and found evidence that medicine reviews had been coded as being reviewed, but individual medicines had not been looked at.
- Following the inspection, the practice told us that the system to carry out monthly searches had failed to identify those searches CQC had undertaken during our inspection, which led to a failure. They assured us they had accessed the searches immediately and had made arrangements for any patients to attend the practice where monitoring was required on the day of the inspection. They sent us an action plan of the system they would use in the interim until they could rectify and embed a new system for monthly monitoring for patients on high risk medicines to ensure all patients were monitored appropriately and safely.
- Patient Group Directions (PGD) were in place to allow the practice nurse to administer medicines in line with legislation, however on reviewing a sample of the PGDs we found that one PGD had not been authorised by a senior person at the practice to ensure the appropriate, qualified staff followed the directions. The practice told us this was an oversight and it was immediately rectified.

Track record on safety and lessons learned and improvements made

The practice did not always 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.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	8
Number of events that required action:	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a significant events policy and procedure in place which was reviewed annually. The significant events procedure outlined that learning from significant events would be analysed and shared in practice meetings to review the effectiveness. However, we were not assured that learning was taking place or had been reviewed with staff as there had been only one practice meeting that had taken place during the last 12 months. 	

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

Event	Specific action taken
One of the locks on the front door broke meaning that there was only one remaining lock in operation.	This was reported immediately to NHS property services and to the security contractors for replacement. All staff were made aware of how to report incidences in relation to security.
GP Smartcard was being kept in an unlocked drawer along with login details.	An external consultant completed an information governance review in the practice, including a review of policies and procedures and a security audit. Staff completed information governance, data protection and (general data protection regulation (GDPR) training.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
There was a system in place to review safety alerts, however this needed reviewing further as we found that a drug alert issued in 2014 regarding simvastatin and amlodipine had not been actioned appropriately.	

Effective

Rating: Inadequate

At our previous inspection in December 2019 we rated the practice as requires improvement for providing effective services as the practice was not meeting the target for cervical cytology uptake and there was a high level of exception reporting for mental health (including dementia). We could therefore not be assured that all patients were receiving care and treatment that met their needs.

At this inspection we have rated the practice as inadequate for providing effective services because:

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had systems to keep clinicians up to date with current evidence-based practice; however, a random view of clinical records showed clinicians did not always assess patients' needs and deliver care and treatment in line with current guidance. For example, patients prescribed a high-risk medicine were not routinely monitored in line with NICE guidance. • A random sample of clinical records we viewed remotely showed patients treatment was not always reviewed or updated. In particular, we saw the use of medication reviews added to clinical records; however, we were unable to evidence that an actual review had been carried out. 	

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The concerns identified with the effectiveness of the practice affected all population groups. • The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medicines reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The concerns identified with the effectiveness of the practice affected all population groups. • Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. • Staff who were responsible for reviews of patients with long-term conditions had received specific training. • GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. • The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. • The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	60.2%	75.4%	76.6%	Variation (negative)
PCA* rate (number of PCAs).	3.6% (8)	6.6%	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)	68.7%	88.0%	89.4%	Variation (negative)
PCA rate (number of PCAs).	4.3% (3)	8.5%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	82.1%	80.6%	82.0%	No statistical variation
PCA rate (number of PCAs).	10.4% (11)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	59.0%	63.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	12.7% (29)	11.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	61.7%	70.4%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	4.9% (20)	5.5%	7.1%	N/A

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)	95.4%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.0% (2)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	64.1%	72.8%	75.9%	No statistical variation
PCA rate (number of PCAs).	14.8% (34)	8.3%	10.4%	N/A

Families, children and young people

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- The practice has not met the minimum 90% for three out of five childhood immunisation uptake indicators. The practice was using locum nurses at the time of the inspection and were working through their recall system in place.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2019 to 31/03/2020) (NHS England)	60	64	93.8%	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) (01/04/2019 to 31/03/2020) (NHS England)	57	68	83.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	59	68	86.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	57	68	83.8%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	60	64	93.8%	Met 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

During our last inspection in December 2019 the practice was above 90% for all their immunisation uptake indicators.

During this inspection, we found:

- The practice was below 90% for three out of five childhood immunisation uptake indicators. The practice told us that they had undergone a restructure in the last 12 months which had impacted on their nursing provision. As a result, the practice was using long term locum nurses who were working through their QOF outcomes. A recall system was in place for following up non-attenders at appointments, however the practice had seen some reluctance from patients to attend face to face appointments during COVID-19. Following the inspection the practice sent us unvalidated data of improving trajectory for some of their childhood immunisations.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice uptake for cervical screening was below average and there was no evidence that the practice had taken action to address this.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could order repeat medicines without the need to attend the practice.

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: 31/12/2020) (Public Health England)	59.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	58.1%	65.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	48.9%	54.9%	63.8%	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) (QoF)	81.8%	84.6%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	68.8%	48.0%	54.2%	No statistical variation

Any additional evidence or comments

During our last inspection in December 2019 we found:

- That the cervical screening was significantly below the 80% coverage target for the national screening programme. The practice told us due to their practice population this presented constant barriers for patients and continued to prove challenging. Although the practice were flexible to patients' needs and offered opportunistic screening there were no active steps taken to regularly review this in meetings or try and engage with their diverse population using a variety of methods to increase uptake. During our inspection the practice told us they would look at ways to engage with hard to reach groups of their population to increase their uptake.

During this inspection we found:

- The practice uptake for cervical screening continued to be significantly below target. The practice were using long term locum nurses to carry out cervical screening for patients and continued to follow up non-attendance, screen patients opportunistically and provide advice and information. The practice told us that they undertook a telephone verbal invitation campaign along with an SMS text message campaign and had seen a 1.6% increase in their outcomes from 58.3% to 59.9% since our last inspection, however this still remained below the target rate of 80%.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed younger adult patients registered who lived at a local hostel.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.

- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	41.4%	74.4%	85.4%	Variation (negative)
PCA rate (number of PCAs).	9.4% (3)	15.6%	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) <small>(QOF)</small>	66.7%	66.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	9.8%	8.0%	N/A

Any additional evidence or comments

During our last inspection in December 2019, we found:

- The practice's QOF achievement for mental health indicators were significantly lower than national averages and the exception reporting rate was significantly higher than national averages. Exception reporting is the removal of patients from QOF calculations where, for example, when patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Due to the high numbers of exclusions, the practice could not be assured that all patients in this population group were receiving care and treatment that met their needs.

At this inspection, we found that:

- The practice was below the threshold for the percentage of people with a diagnosis of severe mental illness who have a mental health review in the past 12 months. Although the personalised care adjustment rate (PCA) had improved since our last inspection, we saw evidence that the overall outcomes of this had declined further since our last inspection in 2019 from 68.2% to 41.4%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	459.4	533.9
Overall QOF score (as a percentage of maximum)	82.2%	95.5%
Overall QOF PCA reporting (all domains)	6.5%	5.9%

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

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

A two-cycle audit was carried out on patients aged 18 years and older presenting with an acute cough due to an upper or lower respiratory tract infection including acute bronchitis, but not pneumonia. The audit reviewed 30 consultations to determine if the practice was compliant in line with NICE guidelines and antibiotic guidelines in general practice. The audit found that the practice was compliant with 73% of patients who were seen were not prescribed antibiotics. This audit was repeated six months later, and the practice continued to be compliant in line with best practice guidelines.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw evidence of an induction pack for clinical staff; however, we were unable to evidence that there was an induction process in place for non-clinical staff. A non-clinical staff member had joined the practice in the last 12 months, however there was no formal induction in place and on reviewing a sample of staff personnel folders, we found no documentation to support an induction had taken place. The practice told us that buddy arrangements were in place to support the non-clinical staff during this time. Training required by the provider was completed via an electronic training system which was monitored by the practice manager. The practice had oversight of completed training for locum staff and non-clinical staff. There was no protected time for learning and development for staff, however the practice told us that non-clinical staff were able to use quieter periods throughout the day to undertake required learning. We found that non-clinical staff had received an appraisal. Although this had been fully completed by staff members this needed to be embedded further as there was limited evidence to demonstrate how objectives, competencies or further development would be reviewed or agreed by the management team. There was no evidence to demonstrate that the practice had assured themselves of the competencies of long-term locum clinical staff working in the practice. The practice could not demonstrate acceptable levels of competence for staff who carried out their roles unsupervised and there was no system in place to ensure the clinical team received regular clinical supervision. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">No multi-disciplinary meetings (MDT) had been held by the practice in the last 12 months. The practice told us that they had difficulties arranging multi-disciplinary meetings (MDT) meetings face to face during COVID-19. The practice told us they planned for an MDT meeting to take place in March 2021, however this was cancelled by other agencies at short notice. Regular monthly MDT meetings were being held within the local network and part of the primary care network (PCN); however, the practice had been unable to attend these meetings and liaised directly with agencies to coordinate care for their patients.	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Patients did not always receive the required monitoring of their health. Systems and processes had not always been effective, which meant that some patients had not had a structured and comprehensive medication review for the monitoring of high-risk medicines.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice told us that alerts were added to patients with DNACPR's in place and these were reviewed. However, we reviewed two DNACPR's and found one patient's DNACPR was put in during COVID-19 and had been overdue a review by 11 months. Following our inspection, the practice told us they had taken action to address this.	

Caring

Rating: Good

At the last inspection we rated the practice as requires improvement for caring because:

- Patient satisfaction rates were significantly lower than local and national averages for data indicators relating to the caring key question. Actions taken in response to this by the practice had not had an impact on levels of patient satisfaction in these areas.

At this inspection we have rated the practice as good for caring because:

- The practice had taken action which demonstrated that improvements had been made in relation to outcomes for patient satisfaction.

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.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
Patient Survey Results	The National Patient Survey results for July 2020 reported that 86% of patients were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment and 80% of patients find the receptionists at this GP practice helpful.
Google Reviews	There was mixed feedback on Google reviews, with largely negative comments in relation to the poor attitude of staff. Whilst some patients had reported that practice staff were unhelpful, rude and there was a lack of care for patients, others had reported that staff were great and helpful.

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)	75.1%	85.2%	88.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	74.2%	83.4%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	88.9%	93.2%	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)	71.1%	76.3%	81.8%	No statistical variation

Any additional evidence or comments

At our previous inspection in December 2019, we found:

- Patient satisfaction rates were significantly lower than local and national averages for data indicators relating to the caring key question. Actions taken in response to this by the practice had not had an impact on levels of patient satisfaction in these areas.

At this inspection we found:

- The practice had completed an action plan between July 2020 and September 2020. They had met with staff to review ways they could shape and improve their service in relation to patient satisfaction in caring. They had completed their own patient survey during this period to look at ways they could improve satisfaction rates, however this had been paused throughout the remainder of COVID-19. We saw evidence that outcomes in relation to caring had improved since our last inspection in all areas relating to caring.

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

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Due to COVID-19 we did not undertake interviews with patients during our 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	86.1%	90.0%	93.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)				

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the time of our inspection, leaflets and literature was limited in the practice due to COVID-19, however information and resources were available on the practice website. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 28 carers which represented 0.6% of its practice population.
How the practice supported carers (including young carers).	Literature was available to support patients who were carers. Information was available on the practice website. All carers were eligible for a flu vaccination.
How the practice supported recently bereaved patients.	The practice would contact patients if appropriate. Literature and information were available for patients on bereavement services available locally.

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
Explanation of any answers and additional evidence:	

Responsive

Rating: Requires Improvement

At the last inspection we rated the practice as good for providing responsive services.

At this inspection we have rated the practice as requires improvement for responsive services because:

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

Responding to and meeting people’s needs

The practice organised and delivered services to meet patients’ needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had signed up to a local initiative for the prescription ordering direct (POD) for all patients registered at the practice. This information was available in the practice and on their website. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am until 6.30pm
Tuesday	8am until 6.30pm
Wednesday	8am until 6.30pm
Thursday	8am until 6.30pm
Friday	8am until 6.30pm
Appointments available:	
Monday	8am until 12pm and 3pm until 6pm
Tuesday	8am until 12pm and 3pm until 6pm
Wednesday	8am until 12pm and 3pm until 6pm
Thursday	8am until 12pm and 3pm until 6pm

Friday	8am until 12pm and 3pm until 6pm
	Extended access appointments are available every Wednesday 6.30pm until 8pm at other sites locally.

Older people

Population group rating: Requires Improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Appointments were available for school age children so that they did not need to miss school.
- We found there were 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were available to all patients at additional locations within the area, every Wednesday 6.30pm-8pm.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- Priority appointments could be allocated when necessary to those experiencing poor mental health.
- Staff interviewed had an understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y

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)	75.8%	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)	63.6%	58.2%	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)	67.8%	58.9%	63.0%	No statistical variation
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)	59.7%	65.4%	72.7%	No statistical variation

Source	Feedback
NHS UK Website	Feedback on NHS UK Website reported that appointments were easy to obtain.
Google Reviews	Whilst some patients reported they were able to access appointments; others had reported they had struggled with obtaining an appointment.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>CQC had received a number of complaints from patients who told us that they had put in formal complaints to the practice on more than one occasion and were told this had not been received. During our inspection the practice had told us they had received three complaints in the last 12 months, however we found that a further formal complaint involving the information commissioner's office (ICO) had not been shared with CQC and therefore we were not assured that the practice were being open and accurate with their complaints process. We reviewed the complaints policy and found this needed embedding further. For example, the practice outlined that complaints would be handled in a timely manner and reviewed as a practice to learn and drive improvements, however only one practice meeting had taken place in the past 12 months where one complaint had been discussed.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained that medicine was delivered to the patient instead of the carer.	Practice reviewed patient alert on record, reviewed it further with the prescription ordering service (POD) to ensure information contained was correct. Reassured patients carer of the steps taken.

Well-led

Rating: Inadequate

At our previous inspection in December 2019 we rated the practice as good for well-led service.

At this inspection we have rated the practice as inadequate for well-led services because:

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

Leadership capacity and capability

Leaders could not always 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- At the time of our inspection there were constraints in the leadership of the practice. The principal GP was unable to carry out clinical duties in the practice but had retained managerial responsibility. This meant that the practice relied on long term locums in all aspects of clinical care.
- Leaders understood the challenges to quality and sustainability and despite these constraints were working to support the delivery of the service. Consideration had been given to the locum arrangements in the absence of the clinical lead as part of succession planning.

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Vision and strategy

The practice had a vision and strategy, but this did not always provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice aimed to provide a traditional family general practice which focused on personalised continuous care and had an emphasis on building relationships with the patients. Whilst some staff understood this vision, other staff were not aware of this.• The practice was trying to maintain the continuity of care through the use of long-term locums and had experienced difficulties in the recruitment of a permanent practice nurse. The practice told us that through an unsettling period of time they had accessed support locally from a neighbouring practice and were continuing to provide continuity of care for their patients.• We found that that the practice were continuing to provide continuity of care through the use of long-term locums and this was being reviewed by the management team to ensure services were meeting the clinical needs of the practice population.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff we spoke to were not aware of the freedom to speak up guardian in the practice but told us they could go to the practice manager or GPs to discuss their concerns. • The practice had policies and procedures in place to ensure compliance with the duty of candor, however they needed to improve how they captured and dealt with complaints in order to respond appropriately and share learning to seek improvement. • There was limited evidence of a systematic approach to staff meetings. We saw evidence that one practice meeting had taken place in the last 12 months and were not assured that learning from safety incidents, complaints and safeguarding concerns were regularly shared with practice staff. 	

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

Source	Feedback
Practice staff	Staff told us they felt safe working at the practice and were able to raise issues or concerns.

Governance arrangements

There were not always clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Although the practice held a range of governance systems in place which were regularly reviewed, we found they were not always effective. For example, we found that the system for carrying out monthly searches for high-risk medicines found gaps in the monitoring of patients. After the inspection, the practice sent us an action plan of the steps they would take to review and embed a new system to ensure high risk medicines were monitored safely. There was a lack of oversight for clinicians. For example, there was no active supervision, peer reviews or clinical meetings to ensure all were working to an appropriate standard. We found that leaders were not aware of the system failure in the monitoring of some patients on high risk medicines, and there was a lack of process and assurance through effective governance systems to identify these risks. Leaders informed us that processes had been reviewed immediately after the inspection, which were intended to improve the monitoring of high-risk medicines. The practice could not assure us there were effective processes in place to ensure clinical staff were assessed for their competencies. Clinical supervision or clinical meetings were not in place at the practice at the time of our inspection. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	

- We found that some of the systems in place were putting patients at risk and the practice was unable to demonstrate areas of effective clinical leadership and oversight of patient care to effectively manage the practice and oversee all clinical areas of the practice adequately.
- The practice was unable to demonstrate they had processes to manage current and future performance. For example, performance of employed clinical staff could not be demonstrated through audit of their consultations or clinical supervision.
- The risks in relation to medicines management and identifying patients had not been identified by the provider's own governance systems.
- During our inspection, the practice took appropriate action to address areas of concern found in relation to high risk medicines and governance processes in place.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

Appropriate and accurate information

There was a demonstrated commitment to using data and information, however the practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial

Performance information was used to hold staff and management to account.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Due to the lack of permanent clinical leadership, performance was not monitored effectively to ensure patients were receiving the appropriate care. Although the practice carried out a range of clinical audits, we were not assured that clinical staff who were employed as locums were provided with clinical oversight or had reviews of their consultations. 	

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw some evidence that the practice had reviewed feedback with staff and used this to drive improvement in relation to patient satisfaction outcomes. There was limited engagement with external stakeholders, for example the practice had opted out of a primary care network (PCN), however still had access to services locally as part of this arrangement. There was no active patient participation group and this had remained inactive since our last inspection in December 2019. The practice told us this had not been prioritised due to the COVID-19 pandemic. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a programme of clinical audits, however due to the lack of clinical and practice meetings during the past 12 months, we were not assured that this was being used to drive continuous learning and development. 	

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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.