

# Care Quality Commission

## Inspection Evidence Table

### Drs Eno and Partners (1-572356028)

Inspection dates: 29 June to 4 July 2022

Date of data download: 30 June 2022

## Overall rating: Inadequate

At our previous inspection we rated the practice as inadequate overall because:

- The practice did not have sufficient systems and procedures to keep people safe;
- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools;
- The practice was not always responsive and patient feedback was not always positive;
- Leaders did not have the capacity or skills to deliver high quality, sustainable care.

At this inspection we have rated the practice as inadequate overall because we found the same concerns.

## Safe

## Rating: Inadequate

At our previous inspection we rated the practice as inadequate for safe. At this inspection we have rated the practice as Inadequate for safe because:

- Clinicians were not trained to the appropriate levels in child and adult safeguarding.
- Clinical searches identified patients at risk of harm on high-risk medicines due to a lack of monitoring.
- There were gaps in recruitment and induction checks.
- The provider had carried out an infection prevention and control audit, but it was not effective.
- Not all staff had completed infection prevention and control training.
- Arrangements for managing waste did not keep people safe.
- There was an internal system for significant events, but it was not effective.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial1
Partners and staff were trained to appropriate levels for their role.	N

Safeguarding	Y/N/Partial
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.	Partial2
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there were no updated safeguarding policies, many staff had not completed training at the required levels and safeguarding registers were not being routinely monitored or reviewed.</p> <p>At this inspection, we found:</p> <p>The practice had created risk registers for children and adults which included the names of relevant patients. The practice had also updated its safeguarding policy in January 2022 to include details of the local safeguarding contacts and explain the practice staff responsibilities.</p> <p>Partial1 – Although the safeguarding policy had been updated and tailored to the practice, the safeguarding lead’s name was not included in the policy and the policy was not being followed by the practice. The policy required that all staff were trained to appropriate levels of safeguarding and the practice could not provide evidence to demonstrate this for all staff. The child safeguarding policy also required that meetings were held every six weeks, however the practice could only provide minutes of one meeting since October 2021 in January 2022 with a health visitor. There was still no register for patients at risk of female genital mutilation.</p> <p>N – The practice provided a staff training matrix which showed that only one staff member had completed safeguarding training. After the inspection the practice provided some other staff members certificates. There was no evidence that the majority of staff members had completed safeguarding training.</p> <p>Partial2 – One nurse and one manager did not have evidence of DBS checks in their recruitment files.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N1
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N2
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that recruitment checks were missing documents including; CVs, references, Disclosure and Barring Service (DBS) checks, proof of current clinical registration and identity verification. We also saw no evidence that staff vaccinations were maintained in line with current</p>	

Public Health England (PHE) guidance if relevant to role, and staff we spoke to told us that they had not had any vaccinations and this had not been asked for or discussed with management.

N1 and N2 - At this inspection we found the same problems and concerns. We reviewed seven staff files and found that six of them were missing required checks or evidence of the checks. There was insufficient evidence of staff vaccinations provided. The practice only had evidence that five staff were immune to Hepatitis B. There was no evidence to show that staff had received vaccines for tetanus, polio, diphtheria or MMR. As recommended in the green book by the UK Health Security Agency.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14/4/22	Y
There was a fire procedure. Date of fire risk assessment: 22/2/22	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At the last inspection we found that there had been no health and safety assessments or fire risk assessments.  At this inspection, both assessments had been completed.	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N1
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 8/6/22	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	N2
Explanation of any answers and additional evidence: At the last inspection we found that not all staff had completed infection control training. We also found that the last audit had been completed in 2019 and in clinical rooms we saw sharps bins not fixed to walls, undated, unsigned and overflowing.  At this inspection we found that a new audit had been completed in June 2022.  N1 – We did not see evidence that all staff had completed infection control training.	

Partial – Although the audit had been completed, we found a sharps bin that was unsigned and undated. We also found an undated clinical curtain. In one consultation room we found multiple expired clinical items. For example we found needles that had expired in 2021. The infection control audit was therefore not sufficiently effective to ensure safety and compliance. We were also told that the practice had been aware of the risks of having carpets in consultation rooms and taps that were not compliant since 2017. Yet the practice had failed to address these risks throughout this time and since the last inspection in October 2021. The practice was unable to provide the inspection team with any completed and tailored COVID policies or risk assessments on the day of the inspection.

N2 – There was no formal process for managing clinical waste. Staff were unable to give inspectors records, checks, audits or policies which explained how, when or why the practice disposed of its clinical waste. Staff explained that reception staff were expected to throw clinical waste out into the clinical waste room but there was no evidence as to who's specific duty or responsibility this was. Some staff told us that they did not know who was supposed to do this. There were no policies or protocols for clinical waste in place. The clinical waste room held a pile of full bin bags which had been put on top of each other to a height of approximately 1.8 metres. We saw clinical waste inside of some of these translucent bags. There was no visible waste classification, category or coding in place to segregate general, clinical or other waste being disposed of. This posed a risk to staff and visitors of the practice and did not comply with National Standards of Healthcare Cleanliness 2021.

## 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.	Partial1
There was an effective induction system for temporary staff tailored to their role.	N1
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial2
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	N2
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there was insufficient evidence of induction checklists being completed for new staff and staff had not completed sepsis training. Staff told us that there were not enough staff throughout the practice.</p> <p>At this inspection we found:</p> <p>N1 – There was still insufficient evidence of induction checklists being completed for new staff.</p> <p>Partial1 – Not all staff had completed sepsis training.</p> <p>Partial 2 and N2 – All staff we spoke to told us that there were not enough doctors, nurses, receptionists, administrators or managers. Due to this staff felt stressed working at the practice. At the last inspection</p>	

there had been 33 staff members. At this inspection there were 23 staff members. Staff told us that they regularly had to work excessive hours due to shortages on a weekly basis.

### 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.	N1
There was a system for processing information relating to new patients including the summarising of new patient notes.	N2
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.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that referrals were not always safety netted and there had been delays for patients who were waiting for two week wait referrals.</p> <p>At this inspection we found that referrals were being managed safely and audited to review their success or failure.</p> <p>N1 – Many patient records were not up to date with clinical data or test results from secondary care. We found over 30 patients who did not have up to date clinical records which reflected their most recent clinical monitoring. For example, we found that four patients prescribed potassium sparing diuretics had not had or had not been recorded as having had the required monitoring which put patients at risk of harm. The clinical management team accepted that some patients had had monitoring completed but that they had not recorded this information on all clinical records.</p> <p>N2 – There was no system for summarising new patient notes. The management team told us that there should be a system and that due to staff shortages and resignations this system had ended.</p>	

## Appropriate and safe use of medicines

### The practice did not have effective 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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.75	0.66	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	13.8%	9.2%	8.8%	Variation (negative)
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 (01/10/2021 to 31/03/2022) (NHSBSA)	8.56	5.45	5.29	Significant Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	81.1‰	60.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.65	0.55	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.6‰	4.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N1

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/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N2
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.	N3
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).	N4
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found:</p> <ul style="list-style-type: none"> <li>- Prescription stationary was not being sufficiently stored, recorded and monitored.</li> <li>- Some patients on high risk medicines were not being safely monitored or their clinical records were not being completed to ensure clear records of monitoring were evident.</li> <li>- Some patients with long-term conditions were not being monitored or their clinical records were not being completed to ensure clear records of monitoring were evident.</li> <li>- Some recommended emergency medicines were not stocked by the practice.</li> <li>- One defibrillator was not working and had expired pads.</li> </ul> <p>At this inspection we found:</p> <p>A new prescription stationary process was implemented in May 22. Prescription stationary was stored securely and recorded with a safe system which was clearly being followed. All recommended emergency medicines were stocked by the practice. The defibrillator was working and had pads that were in date.</p>	

A clinical search of patients with Chronic Kidney Disease showed that 12 patients required monitoring. We reviewed five patient records out of the 12 and found that none of the patients were at risk of harm.

N1 – We saw that one nurse had been administering vaccines since 13 April 2022 such as Shingrix, Pnuemococcal and Zostavax. However, the PGDs for Shringrix and Zostavax were only signed on 4 May 2022 and there was no PGD for Pnuemococcal. Therefore, the nurse had been unlawfully administering vaccines without proper authority or due process.

N2, N3, N4 and Partial – We carried out 14 clinical searches of patients on high risk medicines or with long-term conditions being treated at this practice. Twelve of those searches showed patients were not being monitored, their clinical records were not being updated or their prescriptions were being issued without sufficient review or safe monitoring.

For example:

Searches indicated that 12 patients had been issued more than 12 SABA (Short-Acting Beta-Agonist) inhalers in the last 12 months. We reviewed five of these records and identified that none of the records provided sufficient information in their medication reviews. It was not clear if any changes were required and if these were subsequently actioned; if the patient was complying with the medicine regime or if the patient was experiencing any problems or adverse side effects; and there was no information available for another clinician providing care for the patient. This evidence demonstrated that the practice did not have systems in place to effectively manage patients who are over-prescribed inhalers, which put patients at risk of harm.

A clinical search of patients prescribed Warfarin showed that 8 out of 20 patients had not had sufficient monitoring. We reviewed 5 patient records and identified 2 who were at risk of harm. The practice provided evidence to show that one of the patients was monitored in secondary care. Yet the EMIS records did not include this information and there was no evidence of a date as to when the practice had reviewed test results about these patients.

A clinical search of patients prescribed Methotrexate showed that 8 out of 16 had not had sufficient monitoring. We reviewed 5 patient records and identified 2 who were at risk of harm. The practice provided evidence to show that one of the patients had had monitoring in secondary care. Yet the EMIS records did not include this information and the practice only obtained it either once the issue was alerted to them by the inspector or it was undated as to when the practice had reviewed it.

A clinical search of patients prescribed Azathioprine showed that 5 out of 11 patients had not had sufficient monitoring. We reviewed 5 patient records and identified 2 who were at risk of harm. The practice provided evidence to show that the one of the patients was monitored in secondary care. Yet the EMIS records did not include this information and there was no evidence of a date as to when the practice had reviewed test results about these patients.



## Track record on safety and lessons learned and improvements made

**The practice did not have an effective 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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial1
There was a system for recording and acting on significant events.	Partial2
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial3
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>At the last inspection we found the practice did not have a significant events policy, no system for recording significant events or communicating the outcomes or lessons learned to all staff. We also found that staff were not aware of how to raise concerns or knew what learning outcomes had been implemented.</p> <p>At this inspection we found that the practice had implemented a significant events policy and had held a meeting on 19 May 2022 to record, analyse and resolve four significant events from November 2021 through to May 2022.</p> <p>Partial1, 2 and 3 – Although there was a policy for significant events, there were no written forms or root cause analysis records for staff to complete for any relevant events. The practice relied solely upon the one meeting that took place in May 2022 to record, analyse and resolve all of the events discussed. The practice immediately created templates and completed them on the day of the inspection to ensure adequate monitoring of the significant events. However, this approach was not sufficiently detailed or managed to ensure that this system was effective.</p> <p>For example, one significant event dated 5/11/21 was allegedly reported on 24/1/22 yet there was no record to evidence this. The event concerned wrong test results being recorded for a patient. The action plan stated that the pathology manager would chase up the event for an explanation. The outcome stated that this was pending. That meant that after nearly eight months, no resolution or explanation had been found and no learning or improvements had been recorded as being implemented.</p> <p>In another significant event dated 12/4/22, there was a needle injury of a patient holding another patient. The significant event discussion suggested that the clinician continued to use the same needle to give a vaccination. There was no clear realisation or analysis of the risk of cross contamination between the patients and it seemed as though the clinician had continued to use the same needle to administer the vaccination after the injury had occurred.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Patient samples were lost	A spreadsheet was implemented to ensure reception maintain a list of all patient samples and can monitor their progress

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N1
Staff understood how to deal with alerts.	N2
<p>Explanation of any answers and additional evidence:</p> <p>N1 and N2 – We asked staff for information about what system or process was in place to ensure MHRA alerts were disseminated amongst clinical staff and how the patient list was routinely reviewed to ensure safety. The clinician in charge of this area was unable to describe or demonstrate a system which ensured all staff were aware of MHRA alerts and that all patients were routinely reviewed for risks. The MHRA policy did not set out a process to ensure these actions were carried out and there was evidence that some MHRA alerts had not been actioned or considered. This put patients at risk of significant harm.</p>	

## Effective

## Rating: Inadequate

At our previous inspection we rated the practice as requires improvement for effective. At this inspection the rating has changed to inadequate because we found the same concerns were present and after nine months the practice had failed to resolve them. The concerns are summarised below.

We have rated the practice as inadequate for providing effective services because:

- Systems and processes in place were not always effective in monitoring patients' health in relation to long-term conditions.
- Patients' treatment was not regularly reviewed and updated.
- We identified gaps in staff recruitment and the induction process for new staff, as well as gaps in staff training.
- Audits were not being effectively used to drive improvements or to identify where things needed to improve.
- The practice was not always compliant with legislation regarding do not attempt cardiovascular resuscitation forms and mental capacity assessments.

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

	Y/N/Partial
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.	Partial2
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.	Partial3
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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Partial4
Explanation of any answers and additional evidence:	

At the last inspection we found that monitoring systems were not being reviewed and updated to ensure all patients were captured in the monitoring process. We also found that systems in place to monitor patient referrals did not include all patients that had been referred.

At this inspection we found that monitoring systems were still not being reviewed or updated to ensure all patients were monitored effectively. There was now a system to check and review referrals so that patients were safety netted. We also found that although some patients had received monitoring for long-term conditions, others had not.

For example:

Partial 2, 3 and 4 - A clinical search of patients with Asthma showed that 33 out of 396 patients had not had sufficient monitoring. We reviewed 5 patient records and identified 2 who were at risk of harm. The practice accepted that further work was needed to ensure these patients were safe. They did not have steroid cards, follow up appointments or reviews.

A clinical search of patients with Hypothyroidism showed that 16 out of 254 patients had not had sufficient monitoring. We reviewed 5 patient records and identified 3 who were at risk of harm. The practice accepted that further work was needed to ensure these patients were safe. They did not have steroid cards, follow up appointments or reviews.

## Effective care for the practice population

### Findings

- 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.
- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check.
- End of life care was not always delivered in a coordinated way which considered 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.

## Management of people with long term conditions

### Findings

- Missed diagnosis: We identified some patients as having a potential missed diagnosis of diabetes as they had not been correctly coded and therefore were not receiving the necessary medication to treat their condition. We reviewed five patient records and found that three of those patients should have been coded as being diabetic.
- We identified some patients with hypothyroidism or asthma who had not been sufficiently reviewed or monitored to ensure their safety.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

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)	43	48	89.6%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	50	64	78.1%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	50	64	78.1%	Below 80% uptake
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	64	79.7%	Below 80% uptake
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	54	75.9%	Below 80% uptake

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

Cancer Indicators	Practice	CCG 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: 31/12/2021) (UK Health and Security Agency)	59.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.5%	52.3%	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)	65.1%	63.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	35.5%	52.8%	55.4%	No statistical variation

## Monitoring care and treatment

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

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

The practice had completed an audit of all patients with two-week referrals which considered whether the referrals had been made within sufficient time. Where it had been noted that patients had not had their referrals completed in sufficient time, the reasons, dates and analysis for this could be discussed. However, out of all seven failures being analysed, only one had been completed throughout the audit. There was also no overall analysis, conclusion or action taken to implement changes or improvements in reaction to the findings of the audit.

### Any additional evidence or comments

N – Clinicians were unable to provide any evidence of national or local quality improvement initiatives.

Partial – The referral audit discussed above was the only clinical audit completed at this practice. There was no other evidence of targeted quality improvement programmes.

### 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.	N1
The practice had a programme of learning and development.	Partial1
Staff had protected time for learning and development.	N2
There was an induction programme for new staff.	N3
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.	N4
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N5
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial3
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that not all staff had completed recommended training and staff were not aware of what training was recommended. There was also no oversight of training or competency. There were insufficient appraisals, inductions and training management.</p> <p>At this inspection we found the same concerns and issues were present.</p> <p>N1, Partial1 and N2 – The practice staff did not know how to use their training system to enable management of it. The system showed that the majority of staff had not completed recommended training such as fire safety, infection control, safeguarding, basic life support, health and safety or equality and diversity. The practice staff were not aware of what training was recommended and there was no evidence of there being a programme to ensure learning and development. There was no evidence of protected time for training.</p> <p>N3 – There was no evidence of an induction for new staff and staff told us that they had had insufficient training, support and guidance from management since they started at the practice.</p>	

N4 – We saw one appraisal had been completed for one member of staff. Staff told us there was insufficient coaching, one to ones and mentoring at the practice.

N5 – We saw no evidence of staff competency checks being completed.

Partial 3 – Some staff had been dismissed due to lateness or not turning up to work. However, during the inspection it became clear that some staff members did not know how to carry out their responsibilities and the management team were unable to proffer any plans to resolve these concerns.

### Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	

### 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.	Partial1
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.	Partial2
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: Partial 1 and 2 – Searches indicated that 10 patients potentially had a missed diagnosis of diabetes. We checked five of these records and found that three of them were at risk of harm. None of these patients had had annual reviews, eye screening referrals or records to show that their diagnosis had been discussed with them.	



## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	N1
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	N2
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N3
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that the practice had failed to always record a review date of a DNACPR or a decision of mental capacity.</p> <p>N1, 2 and 3 – At this inspection we found the same concerns. The practice management team told us that nothing had been done regarding DNACPRs since the last inspection. We reviewed one patient with a DNACPR in place who also lacked capacity. There was no record of a mental capacity assessment and the practice were unable to provide one following the inspection. One clinician we spoke to was unable to refer to the mental capacity statutory principles and did not demonstrate any knowledge of the best interests consideration and process.</p>	

## Caring

## Rating: Requires Improvement

At the previous inspection the practice was rated good for caring. At this inspection we rated the practice as requires improvement in caring because:

- Reception staff were sometimes abrupt with patients on the telephone.
- Patients gave us negative feedback about staff attitudes.
- Patients did not always have confidentiality at reception.

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:  At the last inspection we found that patients were complaining about some staff being rude, disorganised and inefficient. We were also told that staff could be rude with patients because of the stress and pressures of the practice and the number of appointments available.  Partial – At this inspection we found the same concerns were still apparent. We over-heard staff being abrupt and rude with patients on the phone. One staff member repeatedly told a patient to stop talking because they needed to end the phone conversation and get on with their work.	

Patient feedback	
Source	Feedback
Patient at Practice	One patient told us that they waited for up to an hour to get through to the practice and that some reception staff were rude and unfriendly.
Patient at Practice	One patient told us that reception staff could be very loud and shout out confidential information at reception and they became irritated if patients asked too many questions.

## National GP Patient 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 (01/01/2021 to 31/03/2021)	89.4%	90.1%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	86.3%	88.5%	88.4%	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 (01/01/2021 to 31/03/2021)	94.1%	96.0%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	83.4%	85.2%	83.0%	No statistical variation

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

Any additional evidence
The practice was receiving feedback via text messages but there was no staff member monitoring, analysing or using this information.

## 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:	

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	93.1%	93.2%	92.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	1% (80 carers identified).
How the practice supported carers (including young carers).	Information available on the practice website.

How the practice supported recently bereaved patients.	Information available on the practice website on what to do in times of bereavement. No signposting or support information available.
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## Privacy and dignity

### The practice did not always 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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that confidentiality was not always possible at reception due to the size of the room.</p> <p>N – At this inspection we found the same problem with reception and patients also told us that sometimes reception staff spoke very loudly to patients about their confidential information. Patients told us that this wasn't nice for them.</p>	

## Responsive

## Rating: Inadequate

At our previous inspection we rated the practice as requires improvement for responsive. At this inspection the rating has changed to inadequate because we found the same concerns were present and after nine months the practice had failed to resolve them. The concerns are summarised below.

We have rated the practice as inadequate for responsive because:

- The complaints log lacked detail and had failed to capture all complaints.
- There was no evidence of learning from complaints, or that they were used to drive quality improvement at the practice.
- Patients were not able to access care and treatment in a timely way; feedback included patients were not satisfied with both the appointments they were offered and the appointment times they received.

### Responding to and meeting people's needs

#### Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N1
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.	N2
The practice made reasonable adjustments when patients found it hard to access services.	N3
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that feedback showed patients were unhappy with the amount of time it takes to access the practice via the phone line and the number of appointments available.</p> <p>At this inspection we found the same concerns were still present.</p> <p>N1 and N3 – The practice had been aware that its phone line was presenting an obstacle to patients and staff in arranging access for its patients for over a year. The practice increased its number of phone lines in September 2021, but this had failed to resolve the problem. Patients and staff told us that the phone line was faulty and prevented patients from accessing the practice and having their needs met.</p> <p>N2 – At the last inspection we found that the reception area was too small to ensure patient confidentiality. We found the same problem at this inspection and patients also told us that this had caused them concerns with their confidential information. The practice had failed to resolve this issue for its patient list.</p>	

Practice Opening Times		
Day	Time	
Opening times:		
Monday	08:30 - 20:00	
Tuesday	08:30 - 19:00	
Wednesday	08:30 - 20:00	
Thursday	08:30 - 20:00	
Friday	08:30 - 19:00	
Appointments available:		
Monday	<u>GP appointments</u> 9.00am-12.00pm 8.30am-11.30am 4.20pm-6.00pm	<u>Nurse appointments</u> 8.45am-12.00pm 3.30pm-5.45pm
Tuesday	<u>GP appointments</u> 9.00am-12.00pm 8.30am-11.30am 4.20pm-6.00pm	<u>Nurse appointments</u> 8.40am-12.00pm 3.30pm-4.00pm
Wednesday	<u>GP appointments</u> 9.00am-12.00pm 8.30am-11.30am 4.20pm-6.00pm	<u>Nurse appointments</u> 8.40am-12.00pm 3.30pm-5.45pm
Thursday	<u>GP appointments</u> 9.00am-12.00pm 8.30am-11.30am 4.20pm-6.00pm	<u>Nurse appointments</u> 8.45am-12.00pm 3.30pm-4.00pm
Friday	<u>GP appointments</u> 9.00am-12.00pm 8.30am-11.30am 4.20pm-6.00pm	<u>Nurse appointments</u> 8.40am-12.00pm 3.45pm-4.30pm

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

- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offered late evening clinics on Mondays, Wednesday and Thursdays.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

## Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	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	N1
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	N2
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that patients were unhappy with their access to the practice.</p> <p>At this inspection we found the same problems with access still existed and nothing had been done to address them since the last inspection.</p> <p>N1 and 2 – Staff told us that due to a number of internal and external complaints about the phone system, a meeting was held with the phone company in September 2021 to address the issues. Patients had been complaining that it was very difficult to get through to reception, they sometimes waiting up to an hour and they were consistently informed that they were only number two or one in a queue. Following the meeting additional lines were added to the system to increase its available volume. The previous inspection took place one month after that meeting in October 2021, but inspectors still found that the practice had poor access, a faulty telephone system and multiple complaints about reception staff. A patient participation group meeting took place on 20 April 2022 where patients commented on poor access to the practice due to the phone system and negative interactions with reception staff. At this inspection, we found multiple written complaints and were told by staff and patients about the same concerns and problems still being experienced by patients. The practice failed to resolve the phone system issue throughout a period of 10 months throughout which it was repeatedly told about the problems by staff, patients, CQC and other stakeholders. We were not assured that the practice was assessing, monitoring or improving the quality and safety of the service.</p>	



## National GP Patient Survey results

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 (01/01/2021 to 31/03/2021)	47.4%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	59.9%	74.7%	70.6%	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 (01/01/2021 to 31/03/2021)	52.1%	71.3%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	68.2%	82.1%	81.7%	Tending towards variation (negative)

Source	Feedback
CQC feedback	All of the feedback received was negative. The two patient's comments related to excessive waiting times in getting through to the practice over the phone and patients not receiving the care or treatment they asked for.

## 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.	22
Number of complaints we examined.	22
Number of complaints we examined that were satisfactorily handled in a timely way.	7
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	N1
There was evidence that complaints were used to drive continuous improvement.	N2
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that:</p> <ul style="list-style-type: none"> <li>- Not all complaints were recorded or responded to.</li> <li>- Staff were not aware of complaint outcomes or improvements made in reaction to them.</li> <li>- The website did not have sufficient information about how to complain or escalate a complaint if a patient was not happy with the outcome.</li> </ul> <p>At this inspection we found the same concerns and issues existed.</p> <p>N1 – The practice website still did not have sufficient information about how to complain or escalate a complaint if a patient was not happy with the outcome.</p> <p>N2 – We saw now evidence that complaints were used for improvements. Four complaints specifically mentioned the phone line since October 2021, and nothing had been done to address this. Two complaint responses, concerning reception staff being described as rude, alleged that staff had been enrolled in compassionate and/or handling difficult situations training courses as a result of the complaints. We saw no evidence that all reception or phone staff had attended, completed or discussed these training courses.</p>	

Examples of learning from complaints.

Complaint	Specific action taken
The phone lines do not work and can make patients wait over an hour	No specific action was taken
Reception staff were rude	No specific action was taken

## Well-led

## Rating: Inadequate

At our previous inspection we rated the practice as inadequate for well-led. At this inspection we have rated the practice as Inadequate for well-led because:

- The management team were disorganised, and roles/responsibilities were unclear.
- The management team had failed to resolve and/or address many of the governance issues found at the previous inspection.
- Staff turnover was high, and moral was low.
- We found patients at risk of harm due to lack of monitoring and clinical governance or oversight.
- There was a lack of oversight and supervision of staff.
- The practice had failed to improve in response to complaints and feedback from staff and patients.
- The practice had no formal auditing cycle or programme of improvement.
- There was no evidence the practice's performance was being discussed between staff and management.

### 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.	N1
They had identified the actions necessary to address these challenges.	N2
Staff reported that leaders were visible and approachable.	N3
There was a leadership development programme, including a succession plan.	N4
Explanation of any answers and additional evidence:  At the last inspection we found that patients and staff were unhappy about access to appointments and access to the practice through the phone system. Staff told us that leaders were not approachable, and staff did not feel comfortable giving feedback. We saw no evidence of a leadership development programme or succession plan.  At this inspection we found the same concerns were still present and had not been resolved.  N1 – The leadership team had nine months to address the concerns found at the last inspection which were communicated to them on the day and in feedback. Given the various concerns found at this inspection it was clear that leaders did not understand the challenges to quality and sustainability. Although some concerns had been addressed such as prescription stationery and infection control audits, these two concerns had only been addressed in May and June 2022 which was eight and nine months after the last inspection. We found that concerns in safeguarding, infection control, staff training, recruitment records, medicines management and significant events were still unresolved after nine months.	

From October 2021 to June 2022 the practice had lost 14 staff members and had 10 less staff in total that it had had at the last inspection. The practice had lost reception staff, administrators, doctors, nurses and health care assistants. We were told by staff that some staff had left because of the negative culture and poor management. Other staff told us that the work was too stressful, and they were unsupported by management. The management team had no credible plan to address the staffing crisis and told us that they were surprised about the comments and negative feedback from staff. This indicated that the leaders did not understand the situation or the challenges they faced.

N2 – As stated above, the leaders had failed to resolve many concerns found at the last inspection because they had not managed to identify the actions required to address the concerns. Staff and patients were still reporting that access was a problem because of the phone system. After nine months the practice had failed to resolve this issue.

N3 – Staff told us that leaders were not approachable. Staff told us that some leaders were condescending and uncommunicative. Staff told us that they did not feel included or supported.

N4 – We did not see evidence of a leadership programme or succession plan.

## Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N1
Staff knew and understood the vision, values and strategy and their role in achieving them.	N2
Progress against delivery of the strategy was monitored.	N3

Explanation of any answers and additional evidence:

At the last inspection we found that staff had not been involved in developing, and did not know of, the vision, values and strategy. We also found that progress against delivery of the strategy was not monitored.

At this inspection we found the same problems.

N1 and 2 – Staff told us that there were not involved in the vision, values and strategy. There had been one all staff meeting since the last inspection and only 60% of staff had attended it. The meeting was not minuted and not communicated to all staff. Leaders were still described as unapproachable and unsupportive. Overall, there did not appear to be a strategy or vision for the practice as a whole. Since the last inspection very little had been improved and/or resolved. The practice did have minutes of regular partner meetings being held but only the four partners and one manager attended these meetings.

N3 – There was no evidence of progress being monitored against any strategies at the practice.

## 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.	N1
Staff reported that they felt able to raise concerns without fear of retribution.	N2
There was a strong emphasis on the safety and well-being of staff.	N3
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	N4
The practice encouraged candour, openness and honesty.	N5
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	N6

#### Explanation of any answers and additional evidence:

At the last inspection we found that:

- Staff performance reviews were inappropriate and unprofessional.
- Staff did not feel able to raise concerns without fear of retribution.
- Staff were not being cared for or supported.
- Patients complaints were not always responded to.
- The majority of staff had not completed equality and diversity training.

At this inspection we found the same concerns were still apparent.

N1 – The reviews were not done routinely, and staff were being reviewed once it had already been decided that their performance was poor.

N2 – Staff reported that they did not feel able to raise concerns without fear of retribution and were nervous to approach certain leaders in the practice due to their personalities and attitudes. We saw an email sent to all staff by the management team which blamed all staff for the negative CQC inspection findings and directly informed staff that due to their comments to CQC inspectors and alleged failings their jobs were now at stake and could be terminated within four weeks. This email was evidence of the negative culture at this practice.

N3 – Since the last inspection the workforce had reduced from 33 staff down to 23. Staff told us they didn't like working there, they frequently had to work additional hours at last minute and they received no support when they received abuse from patients.

N4 – We found complaints that had not been responded to and we saw no evidence of alleged/recorded complaint responses that were supposed to have been completed by staff.

N5 – Inspectors found some staff members to be misleading and dishonest during the inspection. One staff member openly accused another staff member of lying about their involvement in a specific process. Another staff member attempted to mislead inspectors regarding clinical records and significant events.

N6 – We found that at least 12 staff members had not completed equality and diversity training.

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

Source	Feedback
Staff Feedback	<ul style="list-style-type: none"> <li>- Staff told us that they did not feel supported by team leaders or management and that they did not feel they were provided with enough guidance, written procedures and/or policies to perform their role.</li> <li>- Staff told us that there was high tension between staff and staff were not always in agreement on the best way to deliver good quality patient care.</li> <li>- Staff felt that there were not enough GP's, nor enough GP appointments available to provide effective, good quality care to patients.</li> </ul>

#### Governance arrangements

#### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N1
Staff were clear about their roles and responsibilities.	N2
There were appropriate governance arrangements with third parties.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that:</p> <ul style="list-style-type: none"> <li>- Governance structures and systems were not regularly reviewed.</li> <li>- Staff were unclear about their roles and responsibilities.</li> <li>- There was insufficient safety netting for patients with third parties.</li> </ul> <p>At this inspection we found that the same concerns were still present at the practice.</p> <p>N1 – There was little evidence of governance at the practice. There were no governance audits of complaints, patient feedback, staff feedback, staff training, recruitment files, significant events, cleaning, waste disposal, high-risk medicines, long-term conditions, DNACPRs or safety alerts. Management staff did not know how to use all of the software being used by the practice to ensure compliance.</p> <p>N2 – Staff told us that they did not know what the internal structure or organisation of the practice was. During the inspection we frequently found areas of unknown responsibility amongst staff. No one could tell us or demonstrate with certainty who was responsible for new patient record summaries, staff recruitment files, COVID policies, minutes of staff meetings, clinical audit cycles, DNACPRs, cleaning, staff training, clinical waste management, staff inductions, patient feedback, staff feedback, learning and development. The management team consisted of one personnel manager, one assistant business manager and the registered manager. There were no meetings or records of meetings where this</p>	

management team discussed any strategies or goals for the practice. We were not assured that staff clearly understood or knew internal roles and responsibilities.

Partial – We found multiple patient records where insufficient monitoring had been recorded on their clinical records. The management team stated that this was a result of their monitoring in secondary care, but no records had been maintained on the clinical system to ensure patient safety and continuity of care.

### 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.	N1
There were processes to manage performance.	N2
There was a quality improvement programme in place.	N3
There were effective arrangements for identifying, managing and mitigating risks.	N4
A major incident plan was in place.	N5
Staff were trained in preparation for major incidents.	N6
When considering service developments or changes, the impact on quality and sustainability was assessed.	N7

#### Explanation of any answers and additional evidence:

At the last inspection we found that:

- Assurance systems had not ensured that processes were being reviewed or updated regularly and were operating as intended.
- There was a process to manage performance, but it focused largely on the negative areas of performance and little mention was made to positive performance or support that may be needed.
- We saw evidence that the practice had undertaken some audits, however, there was little evidence that these were used to make improvements.
- COVID policies had not been sufficiently completed and had not been signed or dated.
- Some staff reported that they had received Covid specific training but were unaware of having received major incident training.
- Service developments or changes were not implemented with the input of all staff and staff member's opinions were disregarded so the impact on quality and sustainability could not be effectively assessed.

At this inspection we found all the same concerns were present.

N1 – Following the last inspection which highlighted gaps in clinical monitoring of patients on specific medicines, the practice had failed to implement comprehensive assurance systems to address these risks. We found patients in nearly all clinical searches carried out who had not had sufficient monitoring and were at risk because of this.

N2 – Although the practice knew its phone line was faulty and caused problems for patients, nothing had been done to collect data or information about the phone system to enable improvements or changes to be made. The practice was not sufficiently monitoring or managing its performance.

N3 – There was one referrals audit which had considered all of the referrals with 2 week waits made at the practice in 2021 and 2022. However, there were gaps where the clinician had not completed the entire analysis of failures and there was no overall conclusion to enable improvements to be made. The clinician completed a conclusion of this audit after the inspection but was unable to identify any improvements made as a result of it.

N4 – The practice still had no specific COVID policies or protocols.

N5 – We saw no major incident plan in place.

N6 – Staff were not trained in how to manage major incidents.

N7 – In March 2022 a new process was set up regarding prescriptions. This process was in place for a month before one senior manager announced that there could be risks to patients in result of it. The impacts and quality of this process were not considered before it was implemented.

### 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.	N1
There were recovery plans in place to manage backlogs of activity and delays to treatment.	N2
Changes had been made to infection control arrangements to protect staff and patients using the service.	Partial
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there were minimal processes or practices to address COVID or increased infection control risks.</p> <p>At this inspection we found the same concerns.</p> <p>N1 – There were no audits or reviews of patient access at the practice even though this was a known issue. There were complaints from patients and staff about the phone line and lack of available</p>	



appointments. The practice had held a meeting with the patient participation group and received negative feedback about the telephone line and available appointments. In spite of this feedback, nothing had been done to improve access.

N2 – At the last inspection we found delays and gaps in patient monitoring such as high-risk medicines and some long-term conditions. Following that inspection, the practice had failed to implement an effective plan to manage delays and gaps in treatments/monitoring. At this inspection we found multiple examples of patients not having had sufficient monitoring.

Partial – Some changes had been made to the service such as general signage on the floor, plastic screens at reception and masks being worn by staff. However, there were no COVID risk assessments, policies or protocols which had been tailored or completed to ensure the service was safe.

## 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.	N1
Performance information was used to hold staff and management to account.	N2
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that little action had been taken to improve the data performance of the practice and staff had not all had appraisals or supervision.</p> <p>At this inspection we found that the same problems still existed.</p> <p>N1 – There was little to no evidence that data had been used to monitor or improve performance. The practice had access to patient feedback, staff feedback, clinical data and national data. Even with this information at hand the practice did not have a process or system to utilise it and improvements had not been made.</p> <p>N2 – We saw only one appraisal had been completed since the last inspection and there was no evidence of supervision. Some staff had supposedly been dismissed due to poor performance but there was no visible record of this process.</p>	

## 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
Explanation of any answers and additional evidence:	

### 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.	N1
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	N2
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that:</p> <ul style="list-style-type: none"> <li>- Patient feedback had not been used to improve services;</li> <li>- The practice did not have an active PPG</li> <li>- Staff views were not asked for or listened to</li> </ul> <p>At this inspection we found that the practice had held a PPG meeting in April 2022. Unfortunately, the feedback obtained in that meeting had not been acted upon by the practice.</p> <p>N1 – There were feedback text messages and complaints which all informed the practice of the views held by its patients. The reoccurring themes were that the telephone system didn't work well, there were not enough appointments and reception staff were sometimes rude and unhelpful. This same feedback was given to the practice by its PPG. Despite this feedback, the practice had failed to address these issues or resolve any of them.</p> <p>N2 – There were no processes or systems to obtain staff feedback and there was no evidence that any feedback had been acted upon. Staff told us that they were unhappy with the management culture, that</p>	

the telephone system caused problems, there weren't enough staff throughout the practice and that they didn't feel supported. The same concerns and problems were found at the previous inspection.

Feedback from Patient Participation Group.

### Feedback

At a meeting in April 2022 the group gave the following feedback:

- Making appointments is difficult.
- There have been a high number of referrals to A and E.
- There is a lack of continuity of care at the practice.
- Reception staff are sometimes lacking compassion and empathy.
- There have been many prescription delays.
- The phone system has issues.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N1
Learning was shared effectively and used to make improvements.	N2
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there was no managerial oversight regarding mandatory and regular training and there were large gaps in training across all levels of staff at the practice. Some staff told us that they were invited to meetings where learning was shared, and some staff told us that they were not invited to meetings and no learning was shared.</p> <p>At this inspection we found the same concerns.</p> <p>N1 – There was no managerial oversight regarding mandatory and regular training and there were large gaps in training across all levels of staff at the practice.</p> <p>N2 – Some staff told us that they were invited to meetings where learning was shared, and some staff told us that they were not invited to meetings and no learning was shared.</p>	

### Examples of continuous learning and improvement

None

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

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

## Glossary of terms used in the data.

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