

Care Quality Commission

Inspection Evidence Table

Dr Eno and Partners (1-572356028)

Inspection date: 13 October 2021

Date of data download: 04 October 2021

Overall rating: Inadequate

Safe

Rating: Inadequate

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

- There were gaps in recruitment and induction checks, including CVs, signed contracts, confidentiality agreements, references, Disclosure and Barring Service (DBS) checks, proof of current clinical registration, appraisals, identity verification and interview summaries.
- The health and safety policy was a generic template, which was not practice specific and had not been sufficiently completed, signed or dated.
- A health and safety risk assessment and fire risk assessment had not been carried out since 2018 and 2016 in order to identify and address actions to prevent potential risk.
- Safeguarding policies were not practice specific, incomplete and had not been reviewed and updated.
- Clinicians were not trained to the appropriate levels in child and adult safeguarding.
- The provider had not carried out infection prevention and control audits since 2019 or a Covid19 premises risk assessment.
- Not all staff had completed infection prevention and control training.
- We could not find evidence of Portable Appliance Testing (PAT).
- Arrangements for managing waste and clinical specimens did not keep people safe.
- There was no internal system in place for the recording of significant events and learning from significant events, if any, was not shared.
- Not all staff were invited to meetings where significant events were discussed.
- Clinical searches identified gaps in monitoring of patients with long-term conditions.
- We identified ineffective systems and processes in place with regards to patient referrals.

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.	Partial ¹
Partners and staff were trained to appropriate levels for their role.	Partial ²
There was active and appropriate engagement in local safeguarding processes.	Partial ³
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial ⁴
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial ⁵
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> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> - During the inspection we found that safeguarding policies had not been updated and were not practice specific. We reviewed a child safeguarding policy dated 2016 and an adults safeguarding policy dated 2018. 2. <ul style="list-style-type: none"> - At this inspection we found staff members were not working towards the appropriate competency as set out in the updated intercollegiate guidance 2019. - We saw very little evidence to assure us that safeguarding training had been completed at the relevant levels for both clinical and non-clinical staff. The provider informed us that they were not able to access the training records for staff and they were not able to show us evidence of completed safeguarding training for all staff. - We reviewed the safeguarding training records of two non-clinical staff and found that one member of staff had not completed the required level of adults safeguarding training. We reviewed the safeguarding training records of two clinical staff and found that both members of staff had not completed the required level of child or adults safeguarding training and they did not know what level they were expected to be trained to for their role. - We saw evidence that a clinical member of staff had completed child and adult safeguarding level two, however this training was not completed at the practice, but at another place of employment and not to the expected level of competency for their role. - We saw evidence that another clinical member of staff had completed adult safeguarding level three. - An additional two clinical members of staff told us that they had completed the relevant level of child and adult safeguarding training for their role, however we did not see evidence to support this. 3. <ul style="list-style-type: none"> - Evidence of discussions with the health visitor regarding at risk children was seen, however we found that required child safeguarding lists were not being updated. 4. <ul style="list-style-type: none"> - The practice did not keep a register of patients at risk of female genital mutilation (FGM). 	

Safeguarding	Y/N/Partial
<p>5.</p> <ul style="list-style-type: none"> We saw evidence of a current DBS certificate for one member of staff and the practice provided DBS certificate numbers or reference numbers for an additional 27 members of staff. <p>After the inspection the practice told us that there were seven staff members who did not have a current DBS check.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N ²
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> The practice did not have a recruitment policy in place, however during the inspection, the practice provided us with a recruitment and selection policy they had just created. This policy was not signed or dated by a member of staff. When reviewing staff folders, we could not be assured that recruitment checks were carried out in accordance with regulations as folders were missing documents including; CVs, references, Disclosure and Barring Service (DBS) checks, proof of current clinical registration and identity verification. <p>2.</p> <ul style="list-style-type: none"> We saw no evidence that staff vaccinations were maintained in line with current 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. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N ¹
Date of last assessment:	2018
There was a fire procedure.	Partial ²
Date of fire risk assessment:	2016
Actions from fire risk assessment were identified and completed.	N ³
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> We reviewed a health and safety risk assessment completed in 2018, where actions had been identified, but not all actions identified had evidence of being completed. Three out of 11 actions were signed as completed. <p>2.</p>	

- We saw evidence of a fire procedure; however, this was not practice specific and had not been dated.
 - Last fire procedure training for staff was completed in 2017.
- 3.
- The last fire risk assessment carried out at the practice was dated 2016.
 - We saw no evidence of Portable Appliance Testing (PAT).
 - There was no Control of Substances Hazardous to Health (COSHH) risk assessment in place.
 - We saw evidence of completed calibration testing, with no concerns identified.

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.	N ¹
Infection prevention and control audits were carried out.	N ²
Date of last infection prevention and control audit:	Sept 2019
The practice had acted on any issues identified in infection prevention and control audits.	N ²
The arrangements for managing waste and clinical specimens kept people safe.	N ³

Explanation of any answers and additional evidence:

- 1.
- Staff we spoke to told us they had not undertaken any recent infection prevention and control training.
 - Staff we spoke to told us they had not undertaken any Covid19 specific infection control training.
 - Staff we spoke to told us they did not know who the infection control lead was for the practice.
 - Training data provided by the practice listed infection prevention and control training as 'in progress' for 20 staff members, however there was no evidence seen to validate this.
- 2.
- The last infection prevention and control audit was carried out in 2019 so any risks that may have arisen since then had not been identified or acted on.
- 3.
- During the inspection, five out of eight clinical rooms were inspected, and the following was found:
- We observed a purple topped sharps bin (used for the disposal of cytotoxic medicines, which include hormones) in a clinical room that was overflowing with syringes. The sharps bin had a blank label with no signature or date written on it.
 - None of the sharps bins in the clinical rooms we viewed on inspection were fixed to the wall.
 - During the inspection we found visible amounts of dust in clinical rooms.
 - Medical waste was stored securely in a locked space outside of the practice; however, this space was overflowing with waste. Staff we spoke to told us they had not seen any clinical waste collection in recent months.

After the inspection, the practice told us that due to dissatisfaction with their current cleaning company, they had terminated their contract and appointed a new company to clean the practice due to start in late October.

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.	N ¹
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial ²
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
<p>Explanation of any answers and additional evidence:</p> <p>1.</p> <ul style="list-style-type: none"> - We saw evidence of an induction checklist template; however, we did not see a completed induction checklist when reviewing five staff folders. - We did not see an induction system for temporary staff tailored to their role. - One member of staff we spoke to told us that they had not undertaken chaperone training but had acted as a chaperone for the practice. <p>2.</p> <ul style="list-style-type: none"> - Staff we spoke to told us they had not undertaken sepsis training; however, they were aware of actions to take if they encountered a deteriorating or acutely unwell patient. - We saw evidence of posters detailing what to do if sepsis was suspected around the practice. 	

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.	Y
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.	N

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - The system in place to monitor delays in referrals was not always effective and we found that there was no safety netting system in place when reviewing two week wait referrals for patients with symptoms that may indicate they have cancer. - We reviewed the register for patients who had been given an urgent referral and found that two patients who had been given an urgent referral were missing from that register so systems in place to monitor referrals would not have picked up these patients if there was a delay or they did not attend their referral appointment. - Patients were not being consistently reminded to contact the practice if they had not had any communication regarding their referral within two weeks. - We reviewed a two week wait referral for a patient and found that this referral had not been actioned on two separate occasions increasing the risk to the patient and delaying the patient from receiving the treatment they may have needed in a timely manner. 	

Appropriate and safe use of medicines

The practice had some systems for the appropriate and safe use of medicines, including medicines optimisation, however there was no system in place for receiving, storing and monitoring the use of prescription stationary. Prescribing data showed the practice were above average when compared with local and national averages.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.68	0.58	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	15.0%	10.6%	10.0%	Tending towards 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	8.67	5.58	5.38	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
infection (01/01/2021 to 30/06/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	82.4‰	60.2‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.66	0.59	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	5.2‰	4.6‰	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.	N ¹
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
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.	Y
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 ²
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.	Partial ³
For remote or online prescribing there were effective protocols for verifying patient identity.	Y

Medicines management	Y/N/Partial
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial ⁴
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ⁵
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> <p>1.</p> <ul style="list-style-type: none"> - During the inspection, we found that NHS Counter Fraud Authority guidance was not being adhered to concerning blank prescriptions: - The practice did not have clear and unambiguous records of prescription stationery stock received. - The practice did not have clear arrangements for receiving prescription form stock. This should include a pre-determined date of arrival where possible, so a missed delivery can be followed up quickly within 6 working days from the date of the order being placed. - The practice did not have a system for checking prescription form stock on delivery. Bar codes were not recorded, checked against the delivery note and the stock securely stored as soon as possible. - The practice did not ensure prescription stock and blank prescription stationary was stored securely, at least in a locked cabinet within a lockable room or area. - Access to forms was not restricted to authorised individuals. - We found evidence of blank prescription stationary left in three of the printers in clinical rooms we looked in. The printers did not have lockable covers. The clinical rooms were locked with a code needed to enter. <p>2.</p> <ul style="list-style-type: none"> - We looked at a sample of patients taking high risk medicines or Disease Modifying Anti-Rheumatic Drugs (DMARDs) and found gaps in their monitoring, specifically, where monitoring had been done by other services, such as at hospital; recording of monitoring was inconsistent and lacked detail: <p>Disease Modifying Anti-Rheumatic Drugs</p> <ul style="list-style-type: none"> - We reviewed the records of patients taking methotrexate (a medicine used to suppress the immune system) of which 12 out of 18 patients had unclear recording of monitoring. Four out of five patients reviewed in further detail showed a lack of evidence of up to date blood tests having been carried out. - After the inspection, the practice told us that all five patients had their blood tests carried out at hospital and three patients had an up to date blood test. <p>High Risk Drug Monitoring</p> <ul style="list-style-type: none"> - We reviewed the records of patients taking Warfarin (a type of medicine known as an anticoagulant, or blood thinner), and identified 14 patients who did not have evidence of up to date blood monitoring. 	

- After the inspection, the practice told us that 13 of these patients were being monitored by secondary care services which was not recorded on the practice's electronic patient management system.

Chronic Kidney Disease stage 3, 4 or 5

- We identified three patients with Chronic Kidney Disease stage 4 or 5 who had not had the required monitoring in the last 18 months. After the inspection, the practice told us that all patients were being monitored by secondary care.

3.

- Prescribing data showed the practice were above average for prescribing co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs and 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 when compared with local and national averages.

- The practice told us that they adhere to National Institute for Health and Care Excellence (NICE) guidelines with regards to antibiotic prescribing and that they had patients who had been prescribed medicines from secondary care that they have been instructed to continue. They also told us that they had patients who showed adverse reactions to medicines so they had to prescribe an alternative, and older patients with complicated symptoms which may have skewed their prescribing data.

- The practice told us that they had begun to work on a prescribing audit to look at this area in further detail.

4.

- The practice did not stock some emergency medicines and had not assessed the risk this may pose. During the inspection we identified that the practice did not stock: Chlorphenamine for anaphylaxis or acute angio-oedema, Dexamethasone for croup in children, Furosemide or Bumetanide for left ventricular failure.

5.

- During the inspection, we identified one defibrillator that was not working and included pads which had expired in 2008. During the inspection, the practice moved this defibrillator to an office in the practice where staff would be less likely to access it.

- We checked another defibrillator and found it to be in working order, with the pads in date. The oxygen cylinder was checked, and no concerns identified.

After the inspection the practice told us that the defibrillator had since been cleaned, checked and confirmed to be in working order, with pads that are within their expiry date.

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N ¹
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial ²
There was a system for recording and acting on significant events.	N ¹
Staff understood how to raise concerns and report incidents both internally and externally.	Partial ²
There was evidence of learning and dissemination of information.	N ³
Number of events recorded in last 12 months:	0
Number of events that required action:	0
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> The practice did not have a significant events policy or procedure in place, and there was no internal system for recording a significant event. <p>2.</p> <ul style="list-style-type: none"> Whilst staff we spoke to were able to give an example of a significant event, the practice did not have a system in place for recording and acting on significant events internally. Staff we spoke to had different understanding on the process for reporting on significant events, both internally and externally. During the inspection, staff gave examples of what they felt to be significant events, which may have impacted patient care, for example missed childhood immunisations where there was a greater risk, two week wait referrals not being actioned and home visits not being carried out on the day they were supposed to be. These events had not been recorded and it was unclear if there had been any learning shared from these events to prevent them from occurring in the future. <p>3.</p> <ul style="list-style-type: none"> No evidence was seen of significant events being discussed at meetings. Staff we spoke to told us they were not invited to meetings where significant events were discussed and the learning was not shared. 	

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

Event	Specific action taken
Patient died whilst on the premises.	We were told that the lead GP and the Clinical Commissioning Group (CCG) were informed, and the CCG then sent out a form for the staff member to complete and send back to them.
Patient with mental health issues created a disturbance in reception.	We were told that the duty GP and police were called, and the patient was removed. There was a clinical meeting that led to the patient being removed from the practice's patient list.

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:	
<ul style="list-style-type: none"> - Not all staff we spoke to were aware of who managed safety alerts at the practice. - Drug safety/MHRA alerts: We reviewed the records of patients taking medicines used to control an overactive thyroid gland and to treat epilepsy and bipolar disorder, of which two patients had no evidence in their monitoring of having the risks of taking these medicines explained to them. We identified one patient who was potentially at risk of harm due to a lack of advice given or action taken. 	

Effective

Rating: Requires Improvement

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

- Systems and processes in place were not always effective in monitoring patients' health in relation to referrals to secondary care services. Patients' treatment was not regularly reviewed and updated.
- We identified ongoing and further gaps in staff recruitment and the induction process for new staff, as well as gaps in staff training.
- Audits were not being used to drive improvements or to identify where things needed to improve.
- Some clinical staff were unable to demonstrate an understanding of the practice's referral process.
- The practice had not met the minimum 90% target for childhood immunisation uptake indicators or the 80% target for cervical screening.

QOF requirements were modified by NHS England 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.	Y

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial ¹
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial ²
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.	Y
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> - Patients with urgent referrals for suspected cancer had not been appropriately followed up. - Monitoring systems were not being reviewed and updated to ensure all patients were captured in the monitoring. <p>2.</p> <ul style="list-style-type: none"> - Systems in place to monitor patient referrals did not include all patients that had been referred. 	

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 were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74 was limited due to a shortage of appointments available.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Care plans:
 - We reviewed a selection of patient care plans and found them to be completed appropriately with no monitoring issues or evidence of potential patient harm.
 - We identified two patients that had been prescribed the maximum recommended number of asthma inhalers over the past 12 months, however we found no monitoring issues or evidence of potential patient harm.
- 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 two of those patients should have been coded as being diabetic.
- 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 information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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	71	84.5%	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) (01/04/2019 to 31/03/2020) (NHS England)	56	69	81.2%	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	55	69	79.7%	Below 80% uptake

Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)				
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)	54	69	78.3%	Below 80% uptake
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)	69	93	74.2%	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>

Any additional evidence or comments

- The practice told us that they had a new clinical lead for child protection, who had carried out an audit looking at patients who did not attend their appointment and missed six- and eight-weeks baby checks and immunisations.
- The practice told us that some of their patient population were against vaccinations and they were working hard to improve uptake. They told us they had an admin team who ran searches and chased up patients to book appointments and ran a dedicated clinic for childhood immunisations.
- Unverified data provided by the practice showed that they had achieved their targets for childhood immunisations for babies aged eight and 12-weeks old.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	60.4%	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)	69.3%	67.1%	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)	58.8%	57.8%	63.8%	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)	38.8%	54.3%	54.2%	No statistical variation

Any additional evidence or comments

- The practice told us that they had done lots of work in improving the uptake for cervical screening since the pandemic and they had an admin team who called patients regularly to invite them in for cervical screening and had one nurse clinic set aside weekly for cervical screening appointments.

- The practice told us that they had carried out a cervical screening audit in June 2021- comparing their practice to the Primary Care Network (PCN) average for cervical screening appointments. Results showed that there was a higher uptake of appointments across the 25-49 year group during the pandemic.
- The practice also told us that they had a nominated staff member who sends AccruX text messages or called and invited patients to attend cervical screening appointments. They told us they were catching up on their face to face appointments and priority appointments were given to cytology, cervical screening and child and adult vaccinations.
- Unverified data provided by the practice showed that as of October 2021, the practice had achieved 61% for 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 75% for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 5.5 years for women aged 50 to 64), a marginal improvement from the combined 60.4% uptake the practiced had achieved as of March 2021.

After the inspection the practice told us that the reason for the below average data was due to the suspension of a staff member pending an investigation, which had affected the number of cervical screening appointments available.

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided, however there was limited monitoring of the outcomes of care and treatment.

	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.	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

- Some of the practice's prescribing data were significantly above local averages.
- The practice had carried out an audit looking at patients that had been prescribed medicine used for treating bacterial infections. 50 patients were identified from this audit, with the clinical justification for prescribing noted and an action plan in place where necessary.
- The practice provided evidence of meetings that had commenced in April 2021 looking at vaccine surveillance and targeting.

Effective staffing

The practice was unable to demonstrate that all 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 ¹
The practice had a programme of learning and development.	Partial ²
Staff had protected time for learning and development.	Partial ²
There was an induction programme for new staff.	N ³
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ⁴
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 ⁵
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial ⁶
<p>Explanation of any answers and additional evidence:</p> <p>1.</p> <ul style="list-style-type: none"> - Staff we spoke to could not demonstrate that they had the skills, knowledge and experience to deliver effective care, support and treatment; - Non-clinical staff we spoke to were unaware of the guidelines for the use and storage of blank prescription stationary. <p>2.</p> <ul style="list-style-type: none"> - Non-clinical staff we spoke to were unaware of required training that they needed to complete, the system the practice used for completing training and were unaware of the required level of training for their role. - There was no oversight of staff training. - The practice told us they had recently switched to a new system for staff training, however not all staff had been made aware of this new system or been given to necessary details to access this system. <p>After the inspection, the practice provided evidence of an email circulated to all staff in August 2021, informing them that mandatory staff training will be introduced at the practice, starting September 2021 and running quarterly. Also, that reception staff would be having six-weekly problem-solving meetings with the management team.</p> <p>The practice also provided some dates and names of staff who had attended physical, non-mandatory training sessions between September and October 2021.</p> <p>3.</p> <ul style="list-style-type: none"> - There was an induction checklist for staff seen during the inspection, however of the five staff folders reviewed, four had no induction checklist and one contained a partially completed checklist. <p>4.</p> <ul style="list-style-type: none"> - We saw evidence during the inspection that some appraisals had been carried out, however some were outstanding. Staff told us that there was no coaching, one to ones, mentoring or supervision that took place at the practice. 	

- 5.
- The practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice, nursing staff had completed training at another place of employment but not to the required level for their role. Staff folders we looked at contained very little information.
- 6.
- Staff told us that they were sometimes fearful of approaching specific leads within the practice when they needed support.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - Patients who had been referred to other services had not been effectively monitored to ensure the referral took place. 	

Helping patients to live healthier lives

Staff were not always 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"> - Clinical staff we spoke to told us that patients health checks were not being done as there were not enough appointments available at the time of inspection. 	

After the inspection, the practice told us that they were not carrying out patient health checks in line with current NHS guidance.

Additionally, the practice told us that based on NHS guidance, they were continuing to offer a range of patient consultations via telephone.

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 Cardiopulmonary 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"> We reviewed a sample of five patients with a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place and found some gaps in the recording of information, such as evidence of a review date and a recorded decision of mental capacity. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Patient feedback indicated that some staff were rude, disorganised and inefficient. 	

- Staff feedback indicated that staff were often rude to patients calling the practice due staffing pressures and tension amongst staff.

Patient feedback	
Source	Feedback
NHS Choices	Of the four comments received this year, three were negative. The negative comments related to access to appointments, rude reception staff and a lack of confidence in GPs. The practice had not responded to the comments. The positive comment stated that they had never had any issue with the practice.

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%	88.4%	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%	95.9%	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.	Partial
Explanation of any answers and additional evidence:	
- The practice website included a link to the Friends and Family Test, however the last practice survey report on the website was dated 2015/16	

Involvement in decisions about care and treatment

GP Patient Survey data showed that staff helped patients to be involved in decisions about care and treatment, however some patient feedback comments indicated that they were not involved in decisions about care and treatment.

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

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%	93.1%	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

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.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Partial
Explanation of any answers and additional evidence:	
Due to the size of the reception area, ensuring complete confidentiality at the reception desk was not always possible, especially during busier periods. During the inspection, we observed that restrictions regarding the number of patients in the reception area at any one time were not being adhered to.	

Responsive

Rating: Requires Improvement

We have rated the practice as requires improvement for being 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

The practice organised and delivered some 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.	Partial
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.	Partial
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	
Explanation of any answers and additional evidence:	

- Patient feedback and survey data showed patients were dissatisfied with the length of time it takes to access the practice by phone to book an appointment. The practice told us they were aware of the ongoing issues with their phone company and had been in communication with them regarding terminating their contract. At the time of the inspection the practice told us they had started a four-week trial with their phone company to see if measures they had mutually agreed to implement would bring about an improvement in service.
- During the inspection we saw evidence that patients were being called by their GP late into the evening and at night. Clinical staff told us that due to their workload they were not able to call patients that had requested a call during surgery opening hours.
- The practice offered late evening clinics from 6.30- 8pm on Mondays, Wednesday and Thursdays.

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>	<u>Nurse appointments</u>
	9.00am-12.00pm	8.45am-12.00pm
	8.30am-11.30am	3.30pm-5.45pm
	4.20pm-6.00pm	
Tuesday	<u>GP appointments</u>	<u>Nurse appointments</u>
	9.00am-12.00pm	8.40am-12.00pm
	8.30am-11.30am	3.30pm-4.00pm
	4.20pm-6.00pm	
Wednesday	<u>GP appointments</u>	<u>Nurse appointments</u>
	9.00am-12.00pm	8.40am-12.00pm
	8.30am-11.30am	3.30pm-5.45pm
	4.20pm-6.00pm	
Thursday	<u>GP appointments</u>	<u>Nurse appointments</u>
	9.00am-12.00pm	8.45am-12.00pm
	8.30am-11.30am	3.30pm-4.00pm
	4.20pm-6.00pm	
Friday	<u>GP appointments</u>	<u>Nurse appointments</u>
	9.00am-12.00pm	8.40am-12.00pm
	8.30am-11.30am	3.45pm-4.30pm
	4.20pm-6.00pm	

- Further information about how the practice is responding to the needs of their population**
- 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, however the home visits were not always carried out on the same day the patient requested a home visit.

- 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.
- The practice adjusted the delivery of its services to meet the needs of patients 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 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
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.	N ¹
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Partial ¹
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Partial ²
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Partial ²
Explanation of any answers and additional evidence: 1. - The results of the GP Patient Survey showed the practice was significantly below local and national averages for three out of four indicators we reviewed: - 47% of respondents to the GP patient survey responded positively to how easy it was to get through to someone at their GP practice on the phone compared to the national average of 68%; - 52% of respondents to the GP patient survey were very satisfied or fairly satisfied with their GP practice appointment times (local average 71%, national average 67%);	

- 68% of respondents to the GP patient survey were satisfied with the type of appointment (or appointments) they were offered (local and national average 82%).

2.

- During the inspection, clinical staff told us that due to friction amongst staff home visits were not always carried out on the same day the patient requested and would have to be picked up the following day by another GP.

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%	74.8%	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%	71.4%	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)

Any additional evidence or comments

- The practice told us that they used text messaging tool accuRx which allowed patients to contact the practice easier than via phone and book appointments themselves.
- The practice told us they were developing a system that would allow patients to request medication and their medical records via email.

Source	Feedback
CQC feedback	All of the feedback received was negative. The four negative 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.	44
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - The complaints log seen during the inspection was missing the last few months and staff could not account for the gap in complaints recording. Management told us that reception staff keep a separate log of minor complaints but could not provide evidence of this log. - Staff we spoke to told us that there was a complaints policy, but they were unsure when it was last reviewed or updated. - The practice provided evidence of a complaint response to a patient following an investigation, the patient was not satisfied with the response and communicated this back to the practice. We saw no evidence of any further response to this patient to that the patient was given details of how to escalate their complaint. - Staff told us the practice had recently introduced a complaint form which could be given to patients at reception upon request. - Staff told us that they were not made aware of any complaints made regarding the practice and could not give any examples of improvements made following a complaints investigation. - There was some information on the practice website regarding how to make a complaint, however there was no information regarding how to escalate a complaint if a patient was not satisfied with the practice's handling of their complaint. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complaint about treatment during a routine examination.	The practice responded to say the complaint had been investigated and they agreed that mistakes were made. An apology was offered. The patient was not satisfied with the response and no evidence was seen to show the practice took any further action.

Well-led

Rating: Inadequate

We have rated the practice as Inadequate for being well-led because:

- There were limited standing agendas for clinical and non-clinical meetings to ensure full discussion of all issues, including review of incidents, complaints and recent medicines and safety alerts.
- Non-clinical staff told us that they were not invited to attend meetings and there was no provision for distribution of meeting minutes to all staff.
- There was a lack of clinical and non-clinical oversight and supervision with no peer reviews of clinicians' work and appraisals for staff who had worked for the practice for more than 12 months had not been carried out.
- The practice was not recording, investigating or learning from all relevant significant events.
- We were not assured the practice learnt from and made changes to its policies and procedures as a result of complaints.
- We were not assured the practice staff undertook mandatory and regular training to enable them to perform their roles.
- Staff were unaware of who the lead for infection control was at the practice.
- Staff were unaware of who their Freedom to Speak Up Guardian was and if one had been assigned to the practice.
- Some practice policies showed no evidence of creation date or of regular review and updating.
- Some practice risk assessments showed no evidence of creation date or of regular review and updating.
- Although the practice was offering a range of appointment options, the results of the GP Patient survey showed patients were not satisfied with access.
- The practice was not conducting regular audits of the appointment system in order to improve patient access.
- There was no evidence the practice's performance was being discussed between staff and management.
- The practice ran the friends and family survey, however there was no evidence it used the results to make improvements, the last survey reports on the website were dated 2013/14 and 2015/16.

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.	Partial ¹
They had identified the actions necessary to address these challenges.	Partial ¹
Staff reported that leaders were visible and approachable.	Partial ²

There was a leadership development programme, including a succession plan.	Partial ³
Explanation of any answers and additional evidence:	
1.	
- Patient feedback, GP patient survey data and staff feedback all highlighted access as being one of the biggest challenges to quality and sustainability that the practice faced. Evidence provided by the practice showed that some action had been taken to improve time taken to get through to the practice via the telephone, however there was no evidence to show that any changes had been made or that those changes had resulted in improved outcomes for patients.	
2.	
- Staff reported that leaders were visible, however, not all leaders were approachable. Staff told us that they were reluctant and often scared to approach some leaders because their views and opinions would not be listened to and there was a fear of retribution if they spoke out against something that they felt was not working well in the practice.	
3.	
- There was no evidence of a leadership development programme, or a succession plan in place, however leaders did tell us that they had undergone many changes in the last few months including hiring approximately 10 new staff members and were advertising for a salaried GP with a view to adding a GP partner to the practice in the future.	

Vision and strategy

The practice had a vision, but it was not supported by a credible strategy and had not been developed in collaboration with staff and patients to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N ¹
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial ²
Progress against delivery of the strategy was monitored.	N ³
Explanation of any answers and additional evidence:	
1.	
- Staff told us that they had not been involved in developing the strategic planning (mission statement/vision, values) of the practice and that strategic planning was monopolised by leaders at the practice.	
2.	
- Staff understanding of the vision, values and strategy of the practice and their role in achieving them was limited as they had not been involved in the development process.	
3.	
- There was no documented strategy and no evidence that progress against delivery of the strategy was being monitored.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N ¹
Staff reported that they felt able to raise concerns without fear of retribution.	N ²
There was a strong emphasis on the safety and well-being of staff.	N ³
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.	Partial ⁴
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	N ⁵
Staff had undertaken equality and diversity training.	Partial ⁶
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> - We saw evidence of some performance reviews being carried out, however these reviews lacked detail, contained inappropriate language and read more like the personal opinion of the reviewer than factual evidence of performance. The reviews were not done routinely, and staff were being reviewed once it had already been decided that their performance was poor. 2. <ul style="list-style-type: none"> - 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 the nature in which they displayed their authority. 3. <ul style="list-style-type: none"> - Staff feedback indicated that staff turnover was high due to their suggestions for improvements and opinions not being listened to and staff had been signed off from work due to stress because of the working atmosphere in the practice. 4. <ul style="list-style-type: none"> - During the inspection, we reviewed a complaint where an apology was offered, but the patient had not been informed of any resulting action, even after they communicated that they were not satisfied with the practice's initial response to the complaint. 5. <ul style="list-style-type: none"> - Staff we spoke to were unaware of who their Freedom to Speak Up Guardian was and if the practice had appointed one. 6. <ul style="list-style-type: none"> - Evidence provided by the practice showed that only six members of staff out of 33 had completed equality and diversity training in 2020/21. 	

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

Source	Feedback
Staff feedback	<p>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.</p> <p>Other staff told us that they felt supported by team leaders and management, and they were provided with enough guidance, written procedures and/or policies to perform their role.</p> <p>Staff told us that although they felt they had all the required skills and experience, there were no opportunities for upward progression within the practice.</p> <p>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.</p> <p>Staff felt that there was not enough GP's, nor enough GP appointments available to provide effective, good quality care to patients.</p> <p>After the inspection the practice told us that between eight and 13 staff members had recently been offered promotion opportunities within the practice.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N ¹
Staff were clear about their roles and responsibilities.	Partial ²
There were appropriate governance arrangements with third parties.	Partial ³
<p>Explanation of any answers and additional evidence:</p> <p>1.</p> <ul style="list-style-type: none"> - Governance structures and systems were not regularly reviewed, and we found some practice policies and risk assessments that showed no evidence of creation date or of regular review and updating, and some, such as a COSHH risk assessment or PAT testing were not in place at all. <p>2.</p> <ul style="list-style-type: none"> - Staff we spoke to were unaware of how to raise concerns internally and externally, did not feel that they had received enough specific training for their role and were unsure of how to access medicines and equipment in an emergency. <p>3.</p>	

- Systems for documenting governance arrangements with third parties was inconsistent. Safety netting processes were not working effectively and patient monitoring by secondary care was not documented clearly in patient's notes.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N ¹
There were processes to manage performance.	Partial ²
There was a quality improvement programme in place.	Partial ³
There were effective arrangements for identifying, managing and mitigating risks.	N ¹
A major incident plan was in place.	N ⁴
Staff were trained in preparation for major incidents.	N ⁵
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial ⁶
<p>Explanation of any answers and additional evidence:</p> <p>1.</p> <ul style="list-style-type: none"> - Assurance systems had not ensured that processes were being reviewed or updated regularly and were operating as intended. Arrangements for managing risks had not ensured that risks identified had all been recorded and acted upon and that the action taken had effectively mitigated the risk. The impact of failings in monitoring had not been considered. <p>2.</p> <ul style="list-style-type: none"> - 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. <p>3.</p> <ul style="list-style-type: none"> - We saw evidence that the practice had undertaken some audits, however, there was little evidence that these were used to make improvements. <p>4.</p> <ul style="list-style-type: none"> - The practice provided a serious viral epidemic or pandemic policy; however, this was a generic template, which was not practice specific, had not been sufficiently completed and had not been signed or dated. <p>5.</p> <ul style="list-style-type: none"> - Some staff reported that they had received Covid specific training but were unaware of having received major incident training. <p>6.</p>	

- 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.

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.	Partial
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - Staff told us that a protective screen had been installed at the reception desk, a temperature checker had been installed in the reception area and masks and hand sanitiser were being used throughout the practice. - We did not observe any signage informing patients of the direction of travel they should take or reminding patients to stay two metres apart when in the reception area. Staff told us that signage had been ordered and it would be arriving in the coming days after the inspection. - Signage in the practice reception asked for no more than two patients to be in the reception area at once, however we observed throughout the day that there were often more than two patients in the reception area at the same time, which was a confined space. - Staff told us that they were dissatisfied with the health and safety arrangements within the practice. <p>After the inspection, the practice told us they thought this reflected staff unhappiness regarding wearing face masks.</p>	

Appropriate and accurate information

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

	Y/N/Partial
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Staff used data to monitor and improve performance.	Partial ¹
Performance information was used to hold staff and management to account.	Partial ²
There were effective arrangements for identifying, managing and mitigating risks.	Partial ³
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> - Where data showed that the practice's performance was below local and national averages, little action had been taken to improve performance and satisfaction had remained low. <p>2.</p> <ul style="list-style-type: none"> - Appraisals had not been completed for all staff and there was a lack of supervision and one to ones in order to hold staff to account for poor performance. <p>3.</p> <ul style="list-style-type: none"> - Arrangements for identifying, managing and mitigating risks were not always effective as the practice had not considered the risks associated with the way in which they stored and used blank prescription stationary. 	

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.	N ¹
The practice had an active Patient Participation Group.	N ²
Staff views were reflected in the planning and delivery of services.	N ³
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y ⁴
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> - Patient views had been discussed but suitable action had not been taken to improve services and culture. 2. <ul style="list-style-type: none"> - Due to the pandemic the practice did not have an active Patient Participation Group (PPG). The practice had not put in place a virtual PPG to allow patients to meet remotely. 3. <ul style="list-style-type: none"> - Staff told us their views and opinions were not asked for or listened to when planning the delivery of services. 4. <ul style="list-style-type: none"> - The practice told us that they have regular communication with their Primary Care Network (PCN). 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N ¹
Learning was shared effectively and used to make improvements.	Partial ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> - 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. 2. <ul style="list-style-type: none"> - 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. 	

Examples of continuous learning and improvement

- The practice told us that they had started team building exercises, which took place every six to eight weeks on a Saturday and they used that time to carry out role playing and team building exercises.
- The practice told us they were proud to be part of their PCN's Covid vaccination booster programme.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the

practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.
-
- ‰ = per thousand.