

## Inspection Evidence Table

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(1-494062038)

Inspection Date: 30 and 31 August 2023

Date of data download: 25/09/2023

## Overall rating: Inadequate

The last inspection was undertaken on 15 December 2018. At that time the practice was rated good in all key questions and good overall. At this inspection on 30 and 31 August 2023, we found issues around infection prevention and control, maintenance of the environment, medicines management, competence and oversight of clinicians and staff, learning when things go wrong, quality assurance and audits, governance and leadership. We found breaches of Regulation 12 (Safe Care and treatment), Regulation 17 (Good Governance) and Regulation 18 (Staffing). We therefore rated the safe key question as inadequate, the effective key question as inadequate, the caring key question as good, the responsive key question as requires improvement and the well led key question as inadequate. The practice is therefore now rated inadequate.

## Context

The practice is situated within NHS Lancashire and South Cumbria Integrated Care Board (ICB) and delivers General Medical Services (GMS) to a patient population of about 4697. This is part of a contract held with NHS England. According to the latest available data, the ethnic make-up of the practice area is 98% White, 1% Asian, 1% mixed and other. The age distribution of the practice population is 0-18 Years 19%, 18-64 Years 60% and 65 years and over 20%. This is similar to the regional average. Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the higher decile (6 of 10). The lower the decile, the more deprived the practice population is relative to others.

## Safe

## Rating: Inadequate

At the last inspection on 15 December 2018 we rated the practice as good for providing safe services. At this inspection on 30 and 31 August 2023, we have rated the practice as inadequate. This is because:

- Care was not always provided in a way that kept patients safe and mitigated the risk of avoidable harm.
- The environment was cluttered, poorly maintained and not conducive to good infection prevention and control (IPC). Cleaning schedules and IPC audits were not recorded.

## Safety systems and processes

**The practice did not always 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
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The application of a vulnerable patient flags on the electronic patient records system was inconsistent. We saw that flags were present on some records but not on others. For example, we saw that in a family where there were safeguarding concerns, 1 sibling in the household was flagged but the other sibling was not flagged appropriately. Similarly, we identified that some patients were flagged when a DNACPR was in place, but this was not present in other cases.</li><li>• Although we saw that multi-disciplinary and safeguarding meetings took place, our review of the minutes identified that there was little information about the discussions that took place during such meetings.</li><li>• We asked the practice what they did when a child failed to attend an appointment or if attendances at A&amp;E for vulnerable patients and children were monitored for potential non-accidental injuries. We were told that a process was not in place to consider these aspects, but if an obvious safeguarding concern was highlighted to them they would follow this up.</li><li>• A safeguarding policy was in place dated May 2023. It informed staff what they should do if they identified safeguarding concerns and the process to follow. However, the policy included safeguarding contact numbers at Appendix B, but these had all been left blank where the organisational lead contact details should have been and similarly for the local community teams and contact details.</li><li>• An audit tool at Appendix C of the safeguarding policy aimed to help the practice to assess the robustness of their procedures, but there was no evidence this had been completed.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Explanation of any answers and additional evidence:
<ul style="list-style-type: none"> <li>The sample of employment recruitment files checked showed evidence that the practice were compliant with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This describes checks needed for persons employed for the purposes of regulated activity.</li> <li>A recruitment policy was in place dated May 2023. This was consistent with the requirements of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</li> </ul>

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment: Not available	
There was a fire procedure.	Y
Date of fire risk assessment: October 2022	
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice was asked for their health and safety risk assessments. These were not available. Following the inspection the practice told us that they were not aware that these were required and that they would endeavour to start completing these going forward.</li> <li>Portable appliance testing was completed in May 2023.</li> <li>A Legionella risk assessment had been completed in September 2022.</li> <li>A report on waste management dated May 2023 identified issues around waste management and these were highlighted as high risk. Some of the actions were highlighted as requiring immediate or action within 2 weeks. Some required action within 1 month. However, no progress had been made nor evidence of actions taken was available at the time of inspection. We asked the practice for an action plan for this project, but this was also not available. We were told this had not been followed up.</li> <li>An ad hoc room audit was completed in March 2023, this identified areas that required action. These actions were rated according to priority. We found that although some actions had been completed, some of the actions remained outstanding. We asked for an action plan on how these issues would be resolved but this was not available. We were told that many issues remained unresolved.</li> </ul>	

### 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
Infection prevention and control audits were carried out.	N
Date of last infection prevention and control audit:	N/A
The practice had acted on any issues identified in infection prevention and control audits.	N

The arrangements for managing waste and clinical specimens kept people safe.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We asked for cleaning schedules and checklists but this was not available. We were told that the cleaning was done by a contractor who cleaned for 2 hours each day. And that there was no formal oversight or method to monitor the cleaning that was done.</li> <li>We asked for daily room and environmental room checks whereby oversight of the cleanliness, stock control, waste management and equipment was assured, but this was not available. We were told that no such process was in place. This was evident by the out of date stock, storage of stock and poor maintenance of the environment.</li> <li>We observed a clinical member of staff to be wearing a watch and jewellery and was not 'bare below the elbows'. This was contrary to their policy and to nationally accepted best practice.</li> <li>Sharps bins throughout the practice were not labelled correctly, this was contrary to best practice and the practice's own infection prevention and control (IPC) policy.</li> <li>We asked the practice for their hand hygiene audits and these were not available. We were told that no hand hygiene audits had been completed.</li> <li>During the visit we inspected the environment and clinical areas. We found the environment to have been poorly maintained in areas and this was not conducive to good infection prevention and control.</li> <li>We found a leather chair that was threadbare, making it very difficult to wipe down and clean effectively. We observed that blinds in clinical rooms were in a poor state of repair and constructed of fabric which could not be cleaned as it was not wipeable and absorbed moisture. The sink in a clinical room was visibly unclean with hairs and sludge in the plug hole which was also rusty. A plug was also in use which is not in keeping with best practice in relation to clinical areas. A pillow on the examination couch in a clinical room did not have a pillow slip and was visibly soiled and dirty.</li> <li>The environment in the GP's clinical room presented an infection prevention and control risk as it was cluttered. Items such as clothes, paper, files, teaching material and clinical products were stored on the floor and on shelves and surfaces, meaning that surfaces could not be wiped or cleaned effectively. The dressings trolley was soiled and rusty and could not be wiped and cleaned effectively. Furthermore it was laden with items that prevented its cleaning. A cupboard above the sink contained medicines and consumables which were stored in a haphazard and unconventional manner, along with personal items such as a toothbrush, toothpaste and toiletries.</li> <li>The clinical waste bin in the GP's room was broken as the pedal to open it was not functioning meaning the lid had to be lifted by hand to deposit waste.</li> <li>We found out of date consumables therefore as their use by date had expired their sterility could not be guaranteed (see section below).</li> <li>We found dust and dirt on surfaces and floors in clinical rooms.</li> <li>The curtains in the clinical rooms appeared to be clean and recently changed however the curtain in 1 room had no date noted advising of the date it was changed. This had appeared on a room audit in March 2023 but had not been actioned.</li> <li>There was a tear in the flooring in another clinical room, meaning it could not be cleaned effectively.</li> <li>During our inspection we found that no IPC audits had been completed. We asked for evidence of an audit but this was not available. We were told this was not a process that was undertaken. Following the inspection we were supplied with an IPC audit dated 23 September 2023. Whilst this identified some of the issues we observed on inspection, some issues such as poor maintenance of the environment, the flooring, GP chair, examination couch, window blinds, the clutter in clinical rooms which rendered the environment uncleanable, non-adherence to 'bare below the elbow' guidance and presence of personal items in clinical rooms had not been identified and recorded. Furthermore, the audit did not include an action plan of how the issues that were identified would be addressed.</li> <li>We were advised of 3 different members of staff that were the IPC leads, therefore it was not clear who was responsible. This had also been left blank on the practice IPC policy.</li> </ul>	

- At the time of inspection we saw evidence that all administrative staff and one clinical staff member (a locum GP) had completed IPC training. There was no evidence at that time that the other 6 clinical staff had completed IPC training.
- Following the inspection we were supplied with evidence that the GP lead and 2 other clinical staff members had subsequently completed the training and a further clinical staff member had completed it prior to the inspection but their records had not been up to date at that time

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was no induction process in place for clinical staff. New starters and temporary staff were shown around informally and no documentation was recorded or provided to the staff member. There was however an induction process in place for reception staff.</li> <li>• Staffing issues had led to reliance on locum and temporary staff and staff working additional hours. Some staff described a pressure to work additional hours when they did not want to and that a lack of clinical presence was causing pressures in providing appointments and in particular home visits. The days that they could not provide home visits had been escalated several times to commissioners. Staff reported that there were also times when doctors had left the premises leaving administrative staff and nursing staff unsupported in the building.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	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> <ul style="list-style-type: none"> <li>A review of patient records in relation to the clinical searches identified that care records were not managed in a way to protect patients. For example, the searches found there was an inconsistent approach to monitoring of patients who were prescribed high risk medications.</li> <li>History, examination, management plans, safety netting and follow up were not adequately documented within the patient record.</li> <li>During the inspection we found that there was a large number (approximately 100) of physical paper patient records for patients who had transferred into the practice. These had not been summarised and details added to their electronic records, these dated back to 2021. There was a risk that these records may have contained information that affected the care and treatment provided. It may have been that all relevant information had been transferred across with the electronic patient record if the practice they came from had electronic records, but as there had been no assessment of this, there was an unknown level of risk.</li> </ul>	

### Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.22	1.01	0.91	Tending towards variation (negative)
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). (01/07/2022 to 30/06/2023) (NHSBSA)	5.7%	7.5%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	3.72	4.55	5.24	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	129.1‰	153.3‰	129.6‰	No statistical variation



Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.29	0.41	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	9.4‰	5.5‰	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.	N
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	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
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
Explanation of any answers and additional evidence, including from clinical searches.	

- During the inspection we found Depo-Medrone, a steroid injection medication, stored in a non-medical cabinet. This should have been stored in a medicines cabinet or kept secure and according to the manufacturer's instructions stored at a controlled room at a temperature of 20° to 25°C, in order for the medicine to remain effective and safe to use. There was no method of monitoring the temperature at which this was stored.
- We also found a Histofreezer Cryosurgical system, a treatment used for removing skin lesions; which had expired June 2021. Items that have passed their expiry date should be disposed and replaced as they may not be effective and can start to deteriorate, making them unsafe.
- We also found other out of date items which included; Neolus Terumo hypodermic needles which had expired September 2017, Valuetest reagent strips which expired May 2023, a speculum which expired April 2021, softpore surgical dressing which expired February 2019 and Micropore which expired December 2019. There were also out of date needles and syringes in another clinical room. Out of date sterile items are a problem as their sterility and safe use cannot be guaranteed beyond the expiry date.
- During the inspection we reviewed a sample of 8 Patient Group Directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We saw that on 4 occasions a staff member was added to the PGD after the date this had been signed by the authorising manager. The authorising manager had not countersigned these additions, therefore the staff member was not authorised to administer the vaccines. The authorising manager had signed a PGD for the Pneumococcal vaccine on 1 March 2022, the staff member was named on the PGD and had signed the document on 3 January 2023. The authorising manager had signed a PGD for the Diphtheria/Tetanus on 11 August 2022. The staff member was named on the PGD and had signed the document on 3 January 2023. The authorising manager had signed a PGD for the Measles, Mumps, Rubella vaccine on 1 March 2022. The staff member was named on the PGD and had signed the document on 3 January 2023. The authorising manager signed a PGD for the Haemophilus influenzae type b (Hib) and meningitis C vaccine on 14 July 2022. The staff member was named on the PGD and had signed the document on 3 January 2023.
- We saw that prescription paper was not appropriately controlled and recorded. Nor was it kept securely and in a way that prevented their unauthorised access or use, in line with national guidance. We found there was no system in place to monitor and record prescription serial numbers. Therefore it was not possible to determine if items had been misappropriated.
- As part of the inspection a CQC GP specialist advisor reviewed the records of a sample of patients to check that their care and treatment followed recommendation, guidance and best practice.
- Our searches found 12 patients had a potential missed diagnosis of diabetes. A delayed diagnosis can cause diabetes-related complications. The CQC specialist advisor reviewed 5 records and found 4 out of 5 had not had the appropriate follow up monitoring, nor coded as diabetic or advised of their diagnosis. There was also 1 patient who had a result which indicated a referral to a specialist was required but this was not done. It is important that diabetes is diagnosed as early as possible as it can cause long-term health problems if left untreated. Appropriate checks can be arranged for patients diagnosed with diabetes, such as diabetic eye screening to check for eye problems caused by diabetes. Patients with pre-diabetes are at a greater risk of developing type 2 diabetes but the risk can be reduced. Appropriate coding can help in the monitoring and managing of this risk.
- Our searches found that 6 out of 13 patients prescribed Methotrexate who may not have received all the required monitoring, which included up to date blood tests. The CQC specialist advisor reviewed 5 records in more detail and found 2 out of the 5 did not have the required monitoring. Monitoring is required because Methotrexate is a high-risk medicine that can have serious side effects. We also found that there was a lack of evidence that results had been checked prior to the issuing of a prescription in 4 out of the 5 records.
- Our searches found that 5 out of 19 patients prescribed potassium sparing diuretics may not have received the required monitoring. Required monitoring includes regular blood checks as side-effects can be serious. The CQC specialist advisor looked at these 5 records in detail and found that 1 of the 5



patients had a very low kidney function test result but a referral to a kidney specialist had not been completed.

- Our searches found that 31 of the 91 patients prescribed gabapentinoid medications that may not have had their response to the medication and the dosage reviewed for 12 months or more. Regular reviews are recommended for patients on these medicines as when they are taken with some other medications, or for patients with certain other illness, this can lead to a higher risk of problems. The CQC specialist advisor looked at 5 records in detail and found that 4 out of 5 had not had a recent review to determine the suitability of the medicine and if the dose needed amending. They also found 2 out of the 4 patients also had medicine reviews coded but appropriate actions had not been taken and 1 was taking the wrong dose.
- Our searches looked at medication reviews that had been carried out and the CQC specialist advisor looked at 5 records in detail. Medicine reviews are important as they are used to ensure the medicines a patient is taking are still appropriate and are having the desired effect without causing any side effects or complications. We found that 3 of the 5 medicines reviews had not been documented at all, and there was no detail as to what had been reviewed and the outcome. We noted 1 patient was still taking ferritin supplements 5 years after they had a normal test result.
- Our searches found 13 patients with hypothyroidism that may not have had their thyroid function tested in 18 months. The CQC specialist advisor looked at 5 records in detail and found 4 out of 5 had not had the required thyroid function test in the last 18 months. Additionally 4 out of 5 not had a medicine review, 1 patient had received a medicine review but this had not picked up the issue with monitoring. All 5 patients had been prescribed thyroid medication without it being evidenced that it remained appropriate to issue the prescription.
- Our searches reviewed the records of 5 patients with asthma and whom had been prescribed 2 or more doses of rescue steroid medication in 12 months. The CQC specialist advisor looked at these in detail and found that none of these patients had been issued with a steroid warning card when they should have had 1. A steroid warning card is used to help healthcare staff identify certain patients as sometimes if people are taking steroids as medicines, the body stops making enough of its own steroid because it senses that steroids are already in the body. This means that they may not make enough extra steroid of their own if they have another serious illness, need surgery or to fight off infection.
- The practice was unable to demonstrate oversight and competence of clinical staff. This included sessional and locum GP, trainees, nursing staff and primary care network (PCN) staff treating patients of the practice. PCN staff included a non-medical prescriber.

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N

Number of events recorded in last 12 months: Not available – not known
Number of events that required action: Not available – not known
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We asked for evidence of the system for identifying, recording and acting on incidents verbally and in writing on the day of inspection, and again following the inspection. We received copies of 4 incident reports. These incident reports detailed a narrative of what happened and a response by the clinician involved. One included some evidence of an investigation to understand what had happened. However, there was no evidence of any outcomes, that these were discussed or shared, that learning had taken place or there had been mitigation or actions taken to reduce the risk of reoccurrence.</li> <li>More recently the practice provided a copy of an incident log, minutes of a practice meeting, and a list of the numbers of incidents as evidence of their system for identifying, recording and acting on incidents.</li> <li>The data in the log indicated that outcomes in relation to the incidents described above had been updated following the inspection and that a log was now being maintained. However, the incident log was missing key detail including who had ownership of the incident, review dates and progress, how learning was implemented and dates the incident was closed and how the practice had assurance that ongoing risks were mitigated.</li> <li>The minutes provided did not detail how the concerns were discussed and who with, they merely were listed and a comment “needs to be reviewed” added. Therefore there is little assurance that incidents were monitored and collated to consider performance, management issues, risks in relation to the incidents or areas for improvement. Nor did this evidence that incidents were discussed with staff to improve knowledge or share lessons learned.</li> </ul> <p>The practice supplied as evidence a copy of the incident reporting policy. This was due for review in 2021 and contained details of an ex-employee from 2 years prior, as the lead. The policy also referred to an annual incident review process. The list of incidents and number count supplied after the inspection was not evidence of an effective process to review and analyse themes and trends and the sharing of these with staff.</p>

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

Event	Specific action taken
A consultation took place whilst looking at and recording the details of the consultation in an incorrect patient electronic record.	This was recorded as an incident and the staff member involved reflected upon this and some investigation as to how this happened was observed. But this was not reviewed by the GP lead and there were no outcomes, no lessons shared and no changes to procedures identified or implemented as a result.
A task was not followed up and a home visit was not completed which may have led to a deterioration in a patient's condition.	This was recorded as an incident and the staff member involved reflected upon this. But this was not reviewed by the GP lead and there were no outcomes, no lessons shared and no changes to procedures identified or implemented as a result.
A prescription was issued for 5 times the correct dose of medication.	This was recognised by the pharmacy who contacted the practice. This was recorded as an incident and the staff member involved reflected upon this. But this was not reviewed by the GP lead and there were no outcomes, no lessons shared and no changes to procedures identified or implemented as a result.

A prescription was issued for a medicine which was a hospital only medication.	This was recognised by the pharmacy who contacted the practice. This was recorded as an incident and the staff member involved reflected upon this. But this was not reviewed by the GP lead and there were no outcomes, no lessons shared and no changes to procedures identified or implemented as a result.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We were told when the Medicines and Healthcare products Regulatory Agency (MHRA) or National Institute for Health and Care Excellence (NICE) alerts and updates were received they were passed to the clinical lead GP to deal with. It was not clear how these were shared with relevant staff thereafter and how the implementation of any changes to care provided was managed.</li> <li>Our clinical searches identified that it was not always evident that all relevant safety alerts had been responded to and that recommendations around high risk drug monitoring were being adhered to. This was evidenced by the findings of our examination of patient records which identified issues as described under the medicines management section of this report.</li> <li>We saw that patients remained on medicines or combinations of medicines that increased their risk of side effects without anything in their records to indicate this had been identified and monitored in line with recommendations and the risk discussed with the patient or alternative treatments considered.</li> <li>We were told that routine clinical audits for high risk medicines were not being undertaken to determine compliance with recommendations around medicines management and monitoring, so they could be followed up.</li> <li>We found some evidence to show that alerts were acted upon. In relation to the MHRA alert regarding Sodium-glucose co-transporter-2 (SGLT2) inhibitor medication, which was a type of medicines that was used to lower blood sugar in adults with type 2 diabetes and which presented a risk of blood clots and diabetic ketoacidosis (DKA). Our searches showed that the alert had been responded to as in 4 out of 5 cases it was documented that the patient received advice warning them of the risks.</li> </ul>	

# Effective

# Rating: Inadequate

At the last inspection on 15 December 2018 we rated the practice as good for providing effective services. At this inspection on 30 and 31 August 2023, we have rated the practice as inadequate. This is because:

- There was a lack of oversight and ineffective systems and processes to manage staff mandatory training compliance, provide effective clinical supervision and regular appraisals.
- Procedures around the implementation and management of DNACPR orders, mental capacity considerations and best interests were not reliable.
- Best practice and recommendations around medicines monitoring and medicine reviews were not being followed.

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

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients’ treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients’ needs were addressed.	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.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The clinical searches undertaken of patient records indicated that best practice and evidence-based guidance was not always being followed in relation to MHRA, the monitoring of high risk drugs and long term condition monitoring.</li></ul>	

- Our inspection reviewed that guidance around IPC and medicines management was not always being followed.
- Our examination of records in connection with DNACPRs and those in relation to the clinical searches indicated that care plans were not always reviewed regularly and regular monitoring was not always being carried out.

## Effective care for the practice population

We were told that;

- Health checks, including frailty assessments, could be provided to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients with a learning disability could receive an annual health check.
- End of life care was delivered in collaboration with and cooperation with other healthcare providers.
- 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.
- Our clinical review of patients identified issues with monitoring and oversight of those on high risk medications. See section on medicines management.

## Management of people with long term conditions

- Health checks, including frailty assessments, could be provided to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, there was evidence of involvement of other health and care professionals to deliver a care.
- The GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Long term condition reviews were undertaken by the nurse associate, the practice nurse and the GP.
- Our clinical review of patients' records identified good management of those patients with CKD4 or 5 and their oversight and monitoring was up to date.
- Our clinical review of patients with asthma who were being prescribed rescue steroids was in line with best practice, however we noted an issue of them not being issued with a steroid warning card when this was noted to have been necessary.

- Our clinical review of patients' records identified reasonable management of those patients with diabetes and whose latest blood reading indicated they were at risk of eye problems.
- Our clinical review of patient records who had hypothyroidism indicated issues with their management in 4 out of 5 cases we examined in detail. The 4 patients had not had their blood monitoring undertaken to evidence it remained appropriate to prescribe the medication.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	36	40	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	39	41	95.1%	Met 95% WHO based target
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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	39	41	95.1%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	38	41	92.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	52	90.4%	Met 90% minimum

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

#### Any additional evidence or comments

- Childhood immunisations were managed by the practice nurse. There was good uptake of the vaccination service.
- Educational material was available on the practice website and in the practice waiting areas.



Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	59.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	65.6%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	73.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	50.0%	57.0%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice cancer indicators were in line with national averages. Cervical screening uptake was managed by the practice nurse who contacted patients if they failed to attend their appointments.</li> <li>Promotional and educational material regarding cancer screening was available on the practice website and displayed in the practice waiting areas.</li> </ul>

### 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.	N
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years:</p> <ul style="list-style-type: none"> <li>We were sent 2 audits as evidence of quality improvement audit. They were assignments undertaken by trainees in connection with their academic studies.</li> <li>Audit 1 examined 2 week wait referrals for cases of suspected cancer to secondary care. The recommendations and findings from this audit did not lead to any action plan and were not followed up or implemented.</li> <li>Audit 2 looked at high opioid prescribing and appeared to be the second of a 2 cycle audit. The recommendations and findings from this audit did not lead to any action plan and were not followed up or implemented.</li> </ul>	



## Any additional evidence or comments

- We asked for an annual audit plan and this was not available. This was because the practice did not operate an annual audit programme.
- We were told that clinical searches and oversight of medicines management in connection with high risk drugs, MHRA safety alerts and best practice were not conducted to ascertain that treatment followed best practice and national guidance.
- There was no assurance that the practice effectively monitored their performance in order to identify areas of risk or where and how they might improve.
- Following the inspection and prior to the publication of this report, the practice provided evidence of initial participation in a Primary Care Network (PCN) initiatives around 'community pharmacy referral' and 'access'. This was a compulsory and paid for piece of work in connection with their contract with commissioners. One document indicated that after an initial start in July 2023, no further progress, review or completion had been made on this, 4 months after this was started. The other provided retrospective information about the practice implementation of a new telephone system. Neither provided assurance of the effective monitoring of care and treatment.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was no clinical supervision for clinical staff including nurses and sessional and locum GPs and clinical staff. There was also no formal assessment of their competency. Personnel records did not evidence oversight, supervision or assessment of competency. We asked for evidence of supervision and clinical oversight of clinical competency for staff that treated the practice patients and this was not available. We were told this was not in place and there were no such records.</li> <li>• We asked for records of the oversight and supervision of GP trainees who were caring for and treating patients at the practice but these were not available. We were told these were informal and any</li> </ul>	

discussions were recorded on the patient's personal clinical record but we did not receive any evidence of this. We were told that the trainees keep their own portfolio in their academic records.

- We also asked to see induction records for newly recruited staff, locums and temporary staff. We were told that records were not kept of the induction process except for receptionists who followed an induction and training programme.
- We asked for evidence of clinical governance meetings and minutes. We did not receive this evidence. We were told that these did not take place and no such documentation was available.
- We asked for evidence of the sampling of work undertaken by staff such as dip sampling of workflow and document processing or coding. We did not receive evidence of this. Following the inspection we were provided with documentation to show that during their induction period administrative staff had their scanning duties monitored to check they were appropriate. We reviewed these documents and saw that on occasion, issues had been which should have led to learning and been followed up or rectified. However this did not appear to have been done.
- Therefore, we have no assurance that the practice were ensuring that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.
- We asked for evidence that appraisals, one to ones, coaching and mentoring was being carried out. We received 1 appraisal for 1 administrative member of staff.
- Some time after the inspection the practice provided copies of 2 separate monthly one to one meeting records with a further 3 out of the 8 non-clinical staff. These showed a discussion had taken place with an appropriate supervisor and the new staff member. No evidence was presented for the other 4 administrative staff members including the practice manager who had not had an appraisal since they started their employment 2 and a half years before the inspection.
- They also provided a record of a monthly one to one meeting for a clinical member of staff dated 23 July 2021, some two years before the date of the inspection. Furthermore, this had been completed by a non-clinical manager, with no input from a clinician.
- They also provided a more recent probationary meeting report for another clinical member of staff. However, this was also carried out by a non-clinical manager, with no input from a clinician.
- These additional documents did not provide assurance that appraisals, one to ones, coaching and mentoring was being carried out in any meaningful way.

## Coordinating care and treatment

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

	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: <ul style="list-style-type: none"> <li>• The practice worked with other healthcare organisations including other practices in the primary care network (PCN), district nurses, health visitors and palliative care teams. We saw evidence of multidisciplinary team meetings being undertaken with other organisations involvement.</li> <li>• We saw that referrals and communications between secondary care and other services was acted upon appropriately.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
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"><li>The practice had access to additional roles through an arrangement with the PCN such as a health and wellbeing coach, a social prescriber and an associate psychological practitioner. These practitioners could refer patients to sources of help to improve their health and live healthier lives such as smoking cessation, alcohol and drugs counsellors and other sources of help.</li><li>There was advice on healthy living available on the practice website and in the practice waiting areas.</li></ul>	

## Consent to care and treatment

**The practice was not always able to demonstrate that it 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	N
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Our clinical review of notes identified cases where a DNACPR decision had been recorded. A DNACPR order is a document that states if resuscitation of a person should be performed on a person whose heart had stopped beating or dies suddenly. A sample of these records were examined in more detail.</li><li>We found that there were multiple issues with all 5 records we reviewed.</li><li>The records for Patient A revealed that a DNACPR order had been implemented that had not been discussed with the patient as they lacked capacity. However, no mental capacity assessment or best interest decision was documented when the DNACPR order was implemented. It was therefore not established or documented whether the patient lacked capacity and/or was unable to be included in decisions about their treatment.</li></ul>	

- The records for Patient B identified that a mental capacity assessment had been undertaken but this appeared to have been done without actually seeing the patient as this did not coincide with a visit, telephone call or other appointment where the patient was assessed. Furthermore it was not clear what this assessment entailed and whether the two stage test of capacity had been followed. This had been done at the request of a relative who was charged for the assessment. The patient's review of care plan had not been reviewed and was flagged as overdue and this had not been actioned. Furthermore, there was no documentation that the DNACPR order decision had been made in the best interests of the patient in the absence of them being able to be involved in the decision.
- The records for Patient C indicated that their care plan had not been reviewed when the DNACPR order was made in May 2023 and was overdue. Reference to a mental capacity assessment and a best interest decision had been documented in relation to the administration of covert medication but not in relation to the decision to implement a DNACPR order.
- The records for Patient D lacked clarity as to whether a DNACPR order was extant or not. There was no copy of the DNACPR order on the patient record and the record was not flagged or coded for a DNACPR. However, there was a record in the patient's history stating they were not for resuscitation.
- The records for Patient E indicated that a DNACPR was in place, but there was no copy of this on file. There was also a note indicating the patient lacked capacity but there was no documentation of a mental capacity assessment having been completed, nor that a best interests decision had been taken around the DNACPR. Furthermore the record indicated that care plans and reviews were overdue, and the record had not been flagged or alerted that a DNACPR was in place.
- These issues were alerted to managers and we were told they would be looked into. Following the inspection we were told that all DNACPRs had been reviewed.

# Caring

Rating: Good

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The Friends and family test (FFT) surveys were conducted by SMS (text message) auto-polls to gain patient feedback, these were in the vast majority of cases positive.</li><li>• The survey for August 2023 returned 50 responses. Of these 47 (94%) stated they would recommend the practice to their friends and family and 3 (6%) stated they would not recommend the practice. The average recommendation rates across all practices for August 2023 was 90%, therefore the practice result was better than the national average.</li><li>• The practice was able to evidence that feedback from the FFT surveys was circulated to all staff by email, they also displayed the results in the practice waiting area.</li><li>• The practice used the feedback and acted on this to improve the experience for patients and staff. For example, they responded to feedback regarding being able to reach the practice by telephone by installing a new telephone system which has improved patient feedback around access. They also responded to feedback that patients felt it difficult to obtain repeat medication by opening a dedicated prescription line between 11am and 2pm each day. These changes were highlighted in the practice waiting area notice boards in a “You said, we did” format.</li><li>• The National NHS GP patient survey results were in line with national and local averages.</li></ul>	

Patient feedback	
Source	Feedback
NHS GP patient survey.	Patient feedback and satisfaction levels were similar to local and national percentages.
NHS Choices	There was no feedback left in the 12 months before the inspection.
Friends and Family Test	Feedback from patients indicated they found the practice staff polite, friendly and pleasant.

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	93.2%	89.0%	85.0%	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 (01/01/2023 to 30/04/2023)	89.0%	87.1%	83.8%	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 (01/01/2023 to 30/04/2023)	98.6%	95.0%	93.0%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	83.9%	75.8%	71.3%	No statistical variation

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

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Easy read and accessible information was available.</li> <li>• The practice had access to a variety of community and advocacy services via the range of staff provided via the PCN arrangements. These included a health and wellbeing coach, a pharmacist, a pharmacy technician, an associate psychological practitioner, a musculoskeletal first contact physiotherapist and</li> </ul>	

social prescriber. These professionals could signpost patients to appropriate assistance and community support.

- Carers identified were flagged on their records so this could be taken into account as appropriate. Social prescribers introduced carers to local carers centres where appropriate.
- Feedback from patients indicated they felt involved in decisions, for example a patient said the doctor was understanding and responsive to their preference of medication.

Source	Feedback
Friends and Family Test	Feedback from patients stated that they felt listened to and included in decisions about their care and treatment. They said that staff were supportive and helpful and put them at ease.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	90.9%	93.3%	90.3%	No statistical variation
Any additional evidence or comments				
We asked for evidence of actions taken and discussion of the National GP patient survey, this was not available. We were told that the practice did not discuss the patient survey results and this was not a feature of any meetings that took place.				
				Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.				Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Y
Information leaflets were available in other languages and in easy read format.				Y
Information about support groups was available on the practice website.				Y
Explanation of any answers and additional evidence:				
<ul style="list-style-type: none"> <li>• Information about support groups and alternative sources of support was available from the social prescriber, well-being practitioners and practice staff and was displayed on posters in the practice.</li> <li>• The practice website also had sources of information and support, education around health conditions and help with wellbeing and mental health.</li> </ul>				



Carers	Narrative
Percentage and number of carers identified.	The practice identified 212 carers from their patient list; this equated to 5% of patients with caring responsibilities.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• Access to social prescribing link practitioner.</li> <li>• Alert on patient record denoting person is a carer.</li> <li>• Signposted to carers centre.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• Access to a mental health practitioners and associate psychological practitioners.</li> <li>• Signposted to community support providers.</li> <li>• Advise and signposting provided on the practice website.</li> </ul>

## 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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Services were provided in a way that protected the privacy and dignity of patients.</li> <li>• The reception areas were large and spacious, waiting areas were far enough away so that conversations could not be overheard by waiting patients.</li> <li>• Training on information governance and General Data Protection Regulation (GDPR) and the principles around privacy and confidentiality was mandatory. Training records showed that administrative staff were up to date on this training. However, for clinical staff, there was a mixed picture. We saw evidence that at the time of inspection 1 staff member had completed this training and 3 further staff completed it following the inspection. However, this remained outstanding for 2 further clinical staff.</li> <li>• During our inspection we observed a document containing a list of patients in a clinical room in view of a ground floor window.</li> </ul>	

# Responsive

# Rating: Requires Improvement

At the last inspection on 15 December 2018 we rated the practice as good for providing responsive services. At this inspection on 30 and 31 August 2023, we have rated the practice as requires improvement. This is because:

- Information, such as from complaints and significant events, was not used for learning and improvement.
- The facilities and premises was poorly managed and maintained and therefore not suitable for the services provided.

## Responding to and meeting people’s needs

**The practice did not always organise and deliver services to meet the needs of some patients.**

	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.	N
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Learning disability training was deemed mandatory for all staff. From July 2022, all health and social care providers registered with CQC must ensure that their staff receive training in learning disability and autism, including how to interact appropriately with people with a learning disability and autistic people. Training records provided by the practice showed that 1 out of 8 clinical staff had completed the training on ‘supporting people with a learning disability’. The clinical lead and GP had not completed the training and neither had the practice manager. However all administrative staff had completed this training.</li><li>• Dementia awareness training and equality and diversity training for clinical staff was not evident for 7 out of 8 clinical staff. All administrative staff had completed the training.</li><li>• The premises and facilities were not managed well. For example, equipment and the environment was in a poor state of repair in some areas and the management of IPC and waste was in need of attention. This meant the environment was not always fit for purpose.</li></ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm

Tuesday	8am – 6.30pm (Extended hours 6.30pm – 8pm)
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Saturday	Extended hours – 1 Saturday every 2 months 12.30pm – 5pm
Appointments available:	
Monday	9.30am – 12.30pm, 2pm – 6pm
Tuesday	9.30am – 12.30pm, 2pm – 6pm
Wednesday	9.30am – 12.30pm, 2pm – 6pm
Thursday	9.30am – 12.30pm, 2pm – 6pm
Friday	9.30am – 12.30pm, 2pm – 6pm

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

- The practice offered some home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised with the community services to discuss and manage the needs of patients with complex medical issues
- Additional nurse appointments were available until 6.30pm on a Monday for school age children so that they did not need to miss school.
- The practice offered an immunisations service and 6-8 week developmental check.
- The practice provided a service for contraception advice and cervical smears which were carried out by Practice Nurse.
- Where possible parents or guardians calling with concerns about a child were offered a same day appointment or were signposted elsewhere for support.
- The practice was open until 8pm and appointments were available until 8pm on a Tuesday and a Saturday morning once every 2 months 12.30pm until 5pm. This provided some flexibility to enable persons of working age to be seen without missing work or for school age children to be seen without missing school.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice offered online services to order prescriptions, view aspects of their medical records and book appointments.
- The practice provided a dedicated prescription line for patients to order their medications.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
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.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice offered a range of appointments including routine and pre-bookable as well as urgent appointments, both face to face, online and via the telephone. This was based on the patient's choice.</li><li>• There was process for reception staff to identify patients who required an appointment as a priority on the day.</li><li>• The practice had extended hours appointments on a Tuesday evening each week and on a Saturday afternoon once every 2 months.</li><li>• The majority of patients as part of the friends and family test patient survey reported that appointments were on time, although 1 person commented that they had to wait 50 minutes.</li></ul>	

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	53.5%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	68.3%	57.3%	54.4%	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 (01/01/2023 to 30/04/2023)	56.7%	53.4%	52.8%	No statistical variation

The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	85.8%	74.8%	72.0%	Tending towards variation (positive)
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#### Any additional evidence or comments

- At the time of inspection the practice were trying to recruit additional doctors and therefore increase the number of appointments available. In the meantime they were using the services of locum GPs and advanced nurse practitioners. They had plans to employ some of the doctors who were on training placements with them when they qualified. Shortly after the inspection we were told that the practice had secured a new GP partner into the practice.

Source	Feedback
Friends and Family Patient Survey	Feedback indicated that patients felt satisfied about their ability to get an appointment with the practice.

#### 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.	12
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The document supplied as evidence of the practice complaints policy was a document which was due for review in 2021 and which contained details of an ex-employee as the complaints lead. The policy referred to an annual complaints review which we were told was not available as it had not been completed.</li> <li>We asked the practice for evidence of the action taken and outcomes from complaints and how learning was implemented but this was not available.</li> <li>The practice did not have any evidence that the information learned from complaints was used to change or improve their practice.</li> <li>There was no evidence that the information was discussed or shared after the complaint had been responded to.</li> </ul>	

- There was no evidence of the analysis of themes and trends or annual review of complaints.
- Complaints responses we reviewed did not provide details of the complainants' recourse to the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied with the outcome.
- We reviewed 1 complaint that was received on 13 June 2022 but was not responded to until 9 May 2023, the response stated the complaint had not been passed to the appropriate person which caused the delay.
- We saw evidence of action on complaints received as we saw examples where patients were invited to come and discuss their concerns in person with the GP, however it was not clear where this led to as there were no documented outcomes of these nor how the information was used to improve the service.

Example(s) of action taken in response to complaints.

Complaint	Specific action taken
Complaint received via the SICBL regarding an alleged misdiagnosis.	Patient invited to an appointment to discuss their condition.
Complaint regarding the alleged mis management of relative, access to appointments and medicines issues.	Patient's relative invited to an appointment to discuss the issues.
Complaint regarding treatment and delay in referrals to other services.	Explanation to the complainant that GP practice was not responsible for delays.
Complaint regarding cancelled appointment and delay in referral to another service.	Explanation to the complainant that doctor was sick and that GP practice was not responsible for delays.

# Well-led

# Rating: Inadequate

At the last inspection on 15 December 2018 we rated the practice as good for providing well-led services. At this inspection on 30 and 31 August 2023, we have rated the practice as inadequate. This is because:

- Leaders had not identified the risks we found during the inspection.
- Processes to monitor performance, assure quality and drive improvement were not established.
- Systems for managing risks were not effective.
- Policies were not managed well and not always followed.
- Confidential records were not stored securely.

## Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Leaders were not always aware of the risks, issues and challenges relating to the service.</li><li>• The lead GP and practice manager had not identified some of the issues we found during the inspection. They were not always aware of what was required to address some of the challenges they faced.</li><li>• The lead GP had started to consider a succession plan, but no definite plans were in place. Following the inspection the GP informed us that they had taken on a partner, however the legal processes had not been completed nor a change in the registration of the practice.</li><li>• There had been some consideration of an assistant manager to support the practice manager but steps had not yet been taken to enable this to happen. The practice manager felt they were working reactively and not making any ground on tackling the backlog of work that was needed as they spent their time on the everyday here and now running of the practice.</li><li>• Staff did not always feel supported or listened to.</li></ul>	

## Vision and strategy

**The practice did not have a clear vision that was 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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N



Explanation of any answers and additional evidence:

- The practice did not have a vision or strategy in place for their future plans, ambitions, aspirations or goals. They did not have a business plan or mission statement in place.
- The practice did not have a set of beliefs or values or a charter of how they would work and how they treated their patients.
- Staff had not been consulted, nor were involved in creating a vision for the future or the standards and values they should uphold.
- Therefore the practice did not have the capability of monitoring their progress against delivery of a strategy.

## 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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	N
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.	N
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff feedback indicated that the majority of staff felt unsupported in aspects of their roles. Their experience was not one of a supportive culture and this left them feeling uncomfortable. Feedback received and observations undertaken during the inspection indicated staff wellbeing was not a priority, due to competing challenges and the difficulties managers were facing.</li> <li>• Staff reported that they were left alone and felt vulnerable during evening and extended hours clinics as GPs left the building when they had completed their appointments and as the practice was still open patients may come into the practice seeking a doctor's input, but this was not available.</li> <li>• Equality and Diversity training was deemed mandatory by the practice however training records showed that 1 out of 8 clinical staff had completed the training. All non-clinical staff had completed the training.</li> <li>• A freedom to speak up guardian was in place in the practice. However, some staff expressed the view that they were not confident that actions would be taken when they spoke up.</li> <li>• We were told that working relationships between staff were positive on the whole but challenges in staffing and managerial support made it a difficult environment to work in sometimes.</li> </ul>	

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

Source	Feedback
Staff Questionnaires	There were common themes that described a lack of support and visibility of leaders. Staff felt there were good relationships between staff but that leadership and direction was needed.

Governance arrangements

**There were no clear responsibilities, roles and systems of accountability to support good governance and management. The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice governance systems were not established and therefore did not support effective monitoring of performance and standards.</li><li>• There was a lack of oversight to monitor and manage staff mandatory training to ensure staff had up to date knowledge and skills to undertake their roles. This was predominantly an issue for clinical staff as records showed 7 out of 8 clinicians had incomplete evidence of their completed mandatory training. All administrative staff were up to date with their mandatory training. There was limited oversight into the quality and performance of clinical staff and there was no evidence of any formal supervision or monitoring of their performance.</li><li>• The practice did not have effective quality assurance and internal audit processes in place. They did not monitor their performance to identify areas for improvement.</li><li>• The practice policies and procedures were not managed well and were either out of date or not in place at all. The incident reporting policy and the complaints policy were out of date and contained information relating to the previous practice manager who had left the practice 2 and a half years ago.</li><li>• There was no evidence of supervision, oversight and clinical support for clinical staff. No clinical supervision meetings were evidenced and staff told us these did not take place. There was no evidence of oversight of clinical staff whose work was not sampled or assessed for quality.</li></ul>	

**Managing risks, issues and performance**

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Risk management procedures had not been established and managers did not have an understanding or overview of risks within the practice.</li> <li>• Risks were not recorded or routinely reviewed to detail the actions to manage and reduce any known risk. For example, staffing issues, inability to provide home visits at times and backlog of records that required summarising.</li> <li>• Where issues were identified, such as issues with waste management, there were no action plans established to ensure these actions were rectified and completed.</li> <li>• There was no monitoring or any improvement programmes to look at services provided, how the services could be improved, or the impact on the quality and sustainability of the practice.</li> <li>• There were no systems to identify or gather information about the performance of the practice and no processes to then address any identified issues and so improve the quality of the service. For example, there was no auditing of clinical practices or administrative services to then review any risks or changes needed to the service provided.</li> <li>• A business continuity (major incident) plan in was in place in the event of untoward and unexpected events that may affect the service.</li> </ul>	

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
Explanation of any answers and additional evidence:	

- Information and action taken on issues and risks were not all recorded to provide an audit trail of what action was planned or had been taken. For example, complaints and staff performance management had not been recorded to ensure a clear audit trail and evidence of what action had been taken if any.
- We saw that incidents reports were not followed up and their outcomes documented, or if this informed performance management processes.
- There was no evidence of effective performance measurement, quality assurance and audit.
- There was no evidence of staff supervision, oversight of their performance or development and oversight of the training and competence. Only 1 member of staff had received an appraisal.

## Governance and oversight of remote services

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

## Engagement with patients, the public, staff and external partners

**The practice involved the public and external partners to inform their care provision.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice did not have a Patient Participation Group at the time of the inspection.</li> </ul>	

**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
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• We saw evidence that feedback from patients was used to improve services such as the implementation of a new telephone system and the implementation of a dedicated medication line.</li><li>• We saw some examples of incidents being recorded when things went wrong. These were documented on a standalone incident report. We also saw that the clinician responsible made comment or reflection on what went wrong. However, this had never led to the documentation of any meaningful action. There were no examples of any completed investigations, outcomes or actions implemented from these incidents. The incidents we reviewed were not followed up, nor closed or learning shared. We asked for evidence of any other learning or outcomes or where incidents were discussed in meetings and we were told this did not happen. We asked for any other evidence of the management of incidents and this was not provided. A log was not kept of incidents so that analysis of themes and trends could be examined.</li><li>• Complaints were not used to identify areas of risk or to drive improvement. Complaints were responded to in isolation and explanations provided to the complainant. But there was no further discussion, sharing with and involvement of staff, nor consideration of wider learning or implementation of changes made to ways of working. There was no annual review of complaints as described in the practice policy, nor any evidence that these were discussed at team</li></ul>	

Examples of continuous learning and improvement
<ul style="list-style-type: none"><li>• Implementation of a new phone line for medication requests and the installation of a new telephone system.</li></ul>

**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 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 those aged 25 to 49, and within 5.5 years for those 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.