

# Care Quality Commission

## Inspection Evidence Table

### The Firs (1-557829747)

Inspection date: 6 and 7 June 2022

Date of data download: 14 June 2022

## Overall rating: Inadequate

### Safe

### Rating: Inadequate

At the previous inspection on 27 October 2022, we rated the practice as inadequate for providing safe services because:

- Although the practice had taken steps to address the areas of concern identified at our previous rated inspection, we identified further concerns around safe services.
- There was inconsistent follow-up from external safeguarding meetings.
- There were delays in actioning test results and workflow tasks, and a lack of oversight of these processes.
- The system to monitor cervical screening results was not effective.
- We identified instances where medicines for patients with specific long-term conditions had been issued without the appropriate monitoring having taken place.
- The practice did not have an effective recall system to ensure that patients had regular structured medication reviews.

At this inspection we rated the practice inadequate for providing a safe service because:

- The provider had failed to put an effective process in place for the structured annual medicines reviews for patients on repeat medicines and this puts patients at potential risk of harm.
- The practice was unable to complete the backlog of work due to insufficient staff.
- The recall system for patients referred to secondary care did not check that patients with abnormal cervical screening results had attended their appointments.

### Safety systems and processes

**The practice had some 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.	Y
Partners and staff were trained to appropriate levels for their role.	Y

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection on 27 October 2021, we found the systems to safeguard children and adults were ineffective. This was because we identified examples where there was no evidence that the practice had appropriately followed up on information discussed at external safeguarding meetings. Following the inspection, the provider submitted information to state these patients had now been followed up.</li> <li>At the inspection on the 6 and 7 June 2022, the practice manager had implemented a system for both adults and children who were identified as a safeguarding risk, to ensure all were correctly identified on the patient record system and were followed up appropriately. A GP partner was the safeguarding lead and the practice had allocated a member of the administration team so that all work could be processed appropriately.</li> <li>The practice manager explained they held monthly meetings with the health visitor to discuss children's safeguarding concerns, but this had been disrupted whilst they were awaiting the allocation of a new health visitor. However, the safeguarding lead and administrator had continued with the meetings to review the safeguarding lists, and ensure cases were appropriately followed up. Adult safeguarding concerns were discussed at integrated care meetings and a new health visitor was allocated from 31 May 2022. However, we found two patients who did not have the correct alerts to identify them as a safeguarding risk in the patient record system.</li> <li>Staff had completed up to date adult and child safeguarding training to an appropriate level. Staff were able to describe things which might constitute a safeguarding concern and told us they felt confident responding to safeguarding concerns by immediately reporting to a manager or GP.</li> <li>We reviewed two staff files who had recently joined the practice and found the appropriate Disclosure and Barring Service (DBS) checks had been carried out. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</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:	

- We found the practice had a recruitment policy in place which was last reviewed in April 2022, and a review of two staff files who had recently commenced working at the practice had confirmed the practice had the necessary documentation to ensure they were suitable for the role. However, we found the practice did not hold the up-to-date training records of some staff members, which meant they could not be confident they were competent for their roles.
- Systems were in place to ensure staff registration with other bodies was updated, and their immunisation statuses were reviewed.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 5 May 2022	Partial
There was a fire procedure. Date of fire risk assessment: 1 March 2021	Y
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 building was leased from NHS England, who were responsible for the general maintenance. A health and safety risk assessment was completed on the 2 May 2022; however, this did not include the risk in a consultation room where we observed there was a mold area on the ceiling above the GPs desk. Exposure to mold can be an irritant eyes, skin, nose, throat, and lungs.</li> <li>• A fire risk assessment had been carried out by an external fire safety company on 4 March 2021. Recommended actions had been resolved or were in the process of being addressed.</li> <li>• A fire drill was carried out in October 2021.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had responded to the actions required in the infection prevention and control audit. For example, the overflow handbasins were to be improved in September 2022.</li> </ul>	

## Risks to patients

**The systems to assess, monitor and manage risk were sometime ineffective.**

	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.	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>We found there was not enough staff with the appropriate skills to provide appointments. For example:</p> <ul style="list-style-type: none"><li>• The practice had one practice nurse who worked two days a week and was the only member of the nursing team who carried out cervical screening.</li><li>• The number of outstanding long-term condition health and medicines reviews demonstrated that not enough appointments were available.</li><li>• All staff had completed sepsis awareness training and adult and child basic life support.</li></ul>	

## Information to deliver safe care and treatment

### Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
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>The practice had a system in place to monitor urgent two-week wait referrals. However, we found the recall system did not check that patients with abnormal cervical screening results had attended their appointments. At the previous inspection on the 27 October 2021, we found delays in the workflow system for actioning tasks and actioning test results. In response, to our findings, we imposed an urgent condition on the practice's registration. This was that the provider must review the system for managing and actioning pathology results and workflow tasks and ensure appropriate clinical oversight of this process.</li> <li>In response to the condition of registration, the provider submitted that the practice had implemented an actioning pathology results protocol in November 2021, they allocated a clinical lead to have oversight of this process and allocated specific GP time to ensure the pathology results were actioned promptly. In addition, any results or tasks not completed within 2 working days were flagged and appropriate administration time was scheduled to clear this. On the day of our inspection 6 June 2022, we found there was 67 documents to review and the oldest was from the 31 May 2022, (Please note there was a bank holiday on the 2 and 3 June followed by a weekend).</li> </ul>	

## Appropriate and safe use of medicines

The practice had an ineffective system for the appropriate and safe use of medicines, as there was an ineffective recall system to ensure patients had a regular structured medication review.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.55	0.60	0.79	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	12.2%	9.6%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	6.17	5.74	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	90.7‰	64.5‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.51	0.47	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.2‰	5.4‰	6.8‰	No statistical variation

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

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed a sample of records for patients prescribed high-risk medicines which required monitoring (such as methotrexate and warfarin) and found that blood test results were up to date prior to prescribing.</li> <li>• We found there was an ineffective process for the structured annual medicines reviews for patients on repeat medicines. This was because at the previous inspection on the 27 October 2021, we found the practice did not have an effective recall system in place to ensure that patients had regular structured medication reviews. We also, found some examples of patients prescribed multiple medicines for various health issues, where there was no evidence in their records, they had had a medication review. In response, to our findings, we imposed an urgent condition of the practice's registration. This was that the provider by 12 midday on 15 November 2021 must undertake an audit to identify those patients who had not received a medication review in the previous 12 months who should have had one, and put a plan into place to manage the review and the review for all identified patients must be completed by a suitably qualified skilled and competent professional by 1 March 2022.</li> </ul>	



Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• The practice submitted information on the 11 November 2021 which stated the practice had identified 122 patients who had not had a medication review in the last 12 months. An audit the practice carried out in May 2022 stated that on the 18 May 2022 there were 50 outstanding medication reviews, which included new patients who were now due for a medication review. However, on the day of the inspection, we carried out a search of the patient records and found 2865 patients on repeat medications as of 7 June 2022. One thousand one hundred and twenty-two of these patients had a review completed within the last 12 months (39%), with a remaining 1743 (61%) still awaiting a medication review, which would have put patients at potential risk. When we asked the managers about the difference in figures, we were told they had only carried out a search of the patient records where they had a diary entry, which would have restricted the number of patients identified.</li> <li>• Of the 1122 patient reviewed, we reviewed a sample of nine and found eight had an appropriate medication review and one had abnormal test results which was not followed up as well as their observations not being checked.</li> <li>• We were not provided with any evidence that the advanced nurse practitioner, who was an independent prescriber, was part of any medication audits. In addition, we the clinical supervision of the advanced nurse practitioner was sometimes ineffective.</li> </ul>	





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

The practice mostly learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	18
Number of events that required action:	18
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a significant events spreadsheet which was used to record and monitor incidents. The practice manager was responsible for the management of the significant events. We were told that significant events were discussed in meetings. However, from a sample of management and clinical meetings we saw this was not a regular agenda item.</li> <li>The practice nurse gave an example of a significant event where a child was called for their childhood immunisations but had already had the medicines.</li> </ul>	

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

Event	Specific action taken
A fast-track referral to secondary care, was delayed.	The GP had not sent the referral to the administration team via the two weeks wait process. A reminder was sent to send the administration task to administration using the correct process.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a spreadsheet to record receipt of safety alerts which was accessible to clinicians. We saw there was a column to record how many patients were affected by the safety alert and the outcome for any affected patients.</li> <li>We reviewed a sample of patient records who were prescribed sodium valproate and found one patient who had not been informed of the risks of taking this medicine.</li> </ul>	

## Effective

## Rating: Inadequate

*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.*

At the previous inspection on 27 October 2021, we rated the practice inadequate for providing an effective service. This was because patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance. There was ineffective diagnosis, management and oversight of patients with long-term and other health conditions, and no system in place to ensure patients with long-term conditions were offered an annual review. In addition, childhood immunisations and cervical screening uptake rates for April 2019 to March 2020 were below national targets, and some staff did not have the appropriate skills and training to carry out long-term condition reviews.

At this inspection we continued to rate the practice inadequate for providing an effective service, because we found patients were put at risk of harm. For example:

- We found examples where current evidence-based guidance was not followed.
- The practice had only carried out approximately 50% of the outstanding long term health condition annual reviews.
- The practice did not have a system in place to respond to the needs of patients who were receiving end of life care.
- The practice had limited assurance that staff were competent for their roles.
- Patient consultation records for long-term health conditions were sometimes ineffective and had evidence that the patients care, and treatment was not appropriately reviewed.
- The practices uptake for childhood immunisations and cervical screening was below the World Health Organisation targets.
- The practice did not keep a copy of the patients Do Not Attempt Cardiopulmonary Resuscitation form in the patient records.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
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.	N

We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Partial

Explanation of any answers and additional evidence:

- At the previous inspection on 27 October 2022, our review of clinical records demonstrated that patients with long-term health conditions were not offered an annual review to ensure their health and medicines needs were being met. The practice did not have a system in place to ensure that long-term conditions reviews or medication reviews were regularly carried out for patients, to monitor their care and check if they were receiving appropriate treatment.
- In response, to our findings, we imposed an urgent condition of the practice's registration, which required them by 12 midday on 1 March 2022, to carry out all the outstanding monitoring reviews by a suitably qualified, skilled and competent professional. The provider also had to submit what resources would be used to carry this out and provide the Commission with two weekly updates.
- At the inspection of the 6 and 7 June 2022, we found that as of the 23 May 2022 the practice had completed 897 reviews, this was approximately 50% of the outstanding reviews. This meant that 50% of patients had not had a review and continued to remain at potential risk of significant harm.
- In addition, we reviewed the patient consultation records of long-term health conditions and found they were sometimes ineffective and had evidence that the patients care, and treatment was not appropriately reviewed, putting service users at potential risk of significant harm. For example, we found patients with asthma requesting high numbers of inhalers or describing poor asthma control, with no evidence in the patient record that action was taken to review the patient, escalate treatment or follow-up to improve the patient's asthma control. In addition, we found patients with hypothyroidism without up-to-date thyroid function monitoring or clinical staff responding to abnormal blood results.
- A review of patient records found one case where The National Institute for Health and Care Excellence Guidance (NICE) Suspected cancer: recognition and referral guidance (Published: 23 June 2015 Last updated: 15 December 2021) was not followed.
- For patients who did not have a long-term health condition who were prescribed repeat medicines we found for some their treatment was not regularly reviewed and updated.

## Effective care for the practice population

### Findings

- We found the practice did not have a system in place to monitor and respond to the needs of patients who required end of life care, and staff were unaware of the gold standard framework for palliative care.
- The practice provided unverified data to demonstrate they had completed 71% of annual reviews of people with a learning disability.

- The practice provided unverified data to demonstrate they had completed 43% of annual reviews for patients experiencing mental health problems. When we reviewed five patient records, we found three were not carried out in the previous 12 months.
- Staff members explained how they organised online groups for prediabetic patients.

## Management of people with long term conditions

### Findings

- At the previous inspection on 27 October 2021, our review of clinical records demonstrated that patients with long-term health conditions were not offered an annual review to check their health and medicines needs were being met. In response, to our findings, we imposed an urgent condition of the practice's registration, which required them by 12 midday on 1 March 2022, to carry out all the outstanding long-term condition monitoring reviews by a suitably qualified, skilled and competent professional.
- At the inspection of 6 and 7 June 2022 we found that as of the 23 May 2022 the practice had completed 897 reviews long term conditions health reviews, this was approximately 50% of the outstanding reviews. This meant that 50% of patients had an outstanding annual review and continued to remain at potential risk of significant harm.
- In addition, a review of patient consultation records of long-term health conditions, which were carried out by staff members found the annual reviews were sometimes ineffective and had evidence that the patient's care and treatment was not appropriately reviewed. This had put some patients at the potential risk of significant harm.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Hemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	78	95	82.1%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	72	89	80.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	72	89	80.9%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	72	89	80.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	81	126	64.3%	Below 80% uptake

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

### Any additional evidence or comments

- At the inspection on 27 October 2021, the practice's childhood immunisation uptake rates for April 2019 to March 2020 were below the World Health Organisation (WHO) targets for children aged two and five. In addition, we found the recall system for childhood immunisations was not effective, as we identified examples where the practice had not followed up or recalled children for their immunisations.
- In response, to our findings, we imposed an urgent condition of the practice's registration, this was to identify all patients who had not been recalled for childhood immunisations and ensure they were invited for an appointment where required and followed up appropriately and report to the Commission.
- The practice responded to the Commission on the 25 November 2021, the response included the number of patients who were due a vaccination, and how the practice had responded to all of the childhood immunisations age cohorts. On 3 December 2021 the practice submitted an update of the uptake of the childhood immunisations, which stated of the patients identified on the 25 November 2021 the uptake was:
  - For the first dose of measles, mumps and rubella (MMR) the uptake was 73%.
  - For the second dose of MMR and DTaP/IPV booster the updated on the 3 December was 57%.
  - For the third dose DTaP the uptake on the 3 December was 77%.
- In addition, a senior administrator had carried out audit of childhood immunisations in the practice, where they had reviewed all children under the age of five years. For the 12 months prior to 31 May 2022, they had achieved:
  - 41% of children aged eight months 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).
  - 50% of children whose first MMR vaccine administered from the date they reached 12 to 18 months.
  - 51% of children who had two doses of MMR whilst they were aged at least one year and less than five years of age and a booster dose of DTaP/IPV vaccine whilst they were less than five years.
- The audit recognised the data showed a major difference in the percentage of uptake across the board when comparing the Firs to National, London and Local data. This audit stated the practice had enlisted the help of the Clinical Effectiveness Group and a new type of software that enabled the practice to see which patients were overdue their vaccination and those who were upcoming. A further audit was planned for four months' time.
- The practice had implemented a Managing Childhood Immunisation policy in February 2022. This described the process for the recall of patients for their childhood immunisations.

- We checked ten patient records who had been administered a vaccine and found staff had recorded appropriately in their notes.
- However, the above audit submitted by the practice demonstrated that the uptake and follow up of children to attend their vaccinations was not fully effective. In addition, we were told that the practice nurses did not offer early or late appointments, they were only available from 9am to 6pm.



Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	59.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.1%	54.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.8%	58.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	69.2%	53.2%	55.4%	No statistical variation

#### Any additional evidence or comments

- At the previous inspection in October 2021, we found the uptake for cervical screening was below the Public Health England 80% target and recall of patients to attend their appointments was not effective, as we identified examples where the practice had not effectively followed up or recalled patients for cervical screening.
- In response, to our findings, we imposed an urgent condition on the practice's registration, which was to identify all patients who had not been recalled for cervical screening and ensure they were invited for an appointment where required and followed up appropriately and report to their findings to the Commission. The practice responded to the Commission on 25 November 2021, for patients ages 50 to 64 who should have a cervical screen every 5 years, there were 183 patients and for patients ages 25 to 49 who should have a cervical screen every 3 years, there were 559 patients.
- On 3 December 2021 the practice submitted an update regarding the take up of cervical screening by these patients. All patients aged 50 to 64 were called at least once to be invited for their cervical screening, for the age of 25 to 49, the practice had organised three clinics, however, these had not gone ahead due to staff absences.
- The practice nurse had completed an audit of cervical screening in May 2022. The audit was from October 2021 to 31 March 2022, the audit reviewed the overall number of cervical screens carried out and the number of samples that were either rejected or inadequate or came back abnormal. In response to the findings any patients who had a rejected or inadequate smear, were reviewed, and followed up. However, it did not review whether the 10 patients who had abnormal cervical smears had been followed up appropriately.
- The practice had implemented a protocol for Managing Cervical Screening in February 2022. The policy stated for patients who did not respond following three failed attempts and a letter from the practice, they would be invited in the next tax year. However, this did not include the

follow up of patients who had an abnormal cervical smear to check they had been pursued by secondary care. This was confirmed when we spoke with staff who also told us the practice did not follow up patients with an abnormal smear to check they had attended their appointment with secondary care.

- The provider submitted unverified data to show that from 1 April 2021 to 31 March 2022, the practice had achieved 55% for ages 25 to 49 and 74% for ages 50 to 64.
- At the time of the inspection, the practice nurse who worked two days a week, was the only member of the nursing team who carried out cervical screening.
- The system the practice had put in place to recall patients for cervical screening, was not fully effective because it did not include checking patients with an abnormal result had attended an appointment at secondary care. In addition, the uptake had remained below the WHO targets, which may have been caused the use of only one member of the nursing team to carry out cervical screening and the lack of appointments outside of core working hours.

## 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.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Not inspected

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

<p>We were provided with the following audits by the practice manager:</p> <ul style="list-style-type: none"><li>• These two audits which were a report of the number of patients due a review along with a narrative about what actions they plan to take.</li><li>➤ Medication reviews which looked at the backlog of medication reviews that had been noted in October 2021 and spanned from November 2021 to May 2022.</li><li>➤ Long-term condition management to review the progress made since November 2021.</li><li>• DNACPR (Do not attempt to cardiopulmonary resuscitation) from 1 November 2021 to 31 May 2022. The audit reviewed the effectiveness of a new clinical system to identify and review patients who required a DNACPR. It looked at the number which had been reviewed (9) and what had been put in place, it did not look at the quality of the DNACPR.</li><li>• Cervical screening undertaken at The Firs. However, it did not review whether the 10 patients who had abnormal cervical smears had been follow up appropriately.</li><li>• Childhood immunisations, which reviews the practices uptake.</li></ul>
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## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	N
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Following the inspection on 27 October 2021, we imposed a condition on the practice because we found staff without the necessary competencies and training had carried out long-term health reviews. The condition required the practice to ensure that patients who were due or had outstanding monitoring requirements received a monitoring review carried out by a suitably qualified, skilled and competent professional.</li> <li>At this inspection, we carried out a review of staff training records, we found the management team did not have evidence that some staff had completed role specific training, for example, cervical screening, immunisations, diabetes and asthma. This meant that the management team could not have been assured of some staff members competency to carry out their roles, or of their competency to carry out supervision of other staff members. In addition, we reviewed the patient consultation records of some clinical staff and found examples of ineffective health reviews.</li> <li>We found the advanced nurse practitioner did not have a scope of practice in place (A scope of practice is the limit of the healthcare workers knowledge, skills and experience and was made up of the activities that can be carried out within their professional role. As a health and care professional, they must keep within their scope of practice at all times to ensure they are practicing safely, lawfully and effectively).</li> <li>We were told the clinical lead carried out the quarterly review of clinical records for all clinical staff.</li> <li>We reviewed the quarterly review of the clinical records for the advanced nurse practitioner, and looked at three consultation notes from this review, we found that the reviews were inaccurate and did not identify concerns in the prescribing, or monitoring. Also, the reviewer had not recorded the review in the patient records.</li> <li>In addition, the practice did not have a system in place to monitor the competency of locum nursing staff who had carried out patient long-term health condition reviews. When we</li> </ul>	

reviewed ten of the consultations for long term health condition reviews carried out by the locum, we found eight had not been carried out effectively. This demonstrated that the practice did not have a safe and effective system in place to ensure the competency of staff members.

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

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

## Helping patients to live healthier lives

### Staff helped 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 participated in social prescribing (social prescribing is a means of enabling GPs to refer people to services in their community instead of offering only medical solutions).</li> <li>The practice had an in-house social prescriber through their primary care network, to whom staff (both clinical and non-clinical) could refer patients for help or support with the patients' consent.</li> <li>The practice also referred patients to adult improving access to psychological therapies (IAPT) services.</li> </ul>	

## Consent to care and treatment

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

	Y/N/Partial
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Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection we found the practice did not code on its own clinical system when a DNACPR decision had been made, and therefore the practice could not tell us how many patients had a DNACPR decision in place and was not able to run a search to identify, monitor and review any DNACPR decisions.</li> <li>At this inspection we found the practice had now coded patients with DNACPR in their own clinical system and had carried out an audit in May 2022 which covered the time from 1 November 2021 to 31 May 2022. This examined the new system that was in place. We reviewed four patient records and saw that the practice had carried out home visits to put in place the DNACPR and had involved relatives. However, they did not retain a copy of the DNACPR form to add to the patient's medical records. This meant that there could be a lack of sharing accurate and up to date communication affecting continuation of care.</li> </ul>	

## 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

Patient feedback	
Source	Feedback
The practice submitted an audit of patient's feedback carried out in May 2022, where 50 patients submitted feedback.	<p>This included written feedback such as:</p> <ul style="list-style-type: none"> <li>• Staff are always friendly and helpful.</li> <li>• I have always been treated respectfully and really appreciate the doctors &amp; staff of my surgery.</li> <li>• Excellent GP and staff so friendly and polite.</li> <li>• The team at The Firs are very good at the ten times I need to speak to a doctor nine times I have been through the teams very good and try to help us and many mention our names is even more personal that they remember us.</li> </ul>
NHS choices	<ul style="list-style-type: none"> <li>• The overall rating for the practice is 1.5 stars.</li> <li>• The last reviews submitted in the last five months eight were one star and two were five stars. The main issues raised were accessing the practice.</li> </ul>

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	83.1%	85.0%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very	81.7%	82.8%	88.4%	No statistical variation



Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	97.4%	92.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	67.3%	77.0%	83.0%	Tending towards variation (negative)

#### • Any additional evidence or comments

- In the practice survey carried out in May 2022, when asked how they would rate the surgery overall, 65% stated it was good or excellent and 32% stated it was fair. Only 10% stated it was poor.

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

#### Any additional evidence

- The practice had carried out a patient survey in May 2022 to obtain feedback from patients about the service and identify any areas of improvement. The survey included questions relating to overall experience, getting through by telephone, appointments, staff attitude and behaviour, and support to manage health conditions.
- The results for 50 patients who completed the survey form were generally positive about the way they were treated by staff and staff behavior (please note that rounding up/down percentages and some respondents not answering all questions may have resulted in the percentages not totaling 100%):
  - In response to the question 'how helpful are the receptionists', 45% said excellent, 30% said good, 18% said fair, and 8% said poor.
  - In response to the question 'how would rate the GP or nurse at listening to you', 47% said excellent, 31% said good, 14% said fair, and 8% said poor.
  - In response to the question 'how would you rate the GP or nurse at treating you with care and concern', 39% said excellent, 39% said good, 14% said fair, and 8% said poor.
  - In response to the question 'how would you rate your confidence and trust in the nurse or GP', 41% said excellent, 37% said good, 12% said fair, and 10% said poor.

## 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

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	87.6%	88.8%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Not inspected
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>The practice website had information about local diabetes support groups, and links to the NHS website for information and guidance for other issues (such as carers support, paying for care, social services).</li> <li>The staff explained some were able to translate and they had used language line for patients where English was not their first language.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>At our inspection we found the practice had identified 61 carers (0.8% of the practice list).</li> </ul>

How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• There was a carers document to provide carers with information such as national and local organisations, like Carers UK, Waltham Forest, Carers Association, and Carers First Waltham Forest.</li> <li>• Carers were also offered an annual influenza vaccine.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• At the previous inspection we found, the practice had a document to share with recently bereaved patients called 'A guide to the days following bereavement'; this set out practical arrangements (such as contacting a funeral director, obtaining the death certificate and registering the death), as well as sources of help and support (such as Age UK, Bereavement Advice Centre, Samaritans, and The Compassionate Friends). In addition, the practice would send a card to the relatives.</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

## Responsive

## Rating: Requires Improvement

At the inspection in October 2021, we rated the practice as requires improvement for providing responsive services because feedback from patients indicated that they were not always able to access care and treatment in a timely way. The practice's GP patient survey results for 2021 were significantly below the national average in relation to telephone access. Whilst the practice had made changes to its telephone system to improve access, it was too early to ascertain the impact of these changes and whether access had indeed improved for patients.

At this inspection we have continued to rate the practice as requires improvement for providing a responsive service. This is because.

- The practice only offered practice nurse appointments within working and school hours which limited access to appointments for children and working adults.
- The results from the practice's own survey continue to demonstrate that patients find accessing appointments a poor experience.

### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
<b>Opening times:</b>	
Monday to Friday	From 8am to 6.30pm
<b>GP Appointments available:</b>	
Monday to Friday	From 8am to 12pm and from 2.30pm to 6.30pm
Patients telephoning when the practice is closed are directed to the local out-of-hours service provider, which offers evening and weekend appointments for the practice's patients.	

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

- Only one practice nurse who worked two days a week during core working hours carried out cervical screening. This limited patient access to cervical screening.
- The practice did not have nurse appointments available prior to 9am or after 6pm for school age children or working age people so that they did not need to miss school or work (for example, for immunisations)
- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.
- Parents or guardians calling with concerns about a child were prioritised for an appointment when required.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Pre-bookable appointments were available on Saturday and Sunday to all practice patients at additional locations within the area, as the practice was a member of a GP federation.

## Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice	Partial
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	Y
Patients with most urgent needs had their care and treatment prioritised	Y

There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice told us they provided a range of appointments, including e-consults, telephone consultations and face-to-face appointments. We saw evidence on the appointment system that patients were booked for a mixture of telephone consultations and face-to-face appointments. The provider submitted information to demonstrate the range of appointments carried out in May 2022, which stated they had carried out 320 face to face and 1030 telephone triage appointments and two home visits. In addition, they had responded to 172 e-consultations (online). On the 6 June 2022, the practice stated the next pre-bookable appointment was on the 8 June 2022.</li> <li>• We were told by management staff that the majority of GP appointment slots were 'on the day' appointments, so patients needed to call in during the morning to book a appointment.</li> <li>• The practice monitored the telephone calls into and out of the practice, this showed that in April 2022 they had a total of 3,884 were answered and the average wait was 5.52 minutes</li> </ul>	

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	26.3%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	50.5%	65.8%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	50.5%	64.4%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	77.0%	76.3%	81.7%	No statistical variation

### Any additional evidence or comments

- The practice had implemented a new telephone in July 2021, which had a queuing system so patients were made aware where they were in the queue; there was a 'queue buster' feature so patients could put the phone down and be called back automatically when they reached the front of the queue. Live data and regular reporting were available to enable management to monitor demand and telephone usage.
- The practice had carried out a patient survey in May 2022 to obtain feedback from patients about the service and identify any areas of improvement. The results from 50 patients who completed the survey form was mixed about access, appointments and patient needs being met (please note that rounding up/down percentages and some respondents not answering all questions may have resulted in the percentages not totaling 100%):
  - In response to the question 'how was getting through by phone', 24% said excellent, 28% said good, 22% said fair, and 22% said poor.
  - In response to the question 'how was your experience making an appointment', 24% said excellent, 16% said good, 29% said fair, and 31% said poor.
  - In response to the question 'how would you rate the choice of appointments offered', 24% said excellent, 20% said good, 26% said fair, and 34% said poor.
  - In response to the question 'were you given enough time with the healthcare professional', 18% said excellent, 47% said good, 34% said fair, and 20% said poor.
  - In response to the question 'how would you rate your needs being met', 35% said excellent, 39% said good, 18% said fair, and 8% said poor.
  - In response to the question 'how would you rate the support received in the past 12 months to



help you manage your long-term condition(s)', 33% said excellent, 33% said good, 32% said fair, and 10% said poor.

- Patients could also provide comments on the survey form. The comments were positive about the staff team and GPs. With mixed comments about access, one stating the phonenumber is much improved and three stating that more appointments were needed.
- Although the results above were an improvement on the GP survey data taken from 1 January to 31 March 2021 and demonstrated that the new telephone system was an improvement, 22% of patients still found it poor when trying to telephone call the practice and 31% said making an appointment was a poor experience.

Source	Feedback
NHS Choices	<ul style="list-style-type: none"> <li>The overall rating for the practice was 1.5 stars.</li> <li>From the reviews submitted in the last five months, eight were one star and two were five stars. The main issues raised were accessing the practice.</li> </ul>

## Listening and learning from concerns and complaints

### Complaints were listened and responded to and used to review the quality of care.

Complaints	
Number of complaints received in the last year.	44
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a complaints policy in place which was last reviewed in May 2022. The practice manager was responsible for responding to complaints, we reviewed two complaints and found they were responded to in a timely manner and included information about who to complain to if the complainant was unsatisfied with the practice's response. However, the practice manager did not keep the records of the investigation to demonstrate their findings.</li> </ul>	

### Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about the care and treatment provided by a doctor.	We saw the response included an apology and information about the investigation into the concerns and an offer to meet with the doctor.

## Well-led

## Rating: Inadequate

At the inspection on 27 October 2021, we rated the practice as inadequate for providing well-led services. This was because we found a number of concerns around lack of oversight of processes and ineffective clinical systems. In addition, leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care. The practice did not have effective processes for managing risks, issues and performance and we identified several risks to patient safety which had not been recognised by leaders or management. Also, the practice did not use data and information effectively to monitor and improve performance.

At this inspection we have continued to rate the practice as inadequate for providing well-led services. This is because we again found: -

- A number of concerns around lack of clinical oversight of processes and ineffective clinical systems.
- Some leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care.
- We found gaps in the governance arrangements.
- The practice continued to not have effective processes for managing risks, issues and performance.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• At this inspection, leaders did not demonstrate they had the capacity and skills to deliver high quality sustainable care as there was a high number of outstanding long-term health condition and medicine reviews and the limited progress to manage them. This demonstrated a lack of clinical oversight and the potential risk to the patients and the practice.</li><li>• We asked both the practice manager and the clinical lead/GP partner if they had an action plan that included timeframes and risk stratification in place to monitor how they responded to the outstanding reviews of patients with a long-term condition and lapsed medication review and the imposed conditions of registration. We were told they did not have one in place.</li><li>• The management team seemed unclear if they had an organisational risk register, when they were able to find the risk register the management team had not updated it following the imposed conditions and identification of the concerns found at the previous inspection in October 2021.</li><li>• The practice's succession plan was in response to a lead partners prospective retirement.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a mission statement, which stated that ‘they wanted to deliver high quality care to all of our patients tailored and responsive to the needs of the local population’. The outstanding medicine and long-term condition reviews carried out by staff members were sometimes ineffective and had evidence that the patients care, and treatment was not appropriately reviewed. This demonstrated that the leadership strategy for achieving their vision and values was ineffective.</li><li>• Although the practice manager had monitored the progress of the outstanding reviews, during the inspection they did not inform us of a due completion date.</li></ul>	

## Culture

**The practice had a culture which supported, listened to and included staff.**

	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.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
<ul style="list-style-type: none"> <li>Speaking with four non-clinical staff on the day of inspection</li> </ul>	<ul style="list-style-type: none"> <li>The staff we spoke with said they felt well supported and listened to by the leaders and they attended regular monthly meetings</li> </ul>

## Governance arrangements

**There were some gaps in the governance arrangements.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the previous inspection in October 2021, we imposed a condition on the practice's registration that required the practice to inform us of what actions they intended to take to implement a strengthened and sustainable operational clinical and administrative leadership at The Firs. This was to ensure effective governance processes and improvement plans are implemented. The practice responded by allocating clinical responsibilities to the salaried GPs and strengthening the administration leadership.</li> <li>At this inspection we found the practice had two flow charts which clearly described clinical and non-clinical roles. However, we found one member of staff was allocated a role which at the time of the inspection they were not aware of. Also, the clinical lead chart did not fully reflect the previous submission to the Commission.</li> </ul>	

- The practice demonstrated they had regular clinical meetings attended by either or both partners, the practice manager, and the senior administrator, where they had reviewed the progress of the long-term health conditions.
- However, we found clinical oversight of the practice was ineffective due to:
  - The outstanding long-term condition health review and medicine reviews.
  - The lack of effective clinical oversight of clinical staff.
  - The lack of a response to the needs of patients who were on the palliative care register.
  - The lack of an action plan in response to the imposed conditions to monitor progress and completion effectively.

## 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.	Partial
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice manager and senior administration manager had put in place an assurance process to manage any administration risks. However, the clinical system did not have ineffective systems to identify and manage risks. This was demonstrated by the number of outstanding long-term health conditions and medicine reviews that had the potential of risk to patients.</li> <li>• The process to manage performance for the nursing team was ineffective. For example:               <ul style="list-style-type: none"> <li>➤ We reviewed the quarterly consultation notes audit carried out by the clinical lead for the advanced nurse practitioner. Although the audit said they were satisfactory, we found that the some of the reviews were inaccurate and did not identify concerns in the prescribing, or monitoring. Also, the reviewer had not recorded the review in the patient records.</li> <li>➤ In addition, the practice did not have a system in place to monitor the competency of locum nursing staff who had carried out patient long-term health reviews. When we reviewed ten of the consultations for long term health reviews carried out by the locum nurses, we found eight had not been carried out effectively.</li> </ul> </li> <li>• During the inspection when we asked how they had prioritised the outstanding long-term condition and medicine reviews, they were unable to explain how they had taken into consideration abnormal test results.</li> <li>• We found the practices organisational risk register did not include risk found regarding the long-term health condition and medication reviews, or the issues found at the previous inspection.</li> </ul>	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	N
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The outstanding patient reviews demonstrates that the practice did not have effective recovery plans in place to manage backlogs of activity and delays to treatment.</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.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed	Not inspected
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had carried out audits to improve their performance however the outstanding patient reviews demonstrated that this was ineffective.</li> <li>The practice had carried out quarterly consultation reviews of the clinical staff consultation records. However, a review of one member of staff review found these had sometimes not identified the risks. This meant it was difficult to hold staff and management to account.</li> </ul>	

## 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.	Not inspected
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.	Not inspected
The practice ensured patients were informed how their records were stored and managed.	Not inspected
Patients were made aware of the information sharing protocol before online services were delivered.	Not inspected
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Not inspected
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Not inspected



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

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
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.	Not Inspected
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• We spoke with a member of the patient participation group (PPG) who explained the group had been in place for five years and the committee was elected annually at an annual general meeting and they had eight active members. They described the communication as good, and they felt the practice provided open and honest updates. In addition, that they listened to the PPG and responded to their requests.</li><li>• The practice had carried out its own survey in May 2022, to obtain feedback from patients about the service and identify any areas of improvement. The survey included questions relating to overall experience, getting through by telephone, appointments, and staff attitude and behaviour.</li></ul>	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• We were provided with a copy of the most recent meeting minutes on the 12 May 2022, and spoke with the chair, they said the staff listened to their concerns and were open and honest when they updated them about the developments. They said the practice was trying their best under difficult circumstances and the new telephone system was an improvement.</li></ul>

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Not inspected
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had carried out a series of audits to review the number of outstanding reviews with a narrative about what actions they plan to take.</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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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