Care Quality Commission

Inspection Evidence Table

Albany Practice (1-570953512)

Inspection date: 24 September and 14 October 2020

Timeline of inspections

1. We undertook an Annual Regulatory Review (ARR) triggered comprehensive inspection on 09 October 2019. Following this inspection, we issued requirement notices regarding Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance).
2. We requested information from the practice on 11 September 2020 and undertook a comprehensive follow-up inspection on 24 September and 14 October 2020.

Overall rating: Inadequate

Safe Rating: Inadequate

At our previous inspection on 09 October 2019, we rated the practice as requires improvement for providing safe services because we identified concerns in the following areas:

- Safeguarding
- Medicines management
- Recruitment
- Safety-netting of urgent two-week wait referrals
- Safety-netting of cervical screening
- Patient safety alerts
- Infection, prevention and control (IPC)
- Emergency medicines and equipment
- Medicines reviews
- Cold chain management of vaccines and medicines that require refrigeration
- Sepsis and red flag signs training
- Uncollected prescriptions and repeat prescriptions
- Registration of professional staff
- PAT testing
- Fire drills
- Regular training for staff
- Health & safety and premises risk assessments
- Management of test results.

At this inspection on 24 September and 14 October 2020, we rated the practice as inadequate for providing safe services as we found continuing concerns in the following areas:

- Safeguarding
- Medicines management
- Recruitment
- Safety-netting of cervical screening
- Patient safety alerts
- Medicines reviews
- Regular training for staff
- Sepsis and red flag signs training
- Registration of professional staff
- Health & safety and premises risk assessments
- Management of test results

We also found new concerns in the following areas:

- Clinical oversight
- Staff immunisations and certified immunity
- Safe care and treatment
- Missed diagnoses
- Ensuring clinical staff had the necessary qualifications and had been competency checked
- Clinical supervision for clinical staff
- A safe effective system in place to screen appointments for advanced nurse practitioners and clinical pharmacists
- Ensuring clinical staff have valid medical indemnity to undertake services that are not covered by the Crown indemnity scheme for patients at Albany Practice
- Clinical letters and other correspondence were not safely and effectively managed within an appropriate time period

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N 1
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial 2
Partners and staff were trained to appropriate levels for their role.	Partial 3, 4
There was active and appropriate engagement in local safeguarding processes.	N 5
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Partial 6
Disclosure and Barring Service (DBS) checks were undertaken where required.	N 7
Staff who acted as chaperones were trained for their role.	Partial 8
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 9

1. At our previous inspection on 09 October 2019 we identified concerns with the practice's safeguarding processes and procedures. On 11 September 2020 we requested information to follow-up on the requirement notice from 2019 and to inform this inspection on 24 September 2020 (remote review) and 14 October 2020 (on-site visit). At this inspection we found the following:

2. Following our inspection on 14 October 2020, the provider submitted evidence that they had updated their adults and child safeguarding policy on 15 October 2020. The provider had referenced training levels for GP partners, administrative staff and cited a full list of local authority safeguarding contacts. However, neither policy contained references to Intercollegiate safeguarding guidance and female genital mutilation (FGM). For example, their safeguarding policies did not contain details regarding the legal requirement to report FGM; the necessity to undertake safeguarding risk assessments for children whose mother may have been affected by FGM or if they suspected that a female child may be at risk of FGM.

3. We reviewed safeguarding children training records for clinical and non-clinical staff provided by the practice in the form of a training matrix. We found that the practice had not ensured that all staff had undertaken appropriate safeguarding children training in line with 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (January 2019)'. In particular, we found that there was no evidence of any safeguarding children training for three healthcare assistants employed by the practice. In addition, we found that the two practice managers had only been trained to level 1, as had all the non-clinical reception staff. Guidance states that non-clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children should be trained to level 2. This includes practice managers and some reception and administration staff dependent on their role. We saw that all four GPs had undertaken level 3 training within the last couple of months. However, it was unclear if the GP safeguarding children lead, who had undertaken level 3 training on 9 October 2020, had completed a minimum of 16 hours of Level 3 training over a three-year period through a combination of e-learning and face-to-face training in line with Intercollegiate guidance.

4. We reviewed safeguarding adult training records for clinical and non-clinical staff provided by the practice in the form of a training matrix. We found that the practice had not ensured that all staff had undertaken appropriate safeguarding adult training in line with 'Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018)'. In particular, there was no evidence that a practice nurse, a clinical pharmacist and either practice manager had undertaken any safeguarding adult training. We saw that all three healthcare assistants had only been trained to level 1. However, guidance states that all practitioners who have regular contact with patients, their families or carers, or the public would require level 2 safeguarding training. There was no evidence that any of the administrative/reception staff had undertaken safeguarding adult training.

Safeguarding	Y/N/Partial

5. The provider could not demonstrate they were actively and appropriately engaged in local safeguarding processes. For example, they told us they did not attend on-site or virtual meetings and could not produce minutes from local safeguarding meetings. When we asked them if they had engaged with key safeguarding stakeholders, they told us they had not done so. Following our inspection, the practice informed us that vulnerable children were reviewed with the health visitor via email and MDT meetings to discuss vulnerable adults had resumed.

6. The lead GP told us they had not undertaken any reviews of patients on their safeguarding registers since the Covid-19 pandemic began. They did not submit evidence of when they had last reviewed these patients. Following our inspection, the practice informed us that they had contributed to case reviews for vulnerable patients.

7. We asked the provider to demonstrate they were compliant with the regulations regarding Disclosure and Barring Service (DBS) checks undertaken for any new staff they had recruited since our last inspection in 2019. We were concerned that despite providing access to a secure drop box to enable the provider to send us evidence, they submitted information for one locum agency nurse regarding this. Following our inspection, the practice informed us that DBS checks had been undertaken for all new staff recruited.

8. We asked the provider to demonstrate that staff had undertaken appropriate chaperone training since our last inspection in 2019. We reviewed 13 staff training records and saw that three members of staff had completed this training prior to our inspection; nine out of thirteen had completed this training between our GP focused inspection on 24 September 2020 and on-site visit on 14 October 2020, and the provider did not submit evidence for one staff member. Following our inspection, the practice informed us that one member of staff had not completed chaperone training as they worked from home, and the prescribing pharmacist did not undertake chaperone duties. They told us that only staff who had undertaken the necessary training would undertake chaperone duties.

9. The practice had not held multi-disciplinary meetings with health visitors since the onset of the Covid-19 pandemic. They told us if they had any concerns regarding safeguarding, they would refer those concerns to local safeguarding authorities. Following our inspection, the practice informed us that vulnerable children were reviewed with the health visitor via email and MDT meetings to discuss vulnerable adults had resumed.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N [1, 2]
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N [1]
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial [1]

1. We asked the provider on 11 and 24 September 2020 to demonstrate they had carried out recruitment checks in accordance with the regulations. The practice submitted a

recruitment policy following our on-site visit on 14 October 2020. We asked them to submit evidence of recruitment checks undertaken for any new staff they had recruited since our last inspection on 09 October 2019. In addition, when we reviewed the clinical IT system and appointment diary, we saw they had engaged a new locum agency nurse. They did not submit evidence of the recruitment checks they had undertaken for this new member of staff. We were concerned that despite providing access to a secure drop box to enable the provider to send us evidence of recruitment checks, including private sensitive information, for example, photo ID, DBS check, registration checks for professional staff and evidence of immunisations and certified immunity, they had not done so with the exception of a locum agency nurse.

2. The practice did not provide assurance that clinical staff had valid medical indemnity to undertake services that were not covered by the Crown indemnity scheme for patients at the practice.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 07 October 2020	Y 1
There was a record of equipment calibration. Date of last calibration: 19 July 2019	Partial 2
There was a log of fire drills. Date of last drill: 24 September 2020	Y 3
There was a record of fire training for staff. Date of last training: various	Y 4

1. At our last inspection on 09 October 2019 we saw that portable appliance testing (PAT) was last carried out in 2015. This was included in the requirement notice as a breach of Regulation 12. On 11 September 2020 we asked the provider to demonstrate they had carried out PAT testing. Prior to our inspection on 24 September 2020 the provider submitted an email regarding PAT testing that had been arranged for 07 October 2020. At our brief on-site visit on 14 October 2020, we saw records to demonstrate this had been completed.

2. At this inspection we reviewed evidence that calibration for the weighing scale and fridge was overdue. It was last completed on 19 July 2019 and was due to be re-tested in July 2020. The practice showed us email correspondence from 21 September 2020 that confirmed calibration of equipment had been booked for 14 October 2020. Following our inspection, the practice sent us evidence to confirm calibration of equipment such as weighing scales had been undertaken by an external company on 14 October 2020.

3. At our last inspection on 09 October 2019 we saw that the last fire drill undertaken by the practice was in August 2018. This was included in the requirement notice as a breach of Regulation 12. At this inspection we noted the provider had arranged to undertake a further fire drill on the day of our GP focused inspection on 24 September 2020. At our brief on-site visit on 14 October 2020, we saw records to demonstrate this had been completed.

4. The provider submitted evidence regarding fire safety training for staff. We saw that 20 out of 22 staff had completed fire safety training in the last 12 months. We saw from the practice training

matrix that the practice had fire training on a two-yearly update schedule and not an annual update frequency in line with guidance.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2020 and Legionella risk assessment: September 2020	Partial 1

1. We asked the provider on 11 and 24 September 2020 to demonstrate they had undertaken a Legionella risk assessment. They submitted evidence that a Legionella risk assessment had been carried out by NHS Property Services (NHSPS) on 02 April 2020. We noted that there were 19 actions that had not been completed. At our onsite visit on 14 October 2020, we viewed a document which contained a summary of health and safety assessments that had been carried out by either NHSPS or the practice. The practice had tried to engage with NHSPS regarding remedial work identified from risk assessments, however the practice could not be assured that all areas managed by NHSPS were compliant.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial 1
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2020	Partial 2
The practice had acted on any issues identified in infection prevention and control audits.	Partial 2

1. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding infection prevention and control (IPC) training for staff. They submitted evidence regarding IPC training for staff and we saw that one healthcare assistant had not undertaken it and one healthcare assistant had last undertaken this in 2017.

2. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding IPC audits. They submitted evidence they had completed one audit. At our visit on 14 October 2020 we saw the practice had updated their policies relating to IPC and had implemented IPC measures in response to the COVID pandemic. We did not identify any IPC concerns during our site visit.

Risks to patients

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

	Y/N/Partial
Comprehensive risk assessments were carried out for patients.	Partial 1
Risk management plans for patients were developed in line with national guidance.	N 2
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial 3
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.	Partial 3

1. We asked the provider on 24 September 2020 to demonstrate they were compliant with the regulations regarding risk assessments and management plans for patients. At our onsite visit on 14 October 2020, we viewed a document which contained a summary of health and safety assessments that had been carried out at the premises by either NHSPS or the practice. The practice had tried to engage with NHSPS regarding remedial work identified from risk assessments, however the practice could not be assured that all areas managed by NHSPS were compliant. For example, outstanding actions from a Legionella risk assessment.

2. We were not assured that appropriate risk management plans were in place for patients presenting with possible sepsis as some clinical and non-clinical staff had not undertaken training appropriate to their role.

3. We saw the practice had improved its management of emergency medicines and equipment since our last inspection. However, we found from the staff training matrix that not all clinical staff had undertaken sepsis awareness training relevant to their role.

Information to deliver safe care and treatment

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

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial 1
Referral letters contained specific information to allow appropriate and timely referrals.	N 2
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial 2
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial 3, 4
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial 5

1. We asked the provider on the 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, when we discussed safeguarding systems with them, the lead GP told us they had not undertaken any reviews of patients on their safeguarding registers since the Covid-19 pandemic began. They did not submit evidence of when they had last reviewed these patients and did not undertake any virtual or on-site meetings to engage with other stakeholders to share relevant information regarding this. Following our inspection, the practice informed us that they corresponded with the health visitor over email

through the COVID-19 period. Multi-disciplinary team (MDT) meetings to discuss vulnerable adults, including those residing in local care homes, had resumed.

2. During our remote clinical records review on 24 September 2020, we reviewed five patient consultations undertaken by advanced nurse practitioners and a clinical pharmacist. We saw evidence that written consultations did not reflect that these clinical members of staff had checked for 'red flag' signs and symptoms that may indicate serious illness or disease. For example, one referral for a patient with possible cancer symptoms had been delayed and the letter submitted to secondary care was sent as a routine referral. Following our inspection, the practice carried out a significant event analysis on the delayed referral and documented further action that was required for this particular patient. They also planned to review the practices referral processes.

3. During our remote clinical records review on 24 September 2020, we reviewed blood test results for ten patients, used in the diagnosis of type two diabetes. We saw that these patients had had raised results on at least two separate occasions which may indicate they have type two diabetes. The provider could not demonstrate they had reviewed patients' tests results and undertaken appropriate actions for these patients to mitigate the risks associated with this condition. For example, they had not undertaken clinical reviews to confirm the diagnosis, considered prescribing appropriate medicines and referred these patients to the national diabetes programme for screening checks. Following our inspection the practice carried out an audit of these patients and recorded the action they had taken in response. The practice's audit showed that five patients had not been correctly coded as having diabetes and two out of the five had not been correctly diagnosed.

4. During our remote clinical records review on 24 September 2020, we saw seven cervical screening results that remained outstanding and we could not be assured that these results had been reviewed. When we reviewed the relevant patients' records, we saw that six out of seven patients had not been safety-netted. For example, information was not given to the patient about actions to take if their condition failed to improve, changed or they had concerns about their health in the future.

5. During our remote clinical records review on 24 September 2020, we reviewed the management system in place to review pathology results, clinical letters and other items of correspondence. We saw there were 50 outstanding laboratory/pathology results awaiting processing, a significant number of these related to cervical screening/HPV results. There were also 169 correspondence documents awaiting processing, some of these dated back to February 2020. The provider could not demonstrate they had oversight of this to ensure correspondence was actioned and dealt with in a timely manner by clinical and particularly administrative staff. Following our inspection, the provider informed us that outstanding results had been read but were awaiting review by the doctor who requested the test. They informed us that documents awaiting processing had been reviewed but were being held for educational or administrative reasons, for example deferred referrals due to COVID-19. The practice also submitted evidence of a 'results and document processing policy' and a monthly audit for the management of correspondence.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines.

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial 1
There was a process for structured medicines reviews for patients on repeat medicines.	Partial 2
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines with appropriate monitoring and clinical review prior to prescribing.	N 3
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 4
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y 4
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y 5

1. On 11 and 24 September 2020, the provider told us they had informal conversations with the non-medical prescribers at the practice. However, these conversations were not undertaken on a formal basis and were not documented. Following our inspection, the practice sent us evidence that these conversations were now being documented. They also sent us evidence of prescribing training undertaken by the two non-medical prescribers.

2. At this inspection we saw evidence that medicines reviews were not adequately documented following good practice and national guidelines. Of the patient records we reviewed, 27 patients had not had an appropriate review within the past 12 months.

3. At this inspection we saw the provider had made some improvements regarding the management of patients who were prescribed medicines used to treat auto-immune conditions. However, we undertook a review of clinical records regarding medicines management, including those which require monitoring and clinical review prior to prescribing, and we found serious concerns for patients. For example, we saw that 43 patients who were prescribed a medicine to control high blood pressure had not had appropriate blood tests taken within the past 18 months. In addition, we sampled nine patients' records, all of which we had concerns about, and saw that one patient had not had a blood test since November 2017. We were not assured of patient safety regarding medicines management for medicines that required additional monitoring. Following our inspection, the practice informed us they had supplemented their medication review recall system with a secondary monthly assurance dashboard for medicines that require monitoring.

4. At this inspection we saw the provider had made improvements to their emergency medicines and equipment kit since our last inspection on 09 October 2019. This included having risk assessments for three medicines and an effective system to check the kit on a regular basis.

5. At this inspection we saw the provider had made improvements to the management of the cold chain. For example, vaccines and medicines were stored to allow for air circulation. We checked vaccines and medicines and saw they were in date rotated by expiry date. Fridge failure

Medicines management	Y/N/Partial
procedures were kept in a folder with the temperature logs and a warning label was in place on the fridge plug to avoid it being turned off.	

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
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.	Partial 1
Staff understood how to raise concerns and report incidents both internally and externally.	N 2
There was evidence of learning and dissemination of information.	N 1
Number of events recorded in last 12 months:	12
Number of events that required action:	12

1. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding the management of significant events (SEAs). The provider submitted information to us regarding significant events they had recorded and we saw the provider had a system in place regarding this. However, not all incidents and relevant learning were identified or shared to ensure improvements. For example, a missed home visit request and inserting incorrect patient contact details into another patient's clinical record.

2. The provider told us they shared information with staff regarding significant events in monthly meetings. However, on review of minutes of meetings we could not find evidence that SEAs were documented and discussed. In addition, the practice could not demonstrate a system in place that they had reported significant events to the National Reporting and Learning System (NRLS).

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N 1
Staff understood how to deal with alerts.	N 1

1. The practice submitted a spreadsheet they used to manage patient safety alerts. However, when we reviewed a patient safety alert for a medicine used to treat epilepsy and bipolar disorder, we found concerns for six out of six female patients regarding this medicine. For example, there was no evidence on record that female patients have been informed of the risks regarding this medicine or that they had been enrolled on a pregnancy prevention programme. The provider could not demonstrate they had regularly reviewed the patient alert regarding this medicine and taken appropriate actions. The spreadsheet viewed during our inspection did not include all relevant safety alerts including drug safety updates. Following our inspection, the practice reviewed the records of these six patients and outlined the actions they would take to ensure compliance with the safety alert for this medicine.

Effective Rating: Inadequate

At our previous inspection on 09 October 2019, we rated the practice as requires improvement for providing effective services because:

- Childhood immunisations and cervical screening achievement rates were low
- Some staff had not completed training appropriate to their role

At this inspection on 24 September and 14 October 2020, we rated the practice as inadequate for providing effective services because we found further concerns regarding:

- Appropriate core specific training and competency checking for clinical staff
- Childhood immunisations and cervical screening achievement rate
- Sepsis and red flag signs training for staff

We also found new concerns which included:

- Appropriate clinical supervision and appraisal for clinical staff
- Regular training for staff, including infection prevention and basic life support

These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

Effective needs assessment, care and treatment

Patients' 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.	Y 1
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N 1
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N 1
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N 2
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y 3
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A

1. We saw the provider had systems in place regarding accessibility to current evidence-based practice. However, when we reviewed clinical records, we found concerns regarding patient

safety. For example, the monitoring and management of medicines, patients who presented with possible Covid symptoms and patients who had presented with potential symptoms of serious illness or disease. Care and treatment had not been delivered for these patients in line with current guidance.

2. We reviewed blood test results for ten patients, used in the diagnosis of type two diabetes. We saw that these patients had had raised results on at least two separate occasions which might indicate they have type two diabetes. The provider could not demonstrate they had reviewed patients' tests results and undertaken appropriate actions for these patients to mitigate the risks associated with this condition. For example, they had not undertaken clinical reviews to confirm the diagnosis, considered prescribing appropriate medicines and referred these patients to the national diabetes programme for screening checks. Following our inspection, the practice carried out an audit of these patients and recorded the action they had taken in response. The practice's audit showed that five patients had not been correctly coded as having diabetes and two out of the five had not been correctly diagnosed.

3. We reviewed evidence that seven women who had undertaken cervical screening at the practice, had not been followed up and safety-netted. In addition, we found evidence that a referral was delayed for one patient who had presented with potential 'red flag' signs and when the referral had been completed, it was sent as a routine referral.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA)	0.81	0.56	0.70	No statistical variation

Older people — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis. However, we reviewed evidence for one patient in a care home that a home visit had been missed by the practice.

- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.

- The provider told us they participated in regular multidisciplinary meetings with other healthcare professionals to discuss patients at-risk and nearing end-of-life. However, we reviewed evidence that this did not always take place.

- The practice provided care for patients in two care homes in the borough.

- Following our inspection, the practice informed us that they had outsourced home-visiting services to an external provider.

People with long-term conditions Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis. However, we reviewed evidence that care and treatment for patients in this population group had not been managed in a safe and effective way.

- We saw the provider had made improvements to the way it managed medicines for patients with auto immune conditions. However, we found concerns regarding the management of patients with hypertension and in the diagnosis for patients with type two diabetes.

- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.

- The provider could not demonstrate how they had assessed the needs of their patient population.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	82.1%	77.3%	76.6%	No statistical variation
Exception rate (number of exceptions).	1.7% (6)	3.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	90.9%	88.4%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.8% (1)	7.4%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	92.9%	90.2%	91.8%	No statistical variation

Exception rate (number of exceptions).	1.0% (1)	3.1%	4.9%	N/A

Families, children and young people Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis.
- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.
- The data regarding childhood immunisations for 2019-2020 was currently unavailable. Therefore, we had to rely on the available data which covered the time period 2018-2019, as reflected in the report from our previous inspection on 09 October 2019.
- At our previous inspection on 09 October 2019, the provider told us they were aware of the low uptake for childhood immunisations and that historic vaccinations had not been uploaded to the National Health Application and Infrastructure services systems; hence, the data indicated they had low uptake. The provider assured us they had already contacted the local Clinical Commissioning Group to ascertain how they could upload the missing data. However, we have not seen evidence that this has been completed.
- The practice had not met the minimum 90% for four of four childhood immunisation indicators. Therefore, the recommended standard for achieving herd immunity for childhood immunisation uptake indicators had not been reached.

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) (01/04/2018 to 31/03/2019) (NHS England)	86	97	88.7%	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) (01/04/2018 to 31/03/2019) (NHS England)	79	97	81.4%	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	78	97	80.4%	Below 90% minimum

Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	77	97	79.4%	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

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis.
- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.
- The provider's achievement rate regarding cervical screening did not meet the required national target and this was a finding at our last inspection on 09 October 2019. The achievement rate for cervical screening had increased by 2.3% between 2018-2019 and 2019-2020. This was flagged as a significant negative variation.
- Patients could book or cancel appointments online, up to four weeks in advance, and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2020) (Public Health England)	67.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	62.7%	69.2%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	48.8%	50.5%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	100.00%	94.7%		N/A

occurring within 6 months of the date of diagnosis. (01/04/2019 to 31/03/2020) (PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	56.3%	51.5%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis.

- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.

- The practice had a register of patients with a learning disability. At our previous inspection on 09 October 2019, we saw that 51% of this patient group had had a health check undertaken. At this inspection the practice told us that 61 patients were included on the learning disability register and 20 had received their annual health check.

- We saw the provider had provided support to patients, via a social prescriber, who had shielded during the Covid pandemic. However, the provider told us they had not reviewed these patients regularly during the Covid pandemic.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing effective services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

- Due to the Covid pandemic, and in line with current guidance, appointments for patients were being screened initially via an electronic consultation system. Subsequently, appointments were offered and undertaken by telephone, video consultation and on a face to face basis.

- The provider could not demonstrate that all clinical staff had undertaken appropriate core specific training and clinical supervision to safely and effectively manage care and treatment for this patient population group.

- We found concerns regarding the monitoring and management for patients who were prescribed a medicine used in the treatment of bipolar disorder. This was a finding at our previous inspection on 09 October 2019.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, heart disease and access to 'stop smoking' services.

- Same day and longer appointments were offered when required.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	98.4%	88.4%	85.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	19.0% (15)	10.1%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	86.1%	85.4%	81.4%	No statistical variation
Exception rate (number of exceptions).	7.7% (3)	6.8%	8.0%	N/A

Any additional evidence or comments
At our previous inspection on 09 October 2019, we saw that 75.3% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their record. At this inspection on 24 September 2020, we found that 98.4% of patients had a care plan recorded. However, the provider had recorded an exception rate of 19.0% (15 patients), compared with 4.3% (4 patients) at the previous inspection and local and national averages of 10.1% and 16.6%.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	556.2	553.1	539.2
Overall QOF score (as a percentage of maximum)	99.4%	98.9%	96.4%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y 1
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial 1 2
Quality improvement activity was targeted at the areas where there were concerns.	N 2
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

1. On the 24 September 2020 the provider was unable to demonstrate examples of improvements as a result of clinical audits or other improvement activity in the past two years. Following our

inspection, the practice submitted evidence that they had taken part in national and local quality improvement initiatives such as the National Cancer Diagnosis Audit 2020.

2. On the 24 September 2020 the provider could not demonstrate they had a comprehensive programme of quality improvement in place. Following our inspection, the practice provided evidence of quality improvement activities in relation to end of life care and Parkinson's disease. They were also monitoring achievement in areas where concerns had been identified, for example cervical screening and prescribing.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N 1
The learning and development needs of staff were assessed.	Partial 1
The practice had a programme of learning and development.	Y 1
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N 1
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 2
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 1
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

1. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding training for staff. The practice did not send evidence of role-specific training, for example, long-term condition reviews, childhood immunisations and cervical screening. We reviewed the staff training matrix which included the core staff training schedule, for example, safeguarding children and adults, Mental Capacity Act (MCA), basic life support, chaperoning, equality and diversity, fire safety, infection prevention and control (IPC), information governance, sepsis and sepsis awareness. We found gaps in core training for clinical and non-clinical staff in relation to safeguarding children, safeguarding adults, sepsis, chaperoning and IPC. Following our inspection, the practice informed us that not all staff carried out chaperone duties, and they sent us evidence of safeguarding training for some clinical and non-clinical staff. There remained gaps in sepsis, sepsis awareness and safeguarding adults

training for some staff, and the provider did not have oversight of training for an HCA whose main employment was with another practice.

2. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding providing clinical supervision and appraisal for clinical members of staff. The provider told us they had informal conversations with clinical staff at the practice. However, these conversations were not undertaken on a formal basis and were not documented. Following our inspection, the practice informed us that annual appraisals were previously documented. The practice also informed us that supervision with non-medical prescribers would be formally minuted going forward and they provided us with evidence to confirm this had been implemented.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

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, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	95.9%	95.6%	94.5%	No statistical variation
Exception rate (number of exceptions).	0.6% (8)	0.7%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	N/A

Caring Rating: Requires improvement

At our previous inspection on 09 October 2019, we rated the provider as requires improvement for providing caring services because:

- The national GP patient survey indicators were below average.

At this inspection on 24 September and 14 October 2020, we have still rated the practice as requires improvement for providing caring services because:

- The national GP patient survey indicators had deteriorated since our last inspection.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. However, feedback from patients was not always 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

CQC comments cards	
Total comments cards received.	0
Number of CQC comments received which were positive about the service.	0
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0
• For reasons of safety and infection prevention and control related to the Covid pandemic, for both patients and our inspection team, we did not commission patient feedback with CQC comment cards.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	74.2%	84.7%	88.5%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time	66.1%	82.6%	87.0%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	84.4%	93.9%	95.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	55.2%	80.9%	81.8%	Variation (negative)

Any additional evidence or comments

Results from the National GP Patient Survey 2020 showed patient experience on questions about how they were treated had declined since the previous survey carried out in 2019. Results from the 2020 survey showed most outcomes were also considerably below local and national averages. For example:

- The percentage of respondents 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 was 66.1% (CCG 82.6%; National 87%) compared with the 2019 survey which was 69.2% (CCG 81%; National 87.4%).

- The percentage of respondents who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to was 84.4% (CCG 93.9%; National 95.3%) compared with the 2019 survey which was 85.5% (CCG 92.1; National 95.5%).

- The percentage of respondents who responded positively to the overall experience of their GP practice was 55.2% (CCG 80.9%; National 81.8%) compared with the 2019 survey which was 62.2% (CCG 77.8%; National 82.9%).

- The percentage of respondents 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 was 79.2% (CCG 91.1%; National 93%) compared with the 2019 survey which was 85.2% (CCG 89%; National 93.4%).

- The percentage of respondents who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them was 74.2% (CCG 84.7%; National 88.5%) compared with the 2019 survey which was 69.8% (CCG 83.5%; National 88.9%).

The practice had reviewed the results from the National GP Patient Survey 2020 and created an action plan to address three areas where patient feedback was below national averages. However, these areas related to feedback on accessing the service rather than patient feedback on interactions with staff.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y
The practice reviewed feedback received via the Friends and Family Test.	

Any additional evidence or comments
Following our inspection, the practice informed us that they had introduced a daily online patient survey in September 2020 and were also monitoring feedback via their website and NHS choices.

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

Source	Feedback
Interviews with patients.	We did not speak with any patients due to infection prevention and control measures that were in place for patients and our inspection team regarding the Covid pandemic.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	79.2%	91.1%	93.0%	Variation (negative)

	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.	Not reviewed 1
Information leaflets were available in other languages and in easy read format.	Y 1
Information about support groups was available on the practice website.	Y

1. We did not review this question at our inspection on 24 September and 14 October 2020. Primary medical services had been advised to declutter and remove leaflets and posters from practice premises at the start of the Covid pandemic in March 2020. This was in line with current infection prevention and control national guidance during the pandemic.

Carers	Narrative
Percentage and number of carers identified.	3.34% (229)
How the practice supported carers (including young carers).	The practice had a carers pack they distributed to patients as appropriate. In addition, information for carers was available on the practice website.
How the practice supported recently bereaved patients.	Staff told us if patients experienced bereavement, a GP would contact them and arrange a convenient patient consultation to discuss any needs they may have. In addition, information for recently bereaved patients was available on the practice website.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Inadequate

At our previous inspection on 09 October 2019, we rated the practice as requires improvement for providing responsive services because:

- The national GP patient survey indicators in relation to access to appointments were below average.

At this inspection on 24 September and 14 October 2020, we rated the practice as inadequate for providing response services because:

- Actions taken in response to the national GP patient survey 2019 had not been effective
- Results from the national GP patient survey 2020 showed survey indicators relating to access to appointments had deteriorated since our last inspection and were considerably below local and national averages
- We did not see evidence of a complaints policy or that complaints were used to drive continuous learning and improvement.

These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial 1
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial 1
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

1. We did not see evidence that the practice fully considered the needs of its population when planning and delivering services. The practice population was in the fourth most deprived decile in England. People living in more deprived areas tend to have greater need for health services. During the Covid pandemic, the GP partners were shielding and therefore working remotely. We reviewed appointment diaries for staff and saw that several clinical staff were part-time or employed on a locum basis. This reduced the likelihood that patients could be assured of continuity of care.
   Following our inspection, the practice informed us that locum staff were booked for long-term cover to provide continuity of care for patients, and that the GP partners had attended the practice to ensure there was visible leadership. They told us they had outsourced home-visiting services to an external provider. They also told us that patients who were shielding at the onset of the pandemic were contacted by practice staff and a social prescriber.

Practice Opening Times	
Day	**Time**
Opening times:	

Monday	08:00am-6:30pm
Tuesday	08:00am-6:30pm
Wednesday	08:00am-6:30pm
Thursday	08:00am-6:30pm
Friday	08:00am-6:30pm
Saturday	09:30am to 1:30pm
Appointments available:	
Monday	08:00am-6:30pm
Tuesday	08:00am-6:30pm
Wednesday	08:00am-6:30pm
Thursday	08:00am-6:30pm
Friday	08:00am-6:30pm
Saturday	09:30am to 1:30pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	85.4%	92.0%	94.2%	Tending towards variation (negative)

Any additional evidence or comments
Results from the National GP Patient Survey 2020 showed most outcomes for patient experience in relation to the practice providing responsive services had declined since the previous survey carried out in 2019. Results from the 2020 survey showed most outcomes were also considerably below local and national averages.

Older people — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

We spoke with clinical staff on the day of the inspection who told us that:

- 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 was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

People with long-term conditions — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

We spoke with clinical staff on the day of the inspection who told us that:

- The practice was responsive to the needs of patients with long term conditions and complex medical issues.
- The practice was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

Families, children and young people — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

We spoke with clinical staff on the day of the inspection who told us that:

- The practice was responsive to the needs of families, children and young people.
- The practice was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

We spoke with clinical staff on the day of the inspection who told us that:

- The practice was responsive to the needs of working age people (including those recently retired and students
- The practice was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

People whose circumstances make them vulnerable — Population group rating: Inadequate

Findings

We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate.

We spoke with clinical staff on the day of the inspection who told us that:

- The practice was responsive to the needs of people whose circumstances make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings
We rated the practice as inadequate for providing responsive services. These inadequate areas impacted all population groups and so we have rated all population groups as inadequate. We spoke with clinical staff on the day of the inspection who told us that: • The practice was responsive to the needs of people experiencing poor mental health (including people with dementia). • The practice was open on Saturdays between 09:30am to 1:30pm and pre-bookable appointments were also available to all patients at additional locations within the area.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

- The percentage of respondents who stated that at their last general practice appointment, their needs were met was 85.4% (CCG 92%; National 94.2%) compared with the 2019 survey which was 88.3% (CCG 91.2%; National 94.5%).

- The percentage of respondents who responded positively to how easy it was to get through to someone at their GP practice on the phone was 39.2% (National 65.2%) compared with the 2019 survey which was 44.2% (National 68.3%).

- The percentage of respondents who responded positively to the overall experience of making an appointment was 44.5% (CCG 66.1%; National 65.5%) compared with the 2019 survey which was 40.9% (CCG 65%; National 67.4%).

- The percentage of respondents who were very satisfied or fairly satisfied with their GP practice appointment times was 34.6% (CCG 66%; National 63%) compared with the 2019 survey which was 43.2% (CCG 64.3%; National 64.7%).

- The percentage of respondents who were satisfied with the type of appointment (or appointments) they were offered was 55.2% (CCG 69.4%; National 72.7%) compared with the 2019 survey which was 47% (CCG 69.7%; National 73.6%).

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	39.2%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	44.5%	66.1%	65.5%	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 (01/01/2020 to 31/03/2020)	34.6%	66.0%	63.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	55.2%	69.4%	72.7%	Tending towards variation (negative)

Any additional evidence or comments

Results from the National GP Patient Survey 2020 showed most outcomes for patient experience in relation to access had declined since the previous survey carried out in 2019. This was despite the practice taking action in response to the 2019 survey and prior to the changes in how to access the service as a result of the Covid-19 pandemic.

Results from the 2020 survey showed most outcomes were considerably below local and national averages.

We saw that the practice had reviewed the 2020 National GP Patient Survey and produced an action plan to address the outcomes. This included:

- Recruitment of additional staff for reception and administrative roles.
- Additional training for reception and administrators.
- Consideration regarding adding another GP partner was ongoing.

Following our inspection, the practice informed us that they had introduced a daily online patient survey in September 2020. There were ten respondents to the survey in September 2020 and the results showed:

- Five out of 10 people were very satisfied or satisfied with the service they received. Three were neither satisfied or dissatisfied and one was dissatisfied with the service.

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.	19
Number of complaints we examined.	19
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 [1]

1. We asked the provider on 11 and 24 September 2020 to demonstrate they were compliant with the regulations regarding the management of patients' complaints. The provider submitted evidence of a spreadsheet and we saw that 19 patients' complaints had been recorded since January 2020. However, the provider did not submit evidence of a complaints policy, a practice leaflet that set out the complaints process and details for patients who may wish to take their complaint further. For example, to NHS England or the parliamentary health ombudsman (PMHO). They did not submit any examples of complaints for us to review and we saw that learning was limited to clinical staff only. We saw minutes from administration meetings that stated complaints were not discussed at these meetings for staff. We cannot be assured that the provider's complaints system is used to drive continuous learning and improvement.

Well-led Rating: Inadequate

At our previous inspection on 09 October 2019, we rated the practice as requires improvement for providing well-led services because we identified concerns in the following areas:

- Safety and medicines alerts (this has now been addressed under the safe key question).
- Significant events (this has now been addressed under the safe key question).
- Complaints.
- Gaps in business continuity plan.
- Continuous learning and development.
- Shared learning to drive improvement.
- Limited arrangements to manage risks.

At this inspection on 24 September and 14 October 2020, we rated the practice as inadequate for providing well-led services because we found continuing and new concerns in the following areas:

- Complaints
- Gaps in business continuity plan
- Continuous learning and development
- Shared learning to drive improvement
- Limited arrangements to manage risks

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 [1,2]
They had identified the actions necessary to address these challenges.	N [3]

1. We asked the provider on 11 and 24 September to demonstrate they were aware of the challenges to delivering care within a primary care setting or that they had an action plan to address those challenges. At this inspection, the provider could not demonstrate they had made sufficient improvements regarding proactive clinical governance since our previous inspection.

2. At this inspection the provider could not demonstrate they had the capacity to prioritise safety and quality improvement. Several systems and processes had been found to be unsafe. Although we found the provider had made small improvements regarding the management of medicines used to treat auto-immune disease, we found serious concerns in other areas. For example, the management of anti-hypertensive medicines, patients who had undertaken cervical screening who had not been safety-netted, staff immunisations and certified immunity, and premises risk assessments. We found ten instances of potential missed diagnoses for patients.

3. We previously found the practice was reactive rather than proactive and some actions had been undertaken during and immediately following the inspection. During this inspection, we found the provider had not made sufficient improvements in relation to clinical governance and oversight regarding safeguarding. For example, the provider could not demonstrate when the safeguarding

registers for children, their siblings, and vulnerable patients had last been reviewed. In addition, they told us they had not engaged in local safeguarding meetings with relevant key stakeholders since before the Covid pandemic began.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N1
Staff were clear about their roles and responsibilities.	N2

1. We asked the provider to demonstrate they were compliant with the regulations regarding the structures, processes and systems they had in place to support good governance. At this inspection, we found there had been insufficient improvements and we had further concerns regarding this. For example, in the management and monitoring of safeguarding, recruitment, premises risk assessments, safety-netting of cervical screening and patient safety alerts.

2. We asked the provider to demonstrate they had oversight of all systems and processes to ensure good governance. For example, that they had effective staffing in place in relation to core and role-specific training, supervision and appraisal. However, we found the provider could not demonstrate that staff employed to undertake specific roles and responsibilities had undertaken appropriate training and had been competency checked, had regular appraisal and had access to regular clinical supervision and there was an overall lack of oversight to ensure safe and effective care.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N 1
There were effective arrangements for identifying, managing and mitigating risks.	N 2

1. We asked the provider to demonstrate they were compliant with the regulations regarding the systems and process they had in place to enable them to manage risk. For example, we found the provider did not have oversight of medicines management for patients or for patient safety alerts. They could not demonstrate that patients were regularly reviewed and monitored. The provider could not demonstrate that it appropriately identified and responded to risk and assessed the impact on safety and quality.

2. We asked the provider to demonstrate they were compliant with the regulations regarding the systems in place to identify, manage and mitigate risks. We found the provider had taken some actions to mitigate risk. For example, they were in receipt of a Legionella risk assessment that had been commissioned by NHS Property Services (NHSPS). However, they had not assured themselves that action points from the Legionella risk assessment had been completed by following up with NHS Property Services (NHSPS), thereby ensuring to patient safety. In addition, there were gaps within the provider's business continuity plan.

Engagement with patients, the public, staff and external partners

We were unable to review whether 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.	Not reviewed 1

1. We did not speak directly with patients or the Patient Participation Group (PPG) at this inspection due to limited time spent on-site at the practice due to COVID-19 restrictions. However, we did review the National GP Patient Survey undertaken between January and March 2020 and published in July 2020. We found that most outcomes for patient experience in relation to caring and responsive services had declined since the previous National GP Patient Survey undertaken between January and March 2019. In addition, we found most patient outcomes were considerably below local and national averages.

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.	Partial 1
Learning was shared effectively and used to make improvements.	Partial 1

1. We cannot be assured that the provider's complaints system was used to drive continuous learning and improvement.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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