CQC Compliance Assessment Report

demo

Assessment Date: 26 June 2025

Generated by My Practice Manager

About this report

How this assessment works

This compliance assessment was generated using artificial intelligence to help you identify potential areas for improvement in your practice.

Our AI system reviews your uploaded documents against a comprehensive collection of audit questions. These questions are designed to assess compliance across the key areas that matter most to your practice's safety and effectiveness.

Our approach and limitations

Based on CQC guidance:

Our understanding of compliance requirements is influenced by guidance published by the Care Quality Commission. However, this report is not endorsed by the CQC and reflects our interpretation of their guidance as of July 2025.

Document-based assessment:

We can only assess what we can see in your documents. If your procedures state that you check cleaning quality weekly and your checklists show this happening, we treat this as evidence of compliance. We cannot verify what happens beyond what's documented.

Your professional judgement matters:

You are a competent healthcare professional. This report is designed to support your own decision-making, not replace it. Nothing in this assessment reduces your responsibility to critically examine the safety and management of your practice.

Understanding your results

Scoring limitations:

Achieving a high score doesn't guarantee how the CQC will assess your practice. Different inspectors may focus on different areas or interpret requirements differently.

Findings may vary:

We may identify issues that the CQC wouldn't flag, or we may miss things they would notice. Our assessment is one tool among many to help you maintain high standards.

No warranty:

This report is provided as guidance only. We make no guarantees about its completeness or accuracy for your specific situation.

How to use this report

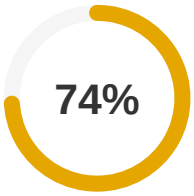
Treat this assessment as a starting point for your own investigation. Review our findings critically, consider your local context, and use your professional experience to determine what actions are right for your practice.

For areas where we've identified potential gaps, we recommend reviewing the relevant CQC guidance directly and considering whether additional documentation or process changes would benefit your practice.

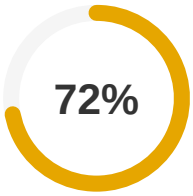
Executive Summary

Overall Compliance Score

Performance Overview



Safe



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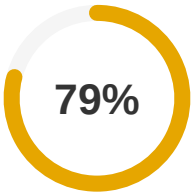
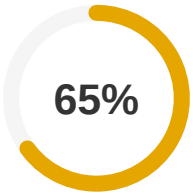
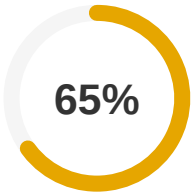


Caring



Responsive



Well-led

Key Focus Areas

- **17 Critical Issues Requiring Immediate Attention**
- **60 Major Issues for Compliance Improvement**

These issues should be addressed in your compliance improvement plan.

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Caring

Assessment Domain

Performance Score

Issue Summary

Critical Issues	1
Major Issues	6
Total Actionable Issues	7

Overview

Staff involve and treat people with compassion, kindness, dignity and respect.

Key Insights

Performance shows room for improvement. Focus on addressing the identified issues to strengthen compliance.

Absence of Patient Participation Group (PPG) documentation and evidence of formal patient engagement.

Issue Description

No documents related to a Patient Participation Group (PPG), including terms of reference, meeting minutes, or evidence of a 'you said, we did' feedback loop, were found. This indicates a critical gap in formal patient engagement and feedback mechanisms beyond general complaints or surveys, which are insufficient for demonstrating active patient partnership in service improvement.

Issue Details

Domain
Caring

Severity
Critical

Criterion
Verification of a formally constituted Patient Participation Group (PPG), active engagement, and demonstration of feedback utilization for service improvement.

Remediation Plans

Immediately establish a formally constituted Patient Participation Group (PPG) with clear terms of reference. Develop a robust process for regular PPG meetings, ensuring comprehensive minutes are recorded. Implement a transparent 'you said, we did' feedback loop, documenting how patient feedback from the PPG is actively used to drive service improvements. Ensure efforts are made to recruit a diverse and representative group of patients.

Evidence Documents

- No evidence documents specified for this finding.

Absence of specific documented procedures for supporting patients with dementia.

Issue Description

While general reasonable adjustments are covered, there is no dedicated policy or detailed protocol specifically addressing the unique needs of patients with dementia. This gap could lead to inconsistent care, missed opportunities for early intervention, and inadequate support for both patients and their carers, potentially impacting patient safety and well-being.

Issue Details

Domain
Caring

Severity
Major

Criterion
Specific Support for Dementia

Remediation Plans

Develop and implement a specific policy or protocol for supporting patients with dementia. This should include guidance on identification, communication strategies, involving carers, memory aids, signposting to specialist services, and proactive care planning. Ensure staff training is provided on this new protocol.

Evidence Documents

- /clinical/patients-with-learning-disabilities.pdf
- /management/protocol-on-ensuring-equal-access-to-services.pdf
- /gdpr/accessible-information-standard-policy.pdf

Key communication and sensitivity training topics are not explicitly covered in staff training programs.

Issue Description

While the practice has a robust framework for staff training, induction, and record-keeping, the documented mandatory training topics do not explicitly include crucial areas such as general communication skills, handling difficult conversations (beyond conflict resolution), breaking bad news, dementia awareness, or specific cultural sensitivity training. This deficiency could lead to patient distress, misunderstandings, and a failure to meet the needs of vulnerable patient groups, impacting the CQC's "Caring" domain.

Issue Details

Domain
Caring

Severity
Major

Criterion
Staff training on communication and soft skills, including handling difficult conversations, dementia awareness, and equality, diversity, and inclusion.

Remediation Plans

Review and update the mandatory training curriculum to explicitly include dedicated modules on advanced communication skills, handling difficult conversations, breaking bad news, comprehensive dementia awareness, and cultural competence. Ensure these modules are integrated into both induction and regular refresher training for all patient-facing staff, and that completion is tracked within the existing training record system.

Evidence Documents

- /hr and recruitment/staff-skills-competencies-training-record.pdf
- /hr and recruitment/training-policy.pdf
- /hr and recruitment/induction-programme.pdf
- /hr and recruitment/appraisal-summary.pdf
- /management/cpd-policy.pdf

Lack of documented evidence for systematic analysis of 'caring' themes in patient feedback and absence of complaints log/meeting minutes.

Issue Description

While a comprehensive Complaints & Comments Procedure is in place, there is no explicit evidence within the policy or supporting documents that the practice specifically analyzes feedback for 'caring' themes such as empathy, communication, or respect. Furthermore, despite the policy stating the maintenance of a 'Complaints Log' and regular discussion of 'key themes' in practice meetings, no such log or relevant meeting minutes were found during the document search. This indicates a significant gap between documented policy and demonstrable implementation, hindering the practice's ability to systematically learn from patient experiences related to caring attitudes.

Issue Details

Domain
Caring

Severity
Major

Criterion
The practice systematically logs, analyzes, and learns from patient complaints and compliments, with a specific focus on themes related to caring attitudes (empathy, communication, respect), and uses this feedback to drive improvements and reinforce positive staff behavior.

Remediation Plans

1. Update the 'Complaints & Comments Procedure' to explicitly include the requirement for analysis of 'caring' themes (empathy, communication, respect) during complaint and compliment review processes. 2. Implement and maintain a formal 'Complaints Log' and

'Compliments Log' that captures details of feedback, investigation outcomes, and identified themes, including those related to caring. 3. Ensure that practice meeting minutes consistently document discussions of complaint and compliment themes, specifically highlighting analysis of caring aspects and any resulting actions or improvements. 4. Conduct a review of past complaints and compliments to retrospectively identify and analyze 'caring' themes, documenting findings and any subsequent actions.

Evidence Documents

- /management/complaints-comments-procedure.pdf
- /management/complaints-comments-leaflet.pdf

Lack of documented evidence of leadership discussion and action on staff wellbeing in meeting minutes.

Issue Description

Despite searches for meeting minutes, no specific documents were found that clearly demonstrate regular discussion and action by leadership (Partners, Practice Manager) on staff wellbeing topics. This absence of documented oversight suggests a potential gap in proactive leadership engagement with staff wellbeing issues, which is crucial for fostering a supportive culture.

Issue Details

Domain
Caring

Severity
Major

Criterion
Leadership Oversight: Do meeting minutes (e.g., practice meetings, partner meetings) show discussion and action on staff wellbeing topics?

Remediation Plans

Ensure that staff wellbeing is a standing agenda item at regular practice and leadership meetings. Document discussions, decisions, and assigned actions related to staff wellbeing initiatives, feedback, and support in meeting minutes. These minutes should clearly reflect leadership's commitment and active role in promoting staff welfare.

Evidence Documents

- No evidence documents specified for this finding.

Lack of Explicit Patient-Facing Chaperone Awareness Materials

Issue Description

Although the Chaperone Policy outlines patients' rights to a chaperone, there is no explicit evidence of patient-facing materials such as posters, leaflets, or website content that proactively inform patients of this right and how to request a chaperone. This omission means patients may not be fully aware of their option to have a chaperone, potentially impacting their comfort, dignity, and safety during sensitive examinations.

Issue Details

Domain
Caring

Severity
Major

Criterion
Patient Awareness Materials: Evidence of patient-facing communication. Look for saved copies or text for posters, leaflets, or website notices explaining the right to a chaperone and how to request one.

Remediation Plans

Develop and implement clear, accessible patient awareness materials (e.g., posters in waiting areas, leaflets, dedicated section on the practice website) that explicitly inform patients of their right to a chaperone, explain the chaperone's role, and detail the process for requesting one. Ensure these materials are prominently displayed and regularly reviewed for clarity and accessibility.

Evidence Documents

- /clinical/chaperone-policy.pdf

No documented process for debriefing or reflective practice after significant events.

Issue Description

There is no documented policy or procedure outlining a formal process for debriefing or reflective practice following significant or challenging events. This gap could impact staff's ability to process difficult experiences, learn from incidents, and maintain their psychological wellbeing, potentially leading to increased stress or burnout.

Issue Details

Domain
Caring

Severity
Major

Criterion
Reflective Practice/ Debriefing: Is there a documented process for debriefing or reflective practice after significant or challenging events?

Remediation Plans

Develop and implement a 'Significant Event Debriefing and Reflective Practice Policy'. This policy should define what constitutes a significant event requiring debriefing, outline the process for conducting debriefs (e.g., who facilitates, who attends, confidentiality), and integrate reflective practice into professional development. Ensure staff are trained on this process.

Evidence Documents

- No evidence documents specified for this finding.

Responsive

Assessment Domain

Performance Score

Issue Summary

Critical Issues	4
Major Issues	7
Total Actionable Issues	11

Overview

Services are organised so that they meet people's needs.

Key Insights

Significant concerns identified that require immediate attention and comprehensive action planning.

Absence of Documented Meeting Minutes or Records of Governance/Feedback Discussions

Issue Description

No documents identified as meeting minutes, action logs, or governance reports were found after comprehensive searches. This indicates a fundamental lack of documented evidence for systematic review of patient feedback, complaints, or access issues, which is critical for demonstrating a learning culture and continuous improvement.

Issue Details

Domain
Responsive

Severity
Critical

Criterion
The practice systematically reviews patient feedback, complaints, and access issues in relevant meetings (Partner, Staff, PPG), documents clear action points, and follows up on these actions to improve service responsiveness.

Remediation Plans

Immediately implement a robust system for documenting all relevant meeting minutes (Partner, Staff, PPG, Clinical Governance). Ensure these minutes clearly record discussions of patient feedback, complaints, and access issues, along with specific, assigned action points and documented follow-up on previous actions. Train all relevant staff on the importance of accurate and consistent minute-taking and document storage.

Evidence Documents

- No evidence documents specified for this finding.

Absence of Documented Opening Hours and Patient Access Information

Issue Description

Despite comprehensive searches using various terms related to opening hours, patient access, enhanced access, and practice information, no relevant documents were found. This indicates a fundamental failure to document how patients can access services, which is a critical barrier to care and a significant patient safety risk.

Issue Details

Domain
Responsive

Severity
Critical

Criterion
To verify that the practice has clearly documented its core, extended, and out-of-hours access arrangements, and that procedures for communicating this information to patients are established, current, and comprehensive.

Remediation Plans

Immediately develop and implement a comprehensive 'Patient Access Policy' or 'Practice Information Leaflet' that clearly outlines core opening hours, details of extended/enhanced access (including PCN arrangements), and explicit instructions for out-of-hours care (NHS 111). Ensure this document is readily accessible to patients via multiple communication channels (website, practice leaflet, waiting room signage) and is regularly reviewed and updated. A review date within the last 18 months must be included.

Evidence Documents

- No evidence documents specified for this finding.

Absence of documented processes for appointment data analysis and access improvement

Issue Description

Despite comprehensive searches, no documents were found that demonstrate a systematic approach to collecting, analyzing, and acting upon appointment data (such as wait times, DNA rates, or patient feedback) to improve patient access. While policies for managing DNAs exist, there is no evidence of their analysis for service improvement. This critical gap indicates a lack of proactive management of patient access, potentially leading to delayed care and patient dissatisfaction.

Issue Details

Domain
Responsive

Severity
Critical

Criterion
Systematic collection, analysis, and action upon appointment data (including wait times, DNA rates, and patient feedback) to improve patient access, evidenced by regular reviews and documented actions.

Remediation Plans

Implement a robust system for collecting and analyzing appointment data, including wait times, DNA rates, and patient feedback on access. Establish a regular review cycle (e.g., monthly or quarterly) where this data is discussed in management or clinical governance meetings. Document specific actions taken as a result of these reviews to improve patient access, assigning clear ownership and deadlines for each action. Ensure these processes are formally documented in a dedicated 'Patient Access Policy' or 'Service Improvement Plan' and are regularly audited for effectiveness.

Evidence Documents

- No evidence documents specified for this finding.

Absence of Patient Participation Group (PPG) engagement evidence

Issue Description

No documents related to a Patient Participation Group (PPG), including meeting minutes, annual reports, or 'You Said, We Did' summaries, were found. This indicates a critical gap in structured patient engagement regarding service delivery, which is essential for meeting CQC regulatory requirements and ensuring services are responsive to patient needs.

Issue Details

Domain
Responsive

Severity
Critical

Criterion
To verify that the practice actively engages its Patient Participation Group (PPG) in discussions about service delivery, consults them on changes, implements their suggestions where appropriate, and provides feedback on the outcomes of their input.

Remediation Plans

Immediately establish a functioning Patient Participation Group (PPG) with clear terms of reference. Develop a robust process for regular PPG meetings, ensuring discussions focus on service delivery, patient suggestions are formally recorded, and the practice documents actions taken and provides feedback on outcomes. Implement a system for maintaining comprehensive records of all PPG activities, including meeting minutes and any 'You Said, We Did' reports, to demonstrate ongoing engagement and compliance.

Evidence Documents

- No evidence documents specified for this finding.

Absence of a comprehensive and dated premises accessibility audit report.

Issue Description

While policies mention regular accessibility audits and DDA risk assessments, no specific, formal audit document with a clear date, scope, findings, and action plan was found. This lack of documented evidence makes it difficult to verify the practice's proactive assessment and remediation of physical access barriers.

Issue Details

Domain
Responsive

Severity
Major

Criterion
Evidence of a formal accessibility audit (date, scope, findings, action plan).

Remediation Plans

Conduct a comprehensive premises accessibility audit immediately, documenting all findings, identified barriers, and a clear action plan with assigned responsibilities and timelines. Ensure this audit is formally reviewed and updated at least every three years.

Evidence Documents

- /management/protocol-on-ensuring-equal-access-to-services.pdf
- /health and safety/estate-management-policies-and-protocols.pdf
- /hr and recruitment/equality-act-operational-procedures.pdf

Absence of documented complaints log and insufficient evidence of systematic learning from complaints.

Issue Description

While a comprehensive and current complaints policy is in place, there is no accessible complaints log to demonstrate systematic recording of complaints. Furthermore, there is a lack of documented evidence, such as meeting minutes or annual reports, to confirm that complaints are regularly analyzed for trends and that learning is consistently disseminated across the practice to drive improvements.

Issue Details

Domain
Responsive

Severity
Major

Criterion
The practice maintains a comprehensive complaints log, conducts thorough and timely investigations for each complaint, communicates outcomes effectively to complainants, and uses the findings to drive learning, identify trends, and implement preventative changes across the practice.

Remediation Plans

Immediately implement and maintain a centralized, accessible complaints log, ensuring all complaints are recorded with relevant details and outcomes. Establish a clear process for regular review and analysis of complaints data, documenting discussions and actions taken in relevant

meeting minutes (e.g., clinical governance meetings). Produce an annual summary report of complaints, trends, and learning points, and ensure this is shared with all relevant staff and, where appropriate, with the Patient Participation Group.

Evidence Documents

- /management/complaints-comments-procedure.pdf

Lack of documented evidence for functional accessible toilet alarm pulls and regular checks.

Issue Description

While accessible toilets are mentioned, there is no documentation confirming the presence of functional alarm pulls within these facilities or a schedule for their regular testing. This poses a direct patient safety risk, as patients in distress may be unable to summon help.

Issue Details

Domain
Responsive

Severity
Major

Criterion
Details on accessible toilets, specifically mentioning functional alarm pulls and checks.

Remediation Plans

Implement a clear procedure for daily or weekly checks of accessible toilet alarm pulls, ensuring they are functional and unobstructed. Document these checks, including the date, time, and person performing the check. Ensure staff are trained on how to respond to an activated alarm.

Evidence Documents

- /management/protocol-on-ensuring-equal-access-to-services.pdf
- /health and safety/estate-management-policies-and-protocols.pdf

Lack of documented evidence for patient feedback analysis and action implementation

Issue Description

While a comprehensive Friends and Family Test (FFT) policy outlines clear processes for collecting, analyzing, and acting upon patient feedback, there is no documented evidence, such as meeting minutes or specific action plans, demonstrating the consistent implementation of this policy. This gap indicates that the practice may not be consistently translating feedback into tangible improvements, hindering its ability to demonstrate responsiveness and continuous learning.

Issue Details

Domain
Responsive

Severity
Major

Criterion
To verify that the practice has a systematic process for collecting, analyzing, and acting upon general (non-complaint) patient feedback from various sources, and to find documented evidence of improvements made as a result.

Remediation Plans

Implement a robust system for documenting the analysis of patient feedback (e.g., FFT results) in meeting minutes, including discussions, identified themes, and agreed-upon actions. Ensure that specific action plans are created and tracked, clearly linking them to patient feedback and demonstrating how improvements are made. Regularly review and audit these documented processes to ensure consistent application and demonstrable outcomes.

Evidence Documents

- /management/friends-family-test.pdf

Lack of specific monitoring evidence for repeat prescription turnaround time.

Issue Description

Although the practice has a stated turnaround time and general auditing procedures for prescribing, there is no specific evidence of regular audits or data analysis focused on monitoring adherence to the 48-hour repeat prescription turnaround time. Without this, the practice cannot effectively identify bottlenecks, measure performance, or ensure consistent timely service delivery.

Issue Details

Domain
Responsive

Severity
Major

Criterion
Evidence of audits or data analysis monitoring adherence to the turnaround time.

Remediation Plans

Implement a robust system for regularly monitoring repeat prescription turnaround times. This should include collecting data on request submission and completion times, conducting periodic audits specifically on turnaround time performance, and analyzing the results. Establish clear metrics and reporting mechanisms to track compliance and identify areas for improvement.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /clinical/prescribing-pathway.pdf

Online consultation safety-netting protocol lacks explicit detail for red flag escalation.

Issue Description

The 'consultations-protocol.pdf' broadly mentions that urgent online issues may require same-day attention. However, it does not provide a clear, explicit protocol for staff to identify 'red flag' symptoms within online consultation requests and the specific steps for immediate escalation to prevent patient harm. This gap creates a risk of urgent clinical needs being missed or delayed.

Issue Details

Domain
Responsive

Severity
Major

Criterion
To verify that the practice has a clearly defined, safe, and effective process for managing online consultation requests, specifically assessing protocols for triage and allocation, target response times, safety-netting for urgent issues, and evidence of ongoing quality monitoring.

Remediation Plans

Develop and implement a specific, detailed protocol for identifying and immediately escalating 'red flag' symptoms or urgent requests received via the online consultation system. This protocol should include clear criteria for what constitutes a red flag, who is responsible for initial screening, the immediate escalation pathway, and documentation requirements. Ensure all relevant staff are trained on this protocol.

Evidence Documents

- /clinical/consultations-protocol.pdf

Significant gaps in documented triage and comprehensive booking procedures.

Issue Description

While appointment types and online booking procedures are detailed, the specific procedures for telephone and in-person booking are not fully elaborated in the reviewed documents. Crucially, the comprehensive 'triage guidelines' or a dedicated care navigation protocol, essential for assessing and directing all patient requests to appropriate care, are referenced but not explicitly documented within the current policies. This represents a significant gap in the documented appointments system, potentially impacting patient safety and efficient access.

Issue Details

Domain
Responsive

Severity
Major

Criterion
To verify that the practice has a documented, comprehensive, and up-to-date policy for managing patient appointments, covering all available booking methods, the full range of appointment types, and the system for triaging or navigating patients to the appropriate care.

Remediation Plans

Develop and integrate a comprehensive, detailed care navigation and triage protocol into the appointments policy, clearly outlining the steps and criteria for assessing and directing all patient requests, regardless of booking method. Ensure all booking methods (telephone, in-person, online) have clearly defined, documented procedures. Consolidate or cross-reference all relevant procedures into a single, easily accessible policy or set of linked documents, ensuring annual

review and staff training.

Evidence Documents

- /gdpr/online-appointment-bookings.pdf
- /clinical/consultations-protocol.pdf

Well-led

Assessment Domain

Performance Score

Issue Summary

Critical Issues	4
Major Issues	11
Total Actionable Issues	15

Overview

Leadership, management and governance assures the delivery of high-quality care.

Key Insights

Significant concerns identified that require immediate attention and comprehensive action planning.

Absence of current ICO registration and annual DSP Toolkit submission evidence.

Issue Description

The audit found no explicit evidence of a current ICO registration number or certificate for 2025, nor a confirmation of the latest annual DSP Toolkit submission for 2024-2025. While policies indicate adherence to these requirements and mention interaction with the ICO, the lack of direct evidence for these fundamental registrations and submissions represents a critical gap in demonstrating robust information governance oversight. This poses a significant regulatory risk and undermines the practice's ability to prove compliance with essential data protection regulations.

Issue Details

Domain
Well-led

Severity
Critical

Criterion
To verify that the practice has established clear leadership and oversight for Information Governance, evidenced by current registrations, annual submissions, and documented reporting on compliance, breaches, and risk assessments to the practice leadership.

Remediation Plans

Immediately locate and provide current evidence of the practice's ICO registration, including the registration number and valid expiry date. Furthermore, furnish the confirmation or certificate of the most recent annual DSP Toolkit submission (2024-2025). If these documents do not exist, initiate immediate action to complete these mandatory registrations and submissions. Implement a robust system for tracking and retaining all regulatory compliance documentation to ensure

easy retrieval for future audits and to prevent recurrence of this critical finding.

Evidence Documents

- /gdpr/information-governance-policy.pdf
- /gdpr/data-protection-_-gdpr-policy.pdf
- /gdpr/data-breach-register-and-risk-register.pdf
- /gdpr/information-asset-register.pdf
- /gdpr/gdpr-information-asset-register.pdf

No documented evidence of active engagement with external health system partners found.

Issue Description

Despite comprehensive searches for meeting minutes, collaboration records, and development plans, no specific, dated evidence of active engagement with PCN, ICB, or Federation was found. The available documents are policies outlining the intent to collaborate, but lack concrete records of participation, discussions, or outcomes from external partner meetings. This indicates a critical gap in demonstrating the practice's role within the wider Integrated Care System and its contribution to population health.

Issue Details

Domain
Well-led

Severity
Critical

Criterion
Active, documented engagement with external health system partners (PCN, ICB, Federation) to ensure collaboration improves patient services, facilitates shared learning, and contributes positively to the wider health system.

Remediation Plans

Immediately implement a robust system for documenting all external partner engagements, including PCN, ICB, and Federation meetings. Ensure minutes, attendance records, discussion points, decisions, and action items are consistently recorded and centrally stored. Designate a lead responsible for collating and maintaining these records. Review and update internal processes to ensure that learning and actions from external meetings are disseminated and integrated into practice operations, with clear evidence of this internal dissemination.

Evidence Documents

- /practice policies/co-operating-with-other-providers-policy.pdf
- /clinical/multidisciplinary-protocol.pdf
- /practice policies/quality-improvement-statement.pdf
- /gdpr/clinical-governance-policy.pdf

No evidence of Patient Participation Group or formal patient engagement process found.

Issue Description

Despite comprehensive searches for 'PPG meeting minutes', 'Patient Participation Group', 'Practice Meeting Minutes', 'Partner Meeting Minutes', 'You Said We Did', 'Patient Survey Action Plan', 'Patient Reference Group', and 'Patient Forum', no documents were found to indicate the existence of a Patient Participation Group or any formal process for senior leadership to engage with patient feedback. This represents a critical gap in patient engagement and feedback integration into practice strategy.

Issue Details

Domain
Well-led

Severity
Critical

Criterion
To verify that senior leadership actively engages with the Patient Participation Group (PPG), and that patient feedback gathered through the PPG is demonstrably used to inform practice strategy and service improvements.

Remediation Plans

Immediately establish a Patient Participation Group (PPG) with clear terms of reference, including regular meetings and defined roles for senior leadership attendance. Implement a robust system for collecting, analyzing, and acting upon patient feedback, ensuring that feedback from the PPG and other sources (e.g., surveys, complaints) is regularly reviewed at senior management and partner meetings. Develop a 'You Said, We Did' mechanism to transparently communicate how patient feedback informs service improvements. Document all PPG activities, meeting minutes, and subsequent actions thoroughly to demonstrate active engagement and the closing of the feedback loop.

Evidence Documents

- No evidence documents specified for this finding.

No evidence of Senior Leadership or Governance Meeting Minutes found in the document system.

Issue Description

Despite comprehensive searches using various terms related to meeting minutes, action logs, and governance, no documents explicitly identified as senior leadership or governance meeting minutes were found within the practice's document system. This complete absence of documented meeting records indicates a fundamental failure in governance oversight, making it impossible to verify that the leadership team is actively managing the practice, overseeing quality and safety, identifying and mitigating risks, and driving continuous improvement as required by CQC.

Issue Details

Domain
Well-led

Severity
Critical

Criterion
To verify that senior leadership and governance meetings occur regularly, cover key strategic, operational, and compliance topics as required by CQC, and that decisions and actions are documented, assigned, and tracked to ensure effective governance.

Remediation Plans

Immediately establish a formal schedule for senior leadership and governance meetings (e.g., Partners' Meetings, Clinical Governance Meetings, Management Meetings). Implement a robust system for recording comprehensive meeting minutes, ensuring they capture discussions on performance data, risk, CQC compliance, finance, and external factors. Crucially, all decisions and actions must be clearly documented, assigned to specific owners, and tracked for completion in subsequent meetings. These minutes must be stored in an easily accessible and identifiable

location within the document management system. Conduct immediate training for all relevant staff on the importance and process of accurate minute-taking and document management for governance records.

Evidence Documents

- No evidence documents specified for this finding.

Absence of a comprehensive and current CQC-compliant Statement of Purpose

Issue Description

No single document explicitly identified as the 'Statement of Purpose' was found. While elements like aims, services, and locations are present across various policies (e.g., Quality Improvement Statement), a consolidated document meeting all CQC regulatory requirements for a Statement of Purpose is missing. This is a legal requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, indicating a significant governance gap.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Documented and Current Statement of Purpose

Remediation Plans

Develop and formally approve a comprehensive Statement of Purpose document that explicitly addresses all CQC regulatory requirements, including aims, objectives, regulated activities, service locations, and registered manager details. Ensure it is regularly reviewed and kept current.

Evidence Documents

- /practice policies/quality-improvement-statement.pdf
- /gdpr/clinical-governance-policy.pdf

Absence of a comprehensive master policy index with consolidated review schedules.

Issue Description

While individual policies include version control and review dates, and a synchronisation form exists for policy dissemination, there is no central, comprehensive master index of all practice policies. This makes it challenging to gain an overview of the entire policy suite, track review schedules efficiently, and ensure all policies are current and accounted for. This lack of a consolidated index increases the risk of policies becoming outdated or key operational areas lacking formal guidance.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Assessment of the system for managing policies (including a master index, version control, and review schedules).

Remediation Plans

Develop and maintain a central, comprehensive master policy index. This index should list all practice policies, their current version numbers, approval dates, and scheduled next review dates. Implement a clear process for updating this index whenever a policy is created, revised, or retired. Ensure this index is easily accessible to all relevant staff.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf
- /practice policies/quality-improvement-statement.pdf
- /hr and recruitment/staff-handbook.pdf

- /practice policies/synchronisation-form.pdf

Absence of documented workforce and succession planning processes.

Issue Description

The practice lacks a formal, documented workforce plan to proactively assess current and future staffing levels, skill mix requirements, or strategic planning for key role departures (succession planning). This absence poses a significant risk to long-term operational stability and effective service delivery, potentially leading to staffing shortages or skill gaps.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Is there a process for reviewing staffing levels, skill mix, and future needs? Is there any mention of planning for key role departures?

Remediation Plans

Develop and implement a comprehensive workforce plan that includes regular reviews of staffing needs, skill mix analysis, and a formal succession planning strategy for critical roles. This plan should be reviewed and updated annually to ensure it remains relevant and effective.

Evidence Documents

- /hr and recruitment/staffing-policy.pdf
- /hr and recruitment/recruitment-statement.pdf
- /hr and recruitment/new-employee-recruitment.pdf

Detailed Business Continuity Plan and evidence of testing are missing.

Issue Description

While a Civil Contingencies Practice Statement outlines the commitment to business continuity and mentions a detailed BCP, the actual comprehensive BCP document was not found. Furthermore, there is no documented evidence of regular testing of the BCP, such as desktop exercises or drills, nor any records of lessons learned or subsequent updates to the plan. This significantly impacts the practice's ability to ensure service resilience during a crisis and poses a direct threat to patient safety by potentially disrupting access to care.

Issue Details

Domain
Well-led

Severity
Major

Criterion
To verify the existence of a comprehensive, up-to-date Business Continuity Plan (BCP) and to find documented evidence of its regular testing (e.g., via desktop exercise), including any lessons learned and subsequent updates to the plan.

Remediation Plans

1. Locate/Develop Comprehensive BCP: Immediately locate the detailed Business Continuity Plan. If it cannot be found, develop a comprehensive BCP that includes activation triggers, roles/responsibilities, up-to-date emergency contact lists (staff and external suppliers), and procedures for critical failures (IT, telephony, premises).
2. Schedule and Document BCP Testing: Schedule and conduct a full desktop exercise or drill of the BCP within the next 3 months. Ensure detailed records of the test, including scenarios, participants, outcomes, and any identified gaps or lessons learned, are formally documented.

3. Implement Lessons Learned: Based on the BCP test, review and update the BCP to incorporate all lessons learned and address any identified deficiencies. Ensure a clear version control system is in place to track changes.
4. Establish Annual Review Cycle: Implement a robust annual review cycle for both the BCP and its testing records to ensure they remain current, comprehensive, and effective.

Evidence Documents

- /management/civil-contingencies-practice-statement.pdf

Documented financial policy exists, but active financial oversight and reporting implementation lack direct evidence.

Issue Description

The practice has a comprehensive financial control policy outlining budgeting, forecasting, and reporting procedures, with clear responsibilities. However, there is no direct evidence, such as recent financial reports or meeting minutes, to demonstrate that these processes are actively implemented and that financial performance is regularly discussed and used for decision-making by the Partners. This gap in documented execution poses a significant risk to effective financial governance and long-term sustainability.

Issue Details

Domain
Well-led

Severity
Major

Criterion
The practice has a robust and documented system for financial planning, monitoring, and governance, ensuring that financial decisions support the long-term sustainability and quality of patient services.

Remediation Plans

1. Provide Evidence of Implementation: Immediately provide recent financial reports (e.g., annual accounts, current budget, latest management accounts) and corresponding meeting minutes (e.g., Partner meetings, management meetings) that clearly show financial performance being reviewed, discussed, and informing strategic decisions.
2. Ensure Policy Currency: Review and update the "Financial Control Budgets Forecasts" policy to reflect the current date and ensure annual reviews are conducted as per the policy's own

requirements.

3. Strengthen Documentation of Oversight: Ensure all financial discussions, decisions, and actions taken based on financial reports are thoroughly documented in meeting minutes, including attendance, key points of discussion, decisions made, and assigned actions.

Evidence Documents

- /management/financial-control-budgets-forecasts.pdf

Inability to verify comprehensive policy coverage and currency due to missing master index.

Issue Description

Although several key policies were identified (e.g., Clinical Governance, Staff Handbook, Quality Improvement), the absence of a comprehensive master policy index prevents a full assessment of whether all key operational areas are covered by approved policies and if these policies are consistently current. This gap in oversight poses a risk of unaddressed operational gaps or reliance on outdated guidance, potentially impacting patient safety and regulatory compliance.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Confirmation that a comprehensive suite of current, approved policies covers all key operational areas.

Remediation Plans

Once the master policy index is established (as per the previous remediation plan), conduct a thorough gap analysis against all required operational areas and CQC standards. Systematically review the currency of all policies listed in the new index, ensuring they are within their prescribed review cycles. Prioritize the development or update of any missing or overdue policies to ensure a comprehensive and current policy suite.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf
- /practice policies/quality-improvement-statement.pdf

- /hr and recruitment/staff-handbook.pdf

Inconsistent and outdated documentation of leadership structure and key personnel roles

Issue Description

The practice's documentation of its leadership and management structure is fragmented and contains significant inconsistencies regarding key personnel names (Senior Partner, Practice Manager) and outdated review dates across several critical policy documents. This lack of a single, consistently updated source for the organizational structure and key roles creates confusion, hinders clear accountability, and poses a risk to effective oversight and decision-making, particularly in critical areas like safeguarding and information governance.

Issue Details

Domain
Well-led

Severity
Major

Criterion
The GP practice has formally documented its leadership and management structure, including the identification of key roles, the definition of their responsibilities, and clear lines of accountability, ensuring this information is accessible and current.

Remediation Plans

1. Conduct a comprehensive audit of all documents related to leadership, management, and key roles to identify all inconsistencies and outdated information. 2. Immediately update all conflicting information, ensuring the current Senior Partner (Dr. Eleanor Vance) and Practice Manager (Laura Davies) are consistently named across all relevant documents. 3. Prioritize the review and update of all outdated policy documents, specifically 'safeguarding-protocol.pdf',

'information-governance-staff-reference.pdf', and 'clinical-governance-policy.pdf', bringing them in line with current practice and personnel. 4. Develop and implement a single, comprehensive organizational chart (visual or detailed textual) that clearly depicts the entire leadership and management structure, including all key roles, their reporting lines, and deputization arrangements. This document must be easily accessible to all staff. 5. Clearly name the external Data Protection Officer (DPO) and provide their direct contact information within the 'information-governance-policy.pdf' and 'information-governance-staff-reference.pdf'. 6. Establish and document a clear deputization arrangement for the Practice Manager role, outlining who assumes responsibilities in their absence. 7. Implement a robust document control process with clear responsibilities and a regular review schedule to ensure all policies and structural documents are consistently reviewed and kept current.

Evidence Documents

- /hr and recruitment/staff-handbook.pdf
- /health and safety/health-_-safety-policy-organisation.pdf
- /hr and recruitment/new-partner-checklist.pdf
- /safeguarding children/childrens-safeguarding-flowchart.pdf
- /safeguarding adults/safeguarding-protocol.pdf
- /safeguarding children/safeguarding-children.pdf
- /hr and recruitment/information-governance-staff-reference.pdf
- /gdpr/clinical-governance-policy.pdf
- /gdpr/information-governance-policy.pdf

Insufficient documented evidence for systematic performance data analysis and responsive action.

Issue Description

While the practice has policies outlining a commitment to data review and quality improvement, there is a significant lack of documented evidence, such as detailed meeting minutes, to demonstrate systematic trend analysis, comprehensive benchmarking against external targets, and specific, documented actions taken by leadership in response to performance data. This gap prevents full verification that data is consistently and proactively used to drive improvement.

Issue Details

Domain
Well-led

Severity
Major

Criterion
The practice leadership systematically reviews key performance data (e.g., QOF, prescribing, appointment access, patient satisfaction), analyzes trends over time, benchmarks performance, and takes documented action in response to concerning findings to drive improvement.

Remediation Plans

Implement a robust system for documenting all performance review meetings (e.g., practice meetings, clinical governance meetings). Ensure minutes from these meetings clearly capture detailed discussions on data trends, comparisons against local/national benchmarks, identified areas of concern, and specific, measurable action plans with assigned responsibilities and deadlines. Regularly review and update these minutes to track the progress and effectiveness of

implemented actions.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf
- /practice policies/quality-improvement-statement.pdf
- /management/friends-family-test.pdf
- /management/medical-procedure-audits.pdf
- /gdpr/mandatory-data-collection.pdf

Lack of a comprehensive corporate risk register for all risk categories.

Issue Description

While an Information Governance Risk Register exists and is well-maintained, there is no evidence of a broader corporate risk register that systematically captures and manages clinical, operational, financial, and reputational risks. This gap prevents a holistic view of the practice's risk profile and proactive management of diverse threats.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Existence and completeness of a corporate risk register covering clinical, operational, financial, and reputational risks.

Remediation Plans

Establish and maintain a comprehensive corporate risk register that includes all relevant risk categories (clinical, operational, financial, reputational). Ensure each identified risk has a clear description, likelihood, impact, mitigation plan, assigned owner, and target completion date.

Evidence Documents

- /gdpr/data-breach-register-and-risk-register.pdf
- /gdpr/clinical-governance-policy.pdf

Outdated Clinical Governance Policy serves as de facto risk management policy, lacking dedicated and current framework.

Issue Description

The practice relies on an outdated Clinical Governance Policy (last reviewed 2022-04-18) to outline its risk management approach. This policy is not specifically a comprehensive risk management policy and its outdated status indicates a lack of regular review and update, which is crucial for effective risk governance.

Issue Details

Domain
Well-led

Severity
Major

Criterion
Existence and currency of a risk management policy.

Remediation Plans

Develop and implement a dedicated, comprehensive Risk Management Policy that clearly defines the practice's approach to identifying, assessing, mitigating, and monitoring all types of risks (clinical, operational, financial, reputational). Ensure this policy is reviewed and updated annually.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf

Statement of Purpose outdated and lacks explicit evidence of Registered Manager's dedicated time.

Issue Description

The 'Health Act Practice Statement' serving as the Statement of Purpose is dated November 2022, making it over two years old and requiring an urgent review. While the Practice Manager, Janice Miller, is identified as responsible for compliance, the document does not explicitly detail the dedicated time allocated for her statutory duties as Registered Manager, which is crucial for effective governance and CQC compliance.

Issue Details

Domain
Well-led

Severity
Major

Criterion
CQC Registration & Compliance Documentation: Statement of Purpose and Registered Manager's Role

Remediation Plans

Immediately review and update the 'Health Act Practice Statement' to reflect current practice activities and ensure it is formally reviewed at least annually. Create or update a job description or role profile for the Registered Manager that explicitly outlines the dedicated time allocation for their CQC statutory duties, ensuring this is formally documented and understood.

Evidence Documents

- /practice policies/health-act-practice-statement.pdf

Effective

Assessment Domain

Performance Score

Issue Summary

Critical Issues	4
Major Issues	10
Total Actionable Issues	14

Overview

Care, treatment and support achieves good outcomes, helps people maintain quality of life and is based on the best available evidence.

Key Insights

Performance shows room for improvement. Focus on addressing the identified issues to strengthen compliance.

Absence of documented Multidisciplinary Team (MDT) meeting minutes or records.

Issue Description

Despite a comprehensive search, no actual meeting minutes, case discussion logs, or similar records evidencing the occurrence, regularity, attendees, patient cases discussed, or actions/outcomes of Multidisciplinary Team (MDT) meetings were found. While a strong MDT protocol exists, the lack of documented evidence of its implementation poses a critical risk to coordinated care and CQC compliance, potentially leading to fragmented care and poor patient outcomes.

Issue Details

Domain
Effective

Severity
Critical

Criterion
To verify that the practice maintains clear, comprehensive records of Multidisciplinary Team (MDT) meetings, demonstrating collaborative, multi-agency care planning and coordination for patients with complex needs.

Remediation Plans

Immediately implement a robust system for documenting all MDT meetings, including regular clinical huddles, formal case discussions, and specific meetings (e.g., palliative care, safeguarding). Ensure minutes clearly record the date, attendees (including external professionals), specific patient cases discussed (anonymized or by NHS number), decisions made, assigned actions, and follow-up plans. Train all relevant staff on the importance and method of accurate MDT documentation. Conduct a retrospective audit of recent complex patient cases to identify any undocumented MDT discussions and capture key decisions.

Evidence Documents

- /clinical/multidisciplinary-protocol.pdf

No documented evidence of clinical effectiveness discussions in meeting minutes.

Issue Description

Despite comprehensive searches for 'meeting minutes', 'governance meeting', 'agenda', 'team meeting', 'clinical meeting', 'quality improvement', 'QOF review', and 'audit review', no documents identifiable as meeting minutes or containing evidence of discussions related to clinical effectiveness, audits, or performance data were found. This indicates a critical gap in the practice's ability to demonstrate a systematic process for reviewing its performance and driving improvements.

Issue Details

Domain
Effective

Severity
Critical

Criterion
To verify that the practice regularly discusses clinical effectiveness in formal meetings, using data and evidence (such as clinical audits, QOF data, and national guidance) to drive improvements, and that these discussions and resulting actions are documented in meeting minutes.

Remediation Plans

Immediately establish a formal process for regular clinical governance or quality improvement meetings. Ensure these meetings have clear agendas that include review of clinical audits, QOF data, prescribing patterns, and national guidance. Mandate detailed minute-taking that captures discussions, decisions, assigned actions, responsibilities, and deadlines. Store these minutes in an easily accessible and searchable format. Conduct an urgent review of current quality assurance processes to identify why this fundamental documentation is absent.

Evidence Documents

- No evidence documents specified for this finding.

No evidence of completed two-cycle clinical audits found despite policy existence.

Issue Description

While a clinical audit policy and a quality improvement statement are in place, no records of completed two-cycle clinical audits within the last 12-24 months were found. This indicates a critical gap in demonstrating a systematic approach to continuous improvement and learning from practice, directly impacting patient safety and CQC 'Effective' domain compliance.

Issue Details

Domain
Effective

Severity
Critical

Criterion
Verification of a documented, ongoing clinical audit programme with evidence of at least two completed two-cycle audits (audit and re-audit) in the last 12–24 months, diversity of topics, documented learnings, and implemented changes.

Remediation Plans

Immediately locate and provide evidence of at least two completed two-cycle clinical audits from the last 12-24 months, including re-audit data, documented learnings, and evidence of implemented changes. If such audits have not been completed or documented, initiate new audit cycles on high-risk or high-volume areas, ensuring full documentation of both audit and re-audit phases, findings, action plans, and evidence of implementation. Ensure all audit documentation is centrally stored and easily retrievable.

Evidence Documents

- /management/medical-procedure-audits.pdf
- /practice policies/quality-improvement-statement.pdf

No evidence of QOF performance data review or quality improvement activities found

Issue Description

Comprehensive searches for QOF achievement data, performance reports, meeting minutes discussing QOF, or related action plans yielded no relevant documents. This indicates a critical gap in the practice's ability to monitor and improve the quality of its clinical care, potentially leading to unaddressed areas of underperformance and impacting patient outcomes.

Issue Details

Domain
Effective

Severity
Critical

Criterion
The practice systematically reviews its latest QOF achievement data, compares it against relevant benchmarks (national/ICB), and develops/documents action plans to address any areas of underperformance or to maintain high achievement.

Remediation Plans

Immediately implement a system for tracking and reviewing QOF achievement data. This must include regular meetings where QOF performance is discussed, benchmarked against national/ICB data, and clear action plans are developed for areas of underperformance. All related documentation (reports, meeting minutes, action plans) must be systematically stored and easily retrievable. Consider assigning a lead for QOF performance monitoring and reporting.

Evidence Documents

- No evidence documents specified for this finding.

Absence of a comprehensive, overarching health equity audit and integrated action plan.

Issue Description

While the practice demonstrates a strong commitment to addressing the needs of specific vulnerable groups and ensuring equal access through various policies, there is no single, overarching health equity audit that systematically analyzes the health needs and identifies inequalities across the entire registered patient population. This fragmented approach may lead to a lack of a holistic view of health disparities and potentially unaddressed systemic inequalities.

Issue Details

Domain
Effective

Severity
Major

Criterion
To verify that the practice systematically analyzes its population's health needs, conducts health equity audits to identify inequalities, and develops actionable plans to improve access and outcomes for all patient groups, particularly those identified as vulnerable or at risk of poorer outcomes.

Remediation Plans

Conduct a comprehensive, practice-wide health equity audit utilizing aggregated patient data, local public health intelligence, and patient feedback to identify systemic inequalities across all protected characteristics and vulnerable groups. Develop a single, integrated action plan with specific, measurable, achievable, relevant, and time-bound (SMART) objectives, assigned

ownership, and regular review dates to address all identified disparities. Ensure this audit and action plan are regularly reviewed and updated (at least biennially).

Evidence Documents

- /safeguarding children/health-wellbeing-policy-for-looked-after-children.pdf
- /clinical/nutritional-needs-policy.pdf
- /clinical/patients-with-learning-disabilities.pdf
- /management/protocol-on-ensuring-equal-access-to-services.pdf
- /hr and recruitment/equality-act-operational-procedures.pdf
- /safeguarding adults/at-risk-adults-policy.pdf
- /clinical/identifying-patient-needs-protocol-_-new-patient-registration-policy-_-form.pdf
- /gdpr/access-to-online-services.pdf
- /gdpr/accessible-information-standard-policy.pdf

Absence of comprehensive Structured Medication Review and Polypharmacy Policy.

Issue Description

The practice lacks a dedicated, comprehensive policy for Structured Medication Reviews (SMRs) and polypharmacy management. While general medication reviews occur, there is no clear process for proactive patient identification for SMRs, a detailed SMR methodology, or specific competency requirements for staff conducting these reviews. This gap increases the risk of suboptimal medicines optimisation and potential patient harm from unmanaged polypharmacy.

Issue Details

Domain
Effective

Severity
Major

Criterion
The practice has a documented, comprehensive, and implemented policy for conducting Structured Medication Reviews (SMRs), with a specific focus on identifying and managing patients with polypharmacy, ensuring reviews are performed by competent staff, and that outcomes are recorded and actioned.

Remediation Plans

1. Develop and implement a dedicated 'Structured Medication Review and Polypharmacy Policy' that clearly defines: criteria for identifying patients requiring SMRs (e.g., polypharmacy, specific long-term conditions, care home residents); a proactive process for maintaining an

SMR register; a detailed, step-by-step SMR procedure, including patient consultation, record review, and use of clinical system templates; and specific competency requirements for staff conducting SMRs, including the role of Clinical Pharmacists or GPs with specialist interest. 2. Ensure all existing medication-related policies (e.g., prescription-protocol.pdf) are reviewed and updated regularly, aligning with the new SMR policy. 3. Provide targeted training to relevant clinical staff on the new SMR policy and the specific methodology for conducting comprehensive SMRs.

Evidence Documents

- /clinical/monitored-dose-system-protocol.pdf
- /clinical/prescribing-pathway.pdf
- /medicines management/prescribing-policy.pdf
- /medicines management/prescription-protocol.pdf

Absence of dedicated antimicrobial stewardship policy and audit evidence

Issue Description

While general prescribing policies mention antibiotic prescribing, there is no specific antimicrobial stewardship policy or evidence of regular antibiotic prescribing audits. This gap poses a significant risk to patient safety due to potential antimicrobial resistance and inappropriate prescribing practices.

Issue Details

Domain
Effective

Severity
Major

Criterion
Antimicrobial Stewardship

Remediation Plans

Develop a comprehensive Antimicrobial Stewardship policy outlining clear guidelines for antibiotic prescribing, monitoring, and review. Implement regular antibiotic prescribing audits, analyze findings, and discuss outcomes and action plans in clinical meetings.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /clinical/prescribing-pathway.pdf

Clinical Governance Policy lacks detailed process for new guideline implementation and communication.

Issue Description

While the Clinical Governance Policy acknowledges the use of NICE guidelines and evidence-based practice, it lacks a clearly defined, systematic process for identifying, discussing, implementing, and communicating new or updated clinical guidelines to all relevant staff. This absence of a formal, documented procedure increases the risk of outdated practices, inconsistent care delivery, and potential patient harm due to missed opportunities to integrate current best practices.

Issue Details

Domain
Effective

Severity
Major

Criterion
To verify that the practice has a documented, systematic process for identifying, reviewing, implementing, and communicating new or updated NICE and other evidence-based clinical guidelines to ensure patient care is based on current best practice.

Remediation Plans

The practice should update its Clinical Governance Policy or create a dedicated 'Clinical Guideline Management Policy' that explicitly outlines a systematic process for: 1) Proactive identification and review of new/updated NICE and other evidence-based guidelines; 2) A formal mechanism for discussion and decision-making on local implementation (e.g., standing agenda item at clinical meetings); 3) A clear process for updating practice protocols, pathways, and

templates; and 4) A robust communication strategy to ensure all relevant clinical and non-clinical staff are informed of changes. Additionally, the practice must maintain clear records (e.g., meeting minutes, updated protocols) demonstrating adherence to this process.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf

Incomplete Clinical Audit Cycle: Lack of Documented Re-Audits to Confirm Improvements

Issue Description

While an initial clinical audit with a clear methodology, benchmarking against standards, and an action plan was identified, there is no documented evidence of a completed re-audit. This indicates a fundamental break in the quality improvement loop, as the effectiveness of implemented actions cannot be verified.

Issue Details

Domain
Effective

Severity
Major

Criterion
Verification that the practice conducts, documents, and acts upon clinical audits, including sound methodology, benchmarking, clear action plans, and re-audits to demonstrate improvements.

Remediation Plans

Implement a robust system for documenting and tracking the completion of re-audits for all clinical audits. Ensure that re-audit reports clearly demonstrate the impact of previously implemented action plans and confirm sustained improvements. Prioritize the completion and documentation of the planned Hand Hygiene re-audit for November 2024 and ensure all future audits include a documented re-audit phase.

Evidence Documents

- /infection control/hand-hygiene-policy-audit.pdf
- /management/medical-procedure-audits.pdf

Insufficient evidence of ongoing referral quality monitoring and overdue policy review.

Issue Description

The practice has robust referral policies, including for urgent cases and managing returned referrals. However, there is a significant gap in documented evidence of actual internal audits or regular discussions on referral quality and outcomes. Furthermore, a critical referral protocol is overdue for its annual review, indicating a lapse in maintaining current and effective procedures.

Issue Details

Domain
Effective

Severity
Major

Criterion
The practice has a documented, systematic, and monitored process for managing patient referrals, ensuring they are appropriate, high-quality, and tracked effectively, particularly for urgent cases. The audit will assess how the practice learns from internal analysis and external feedback to improve its referral process.

Remediation Plans

1. Establish and Execute Audit Program: Develop and implement a recurring schedule for internal audits of referral quality, appropriateness, and outcomes. Ensure audit findings, action plans, and review dates are thoroughly documented.

2. Formalize Quality Review Discussions: Integrate regular discussions on referral quality, audit results, and feedback from secondary care into clinical governance or team meetings. Document these discussions and resulting actions in meeting minutes.
3. Update Overdue Policy: Promptly review and update the "Referral Protocol & Additional Guidance" to ensure its currency and alignment with best practices. Implement a proactive system for timely policy reviews.
4. Document Feedback Loop Actions: Systematically record and track actions taken in response to feedback from secondary care, particularly concerning rejected or inadequate referrals, to demonstrate continuous process improvement.

Evidence Documents

- /clinical/referral-protocol-_-additional-guidance.pdf
- /safeguarding adults/national-referral-form-briefing-note-v2.pdf
- /practice policies/urgent-referral-safety-net-protocol.pdf

Lack of a dedicated and comprehensive clinical supervision policy with clear recording mechanisms.

Issue Description

While elements of supervision are present across various HR and governance documents (e.g., appraisals, induction, peer review mentions), there is no single, explicit policy for clinical supervision that consolidates these, defines specific processes for ongoing clinical supervision (beyond annual appraisals), and mandates clear recording for all types of supervision, including reflective practice or case discussions. This fragmentation could lead to inconsistencies in practice and difficulty in demonstrating a robust, systematic approach to clinical oversight.

Issue Details

Domain
Effective

Severity
Major

Criterion
The practice has a clear, documented policy for clinical supervision covering all relevant clinical staff, and evidence that this supervision is regularly occurring and being recorded.

Remediation Plans

Develop and implement a standalone "Clinical Supervision Policy" that clearly defines the purpose, scope (all clinical staff), frequency, process (including formal and informal supervision, peer review, and reflective practice), and mandatory recording mechanisms (e.g., a standardized log or template) for all clinical supervision activities. Ensure this policy integrates with existing appraisal and induction processes, and is regularly reviewed and communicated to all staff.

Evidence Documents

- /gdpr/clinical-governance-policy.pdf
- /hr and recruitment/induction-programme.pdf
- /hr and recruitment/new-staff-performance-review.pdf
- /hr and recruitment/pre-appraisal-guidelines-and-self-assessment-form.pdf
- /hr and recruitment/revalidation-process-for-gps.pdf
- /hr and recruitment/appraisal-staff-survey-360.pdf
- /hr and recruitment/appraisal-summary.pdf

Lack of documented evidence for regular prescribing audits and clinical meeting discussions

Issue Description

Policies state that regular prescribing audits are undertaken and discussed in clinical meetings. However, no actual audit reports (e.g., for cost-effectiveness, safety, or specific drug classes) or clinical meeting minutes demonstrating these discussions were found. This indicates a significant gap in demonstrating the implementation and effectiveness of the audit cycle and a learning culture.

Issue Details

Domain
Effective

Severity
Major

Criterion
Prescribing Audits & Reviews

Remediation Plans

Ensure all prescribing audits (including those for cost-effectiveness, safety, and specific drug classes) are formally documented with clear findings and action plans. Schedule and document regular clinical meetings where these audit findings are discussed, actions are agreed upon, and progress is reviewed. Ensure the 'prescribing-policy.pdf' has a current review date.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /clinical/prescribing-pathway.pdf
- /medicines management/dmard-initiation-protocol.pdf
- /clinical/monitored-dose-system-protocol.pdf

Significant gap in documented post-diagnosis cancer patient support.

Issue Description

The practice's documentation primarily addresses follow-up for abnormal cervical screening results and end-of-life care. There is a notable absence of a comprehensive policy outlining procedures for general post-diagnosis support for all cancer patients, including communication protocols, care planning, and systematic coordination with oncology and other specialist services. This gap poses a risk to holistic patient care and timely access to necessary support.

Issue Details

Domain
Effective

Severity
Major

Criterion
Procedures for supporting diagnosed patients, including communication, care planning, and coordination with oncology or palliative care services.

Remediation Plans

Develop a dedicated policy or integrate comprehensive sections into existing policies that specifically address post-diagnosis support for all cancer patients. This should include guidelines for initial communication post-diagnosis, shared care planning, signposting to support services, and clear pathways for coordination with secondary care oncology teams and palliative care services.

Evidence Documents

- /practice policies/smear-protocol.pdf
- /clinical/alerting-ooh-to-patient-dying-at-home.pdf

Significant gaps in performance monitoring for general vaccination and public health campaign uptake.

Issue Description

Performance monitoring is evident for child development checks and chronic disease management (via QOF targets). However, there is no explicit documentation of performance monitoring, such as uptake rates or dashboards, for broader public health campaigns like general immunisations (e.g., flu, COVID-19) or lifestyle information provision. This absence makes it difficult to assess the effectiveness of these crucial preventative services and identify areas for improvement.

Issue Details

Domain
Effective

Severity
Major

Criterion
Presence of performance monitoring (uptake data, reports) for key preventative services and public health campaigns.

Remediation Plans

Implement a systematic process for tracking and reporting uptake rates for all major preventative health services and public health campaigns, including general immunisations. Establish clear metrics and regular reporting mechanisms (e.g., monthly dashboards) to monitor performance. Assign responsibility for data collection, analysis, and reporting to a designated team member or lead clinician.

Evidence Documents

- /safeguarding children/child-development-checks.pdf
- /clinical/chronic-disease-plan-and-protocol.pdf
- /practice policies/vaccine-administration-protocol.pdf
- /clinical/vaccines_-handling_-storage-and-administration-policy.pdf

Safe

Assessment Domain

Performance Score

Issue Summary

Critical Issues	4
Major Issues	26
Total Actionable Issues	30

Overview

Ensures people are protected from abuse and avoidable harm.

Key Insights

Performance shows room for improvement. Focus on addressing the identified issues to strengthen compliance.

Absence of documented Patient Group Direction (PGD) and Patient Specific Direction (PSD) protocol and records.

Issue Description

No dedicated policy or protocol for the management, authorisation, and use of PGDs or PSDs was found. While general prescribing policies exist, they do not cover the specific legal framework and operational requirements for PGDs, nor is there evidence of a master list of PGDs or staff authorisation records. This represents a critical failure in safe care delivery and a breach of medicines legislation.

Issue Details

Domain
Safe

Severity
Critical

Criterion
A clear, robust, documented protocol for the management, authorisation, and use of Patient Group Directions (PGDs) and Patient Specific Directions (PSDs), ensuring all related documentation is current, complete, and staff are appropriately trained and authorised.

Remediation Plans

Immediately develop and implement a comprehensive Patient Group Direction (PGD) and Patient Specific Direction (PSD) policy. This policy must include clear procedures for development, authorisation, review, and withdrawal of PGDs, a master list of all PGDs in use with valid dates and signatures, and a robust system for recording staff authorisation and competency for each PGD. Ensure all relevant staff are trained on the new protocol and that all PGDs and PSDs are

managed in accordance with NICE guidelines and medicines legislation.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /medicines management/prescription-protocol.pdf
- /gdpr/clinical-governance-policy.pdf

Absence of key premises safety and maintenance logs and certificates.

Issue Description

Despite the presence of comprehensive policies outlining the need for premises safety and maintenance, no actual logs or certificates (e.g., PAT, EICR, Gas Safety, LOLER, general maintenance log, Legionella monitoring) were found. This indicates a systemic failure in documenting and providing evidence of essential safety activities, posing a direct and serious risk to patient and staff safety.

Issue Details

Domain
Safe

Severity
Critical

Criterion
Verification of current, complete, and accessible logs and certificates for all legally required premises safety and maintenance activities, including electrical, gas, and lift safety, as well as general building maintenance.

Remediation Plans

Immediately implement a robust system for maintaining and storing all required premises safety and maintenance logs and certificates. This includes obtaining current PAT, EICR, Gas Safety, and LOLER certificates (if applicable), establishing an active general maintenance log with clear records of issues and resolutions, and ensuring all Legionella monitoring logs are consistently maintained. Conduct an urgent internal audit to identify all missing documentation and rectify these gaps without delay. Ensure all staff responsible for premises management are fully trained on record-keeping requirements.

Evidence Documents

- /health and safety/maintenance_-servicing-_-calibration-of-equipment-protocol-_-template.pdf
- /health and safety/building-hazards-policy.pdf
- /health and safety/estate-management-policies-and-protocols.pdf
- /health and safety/health-_-safety-policy.pdf
- /health and safety/health-_-safety-policy-organisation.pdf
- /health and safety/fire-safety-policy.pdf
- /infection control/legionella-management-policy.pdf

No actual safeguarding training record or matrix found, only a policy describing record-keeping.

Issue Description

The 'staff-skills-competencies-training-record.pdf' document outlines the procedure for recording staff training and mentions that a central overview (e.g., spreadsheet) is maintained. However, the actual record or matrix containing completed safeguarding training details for staff, including levels, dates, and refreshers, could not be located within the document system. This absence prevents verification of staff competence in safeguarding.

Issue Details

Domain
Safe

Severity
Critical

Criterion
Maintenance of a comprehensive and up-to-date record or matrix of safeguarding training for all staff members (clinical, non-clinical, and locums), demonstrating completion of appropriate levels (1, 2, and 3) for both adults and children, including training dates and scheduled refreshers, in line with current intercollegiate guidance.

Remediation Plans

Immediately locate and upload the comprehensive safeguarding training matrix or record for all staff (clinical, non-clinical, and locums) to the central document management system. Ensure this record clearly details adult and child safeguarding training levels (1, 2, 3), completion dates, and

scheduled refresher dates for each staff member. Implement a robust system for regular updates and accessibility.

Evidence Documents

- /hr and recruitment/staff-skills-competencies-training-record.pdf

No documented meeting minutes or evidence of systematic safety discussions found.

Issue Description

Despite comprehensive searches for 'meeting minutes', 'meeting notes', 'clinical governance', 'safety meeting', 'significant event', and 'action points', no documents clearly identifiable as meeting minutes were found. This indicates a critical gap in documenting the practice's proactive safety and learning culture, making it impossible to verify if safety matters are systematically discussed, learned from, and acted upon in a structured meeting environment. This poses a significant risk to patient safety as recurring issues may not be identified or addressed.

Issue Details

Domain
Safe

Severity
Critical

Criterion
Evidence of systematic discussion of safety matters in relevant meetings, documentation of learning points, assignment of actions, and tracking to completion.

Remediation Plans

Immediately establish a formal process for conducting and documenting regular clinical governance and practice meetings. Ensure these meetings consistently include dedicated agenda items for safety discussions, incident reviews, audit findings, and patient feedback. Implement a standardized template for meeting minutes that clearly captures discussions, identifies specific learning points, assigns actionable tasks with clear ownership and deadlines, and includes a mechanism for tracking the completion of these actions in subsequent meetings. All meeting minutes must be centrally stored and easily retrievable.

Evidence Documents

- No evidence documents specified for this finding.

Absence of a consolidated, anonymised log demonstrating comprehensive non-clinical incident record-keeping.

Issue Description

While policies outline the process for reporting and documenting non-clinical incidents, and a specific register exists for data breaches, there is no clear evidence of a single, consolidated, anonymised log or register for all types of non-clinical incidents (e.g., accidents, security breaches, equipment failures, violent incidents). This absence hinders comprehensive oversight, trend analysis, and the demonstration of shared learning across all non-clinical incident categories.

Issue Details

Domain
Safe

Severity
Major

Criterion
Confirmation that anonymised records of such incidents are maintained and that these records document appropriate follow-up actions, preventive measures, and shared learning.

Remediation Plans

Implement and maintain a centralised, anonymised non-clinical incident log (e.g., a dedicated spreadsheet or database) that captures all reported non-clinical incidents, their investigation findings, follow-up actions, and identified learning points. Ensure this log is regularly reviewed by management to identify trends, inform continuous improvement initiatives, and demonstrate compliance with record-keeping requirements. Integrate data from existing specific registers (like the Data Breach Register) into this overarching log or ensure clear cross-referencing.

Evidence Documents

- /practice policies/accident-reporting-policy.pdf
- /management/notification-of-incidents.pdf
- /management/significant-event-monitoring-analysis-template.pdf
- /gdpr/data-breach-register-and-risk-register.pdf

Absence of a dedicated and current Fire Risk Assessment document.

Issue Description

The practice's fire safety policy states that a Fire Risk Assessment (FRA) will be conducted and reviewed annually, but no dedicated FRA document was found in the system. This is a significant regulatory gap as the FRA is the cornerstone of fire safety management, identifying hazards and control measures. Without a current FRA, the practice cannot demonstrate it has systematically assessed and mitigated fire risks, posing a direct threat to patient and staff safety.

Issue Details

Domain
Safe

Severity
Major

Criterion
Current fire risk assessment.

Remediation Plans

Immediately commission a competent person to conduct a comprehensive Fire Risk Assessment for both practice sites. Ensure the FRA is documented, includes an action plan, and is reviewed at least annually. File the completed FRA in an easily accessible location within the document management system.

Evidence Documents

- /health and safety/fire-safety-policy.pdf

Absence of accessible digital records for emergency medicine and equipment checks.

Issue Description

While a robust policy outlines the requirement for an 'Emergency Drug Check Log' and specifies its contents, no corresponding digital log files or records were found during the audit. This lack of accessible, auditable records prevents verification of compliance with the documented check frequencies and processes, posing a significant risk to patient safety as it's impossible to confirm that critical emergency equipment and medicines are consistently ready for use.

Issue Details

Domain
Safe

Severity
Major

Criterion
Emergency medicine and equipment checks are recorded and auditable.

Remediation Plans

Immediately implement a system for digital record-keeping of all emergency medicine and equipment checks. Ensure these digital logs are regularly updated, easily accessible for audit, and stored in a designated, searchable location within the practice's document management system. Conduct a retrospective review to digitize any existing physical logs if feasible, and train all relevant staff on the new digital logging procedures to ensure consistent adherence.

Evidence Documents

- /medicines management/policy-for-checking-emergency-drugs.pdf

Absence of detailed process for strategic staffing level review against patient demand.

Issue Description

While the Clinical Governance Policy mentions "Workforce Planning" to ensure adequate staffing, there is no explicit, detailed process outlining how overall staffing levels are regularly reviewed and assessed against patient demand, changes in list size, or new service offerings. The current documentation focuses on reactive measures for covering absences rather than proactive strategic planning. This gap could lead to persistent understaffing or inefficient resource allocation, impacting patient access and staff well-being.

Issue Details

Domain
Safe

Severity
Major

Criterion
Documented process for reviewing staffing levels to ensure they are safe and meet patient demand.

Remediation Plans

Develop and implement a comprehensive "Staffing Level Review Policy" that outlines a regular, proactive process for assessing staffing adequacy across all roles. This policy should include triggers for review (e.g., patient demand fluctuations, service changes), methodologies for assessment (e.g., workload analysis, patient feedback), and a clear decision-making framework for adjusting staffing levels. Integrate this with existing HR and clinical governance frameworks.

Evidence Documents

- /hr and recruitment/staffing-policy.pdf
- /hr and recruitment/employing-agency-workers.pdf

- /hr and recruitment/locum-appointment-protocol.pdf
- /gdpr/clinical-governance-policy.pdf

Absence of documented evidence for Duty of Candour policy application.

Issue Description

The practice possesses comprehensive Duty of Candour policies, but there is no documented, anonymised evidence of their practical application. This includes a lack of records for verbal notifications, written follow-up, or explicit patient communication within significant event reviews, hindering verification of consistent compliance with Regulation 20.

Issue Details

Domain
Safe

Severity
Major

Criterion
To verify that the practice has a comprehensive Duty of Candour policy that aligns with statutory Regulation 20, and to find anonymised evidence demonstrating its consistent application when things go wrong.

Remediation Plans

Establish a clear process for documenting all Duty of Candour communications, including verbal and written interactions. Implement standardised templates for patient correspondence and ensure these records are consistently maintained and accessible for audit. Integrate the review of these documented applications into regular clinical governance meetings to ensure ongoing compliance and learning.

Evidence Documents

- /practice policies/duty-of-candour.pdf
- /management/being-open-policy.pdf
- /management/significant-event-monitoring-analysis-template.pdf
- /medicines management/scp-policy.pdf

Absence of documented Legionella Risk Assessment report and findings.

Issue Description

While a Legionella Management Policy is in place and current, the actual Legionella Risk Assessment report, including its findings, the competent person who conducted it, and the scheduled review date, is not present in the document system. The policy contains placeholders for this critical information, indicating it is either missing or not yet completed/documented. This poses a significant compliance risk as the practice cannot demonstrate that the specific risks of its water systems have been identified and assessed.

Issue Details

Domain
Safe

Severity
Major

Criterion
Presence of a formal, current Legionella Risk Assessment conducted by a competent person.

Remediation Plans

Immediately commission a competent person to conduct a comprehensive Legionella risk assessment for all practice premises. Ensure the full risk assessment report, including identified risks, recommendations, and review dates, is formally documented and stored in the document management system. Update the Legionella Management Policy to reference the completed risk assessment document.

Evidence Documents

- /infection control/legionella-management-policy.pdf

Absence of specific Significant Event Audits or documented learning from safeguarding incidents.

Issue Description

Although policies mention the process for Significant Event Audits (SEAs) and policy review, no actual SEA reports or explicit 'lessons learned' documentation specifically related to safeguarding cases were identified. This lack of evidence suggests that the practice may not be consistently demonstrating learning from safeguarding events to improve patient safety and practice procedures.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence of Learning: Is there documented evidence of learning from cases, such as in a Significant Event Audit (SEA), a "lessons learned" section of minutes, or updates to policy following an incident?

Remediation Plans

Establish a clear process for conducting and documenting Significant Event Audits (SEAs) specifically for safeguarding concerns. Ensure that findings from these SEAs, including 'lessons learned' and resulting policy/procedural updates, are formally recorded and disseminated to relevant staff. Integrate a 'lessons learned' section into meeting minutes where safeguarding cases are discussed, detailing how insights from these cases will drive improvements.

Evidence Documents

- /management/significant-event-monitoring-analysis-template.pdf
- /medicines management/scp-policy.pdf

Absence of specific, current test records for the panic alarm system.

Issue Description

While a comprehensive panic alarm protocol is in place and a general equipment maintenance policy outlines record-keeping for alarm systems, no specific or current test logs for the panic alarm system itself were found. This lack of documented testing means there is no verifiable assurance that the system is regularly checked for functionality, posing a significant safety risk to staff and patients in an emergency.

Issue Details

Domain
Safe

Severity
Major

Criterion
Existence of a formal policy governing the use of panic alarms and confirmation that records of regular system testing are maintained and current.

Remediation Plans

Immediately implement a dedicated, auditable log for panic alarm system testing, detailing dates, personnel, and outcomes. Ensure this log is regularly updated (e.g., monthly or quarterly as per the general maintenance policy's frequency for alarm systems) and reviewed by the Practice Manager to confirm ongoing functionality and compliance.

Evidence Documents

- /health and safety/panic-alarm-protocol.pdf
- /health and safety/maintenance_-servicing-_-calibration-of-equipment-protocol-_-template.pdf

Comprehensive MCA Policy Present, but DoLS Procedures Are Absent

Issue Description

The practice has a robust and detailed Mental Capacity Assessment Policy and accompanying guidance that thoroughly covers MCA principles, capacity assessment, best interest decisions, and documentation. However, there is a complete absence of documented procedures for Deprivation of Liberty Safeguards (DoLS), including what constitutes a deprivation of liberty and the process for seeking authorisation. This omission represents a significant gap in the practice's legal and ethical framework for protecting vulnerable patients.

Issue Details

Domain
Safe

Severity
Major

Criterion
Existence and adequacy of documented policy and procedures for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Remediation Plans

Develop and implement a comprehensive Deprivation of Liberty Safeguards (DoLS) policy and procedure. This policy must clearly define what constitutes a deprivation of liberty, outline the process for identifying and assessing potential deprivations, detail the steps for seeking DoLS authorisation from the supervisory body, and specify roles and responsibilities for staff. Integrate this new policy with existing MCA and safeguarding policies, ensuring clear cross-referencing and consistent application.

Evidence Documents

- /safeguarding adults/mental-capacity-assessment.pdf
- /clinical/mental-capacity-assessment-guidance.pdf

DSE Policy Present, but No Evidence of Assessment Records or Action Plans

Issue Description

The Health & Safety Policy mentions that DSE workstation assessments are available and advice is provided. However, the policy does not outline a systematic process for conducting these assessments, nor does it provide any indication of where records of completed assessments are maintained. There is also no mention of how identified issues are actioned or resolved.

Issue Details

Domain
Safe

Severity
Major

Criterion
To verify that the practice has a systematic process for conducting Display Screen Equipment (DSE) assessments for relevant staff, maintains clear records of these assessments, and documents actions taken to resolve any identified issues.

Remediation Plans

Develop and implement a clear DSE assessment procedure that includes a systematic approach for conducting assessments (e.g., for new starters, annually, upon request). Establish a centralized system for recording all DSE assessments, including dates, findings, and documented action plans for any identified issues. Ensure that all DSE-related issues are tracked to resolution and that staff are aware of the assessment process and how to request one.

Evidence Documents

- /health and safety/health-_-safety-policy.pdf

Incomplete documentation of high-risk medication list and specific monitoring protocols.

Issue Description

The practice's 'Prescribing Policy' provides a general mention of high-risk drugs but lacks a comprehensive, explicit list of all high-risk medications. While a detailed 'DMARD Initiation Protocol' exists, specific monitoring protocols for other critical high-risk medications like Warfarin or DOACs are not explicitly documented within the practice's internal policies, relying instead on external Shared Care Protocols (SCPs) which are not provided as part of the practice's internal documentation.

Issue Details

Domain
Safe

Severity
Major

Criterion
Existence of a robust, documented policy and system for monitoring patients prescribed high-risk medications, including a comprehensive list of high-risk drugs.

Remediation Plans

Develop and integrate a comprehensive list of all high-risk medications managed by the practice into a central policy. For each high-risk medication, either incorporate detailed monitoring protocols (tests, frequency, acceptable ranges, action on out-of-range results) directly into practice policies or ensure all relevant external Shared Care Protocols are formally adopted, readily accessible, and clearly referenced within the practice's internal documentation system.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /medicines management/dmard-initiation-protocol.pdf
- /practice policies/co-operating-with-other-providers-policy.pdf

Incomplete documentation of IPC audit action plans and lack of comprehensive IPC audit reports.

Issue Description

While a hand hygiene audit report was found with identified issues, a formal action plan with assigned responsibilities and deadlines was not clearly documented. Furthermore, comprehensive, dated IPC audit reports covering all aspects of infection control, as suggested by the IPC checklist template, were not readily available, indicating a gap in regular, fully documented IPC audit cycles.

Issue Details

Domain
Safe

Severity
Major

Criterion
The GP practice regularly conducts and documents Infection Prevention and Control (IPC) audits, records the findings, and creates and implements documented action plans to address any identified issues.

Remediation Plans

Implement a robust system for documenting all IPC audit findings, including a clear, detailed action plan for each identified issue. Ensure action plans specify responsible persons, target completion dates, and a mechanism for verifying completion. Conduct regular, comprehensive IPC audits as per the practice's IPC checklist and policy, ensuring all audit reports and corresponding action plans are centrally stored and easily accessible.

Evidence Documents

- /infection control/infection-control-checklist.pdf
- /management/medical-procedure-audits.pdf
- /infection control/hand-hygiene-policy-audit.pdf

Incomplete IPC Training Records for All Staff and Key Topics

Issue Description

While policies outline the need for IPC training and record-keeping, and a decontamination training register exists for clinical staff, a comprehensive training record for all staff (including non-clinical and cleaning staff) covering all key IPC topics (hand hygiene, PPE, and decontamination) was not found. This lack of a centralized, complete record makes it difficult to verify compliance with mandatory IPC training requirements across the entire practice.

Issue Details

Domain
Safe

Severity
Major

Criterion
Verification of up-to-date training records for all staff (clinical, non-clinical, and cleaning) demonstrating completion of role-appropriate Infection Prevention and Control (IPC) training, including regular updates and coverage of key topics such as hand hygiene, PPE, and decontamination.

Remediation Plans

Develop and implement a centralized, comprehensive IPC training matrix or log that includes all staff roles (clinical, non-clinical, cleaning). Ensure this record clearly documents completion dates for all mandatory IPC training, including specific modules on hand hygiene, PPE, and decontamination, with evidence of regular updates. Assign clear responsibility for maintaining and regularly auditing this record.

Evidence Documents

- /hr and recruitment/staff-skills-competencies-training-record.pdf
- /infection control/infection-control-policy.pdf
- /infection control/decontamination-training-policy-and-register.pdf

Insufficient evidence of specific learning points and implemented changes from incidents.

Issue Description

Although policies outline the importance of learning from incidents and developing action plans, there is no documented evidence (e.g., in completed incident forms or meeting minutes) of specific learning points being identified or subsequent changes being implemented as a direct result of incident investigations. This prevents the practice from demonstrating a closed-loop learning system.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence of Learning: Do the completed records or meeting minutes contain specific "learning points," "actions taken," or "changes implemented" as a result of the investigation?

Remediation Plans

For every significant event or incident investigated, ensure that specific, actionable learning points and resulting changes are clearly documented. This documentation should include details of the implemented changes, responsible persons, and target completion dates, demonstrating how the practice actively learns and improves patient safety.

Evidence Documents

- /medicines management/scp-policy.pdf
- /management/significant-event-monitoring-analysis-template.pdf
- /management/notification-of-incidents.pdf
- /practice policies/accident-reporting-policy.pdf

Key prescription protocol is significantly outdated, and main prescribing policy lacks specific review date.

Issue Description

The "Prescription Protocol" document (/medicines management/prescription-protocol.pdf) has a review date of May 2023, making it over two years overdue for review. Additionally, the "Prescribing Policy" (/medicines management/ prescribing-policy.pdf) uses a template for its review date, indicating a potential oversight in formalizing its review schedule. This lack of current review for critical documents poses a significant risk as procedures may not reflect current best practices, legislation, or CQC expectations, potentially compromising patient safety and compliance.

Issue Details

Domain
Safe

Severity
Major

Criterion
All relevant policies and procedures for prescription management and security are current and regularly reviewed (within the last 1-2 years).

Remediation Plans

Immediately schedule a comprehensive review and update of the "Prescription Protocol" and "Prescribing Policy" documents. Ensure all policies have specific, future-dated review dates and that these reviews are actioned promptly. Implement a robust system for tracking policy review cycles to prevent future lapses in currency.

Evidence Documents

- /medicines management/prescribing-policy.pdf
- /medicines management/prescription-protocol.pdf

Lack of documented evidence for anonymised safeguarding case discussions in meeting minutes.

Issue Description

While safeguarding policies outline the importance of discussion, no specific meeting minutes or records demonstrating anonymised discussions of safeguarding cases were found. This absence indicates a gap in the documented implementation of case review and oversight, which is crucial for effective safeguarding practice and continuous improvement.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence of Discussion: Do meeting minutes (e.g., clinical, safeguarding, or partner meetings) show anonymised discussion of safeguarding cases?

Remediation Plans

Implement a robust system for documenting anonymised safeguarding case discussions in relevant meeting minutes (e.g., clinical governance, safeguarding lead meetings). Ensure these minutes clearly reflect the discussion, decisions made, and actions assigned, without compromising patient confidentiality. Regularly audit these records to confirm consistent practice.

Evidence Documents

- No evidence documents specified for this finding.

Lack of documented evidence of completed significant event and incident investigations.

Issue Description

While policies and templates for incident reporting and significant event analysis are in place, there is no evidence of these processes being actively used. No completed, anonymised SEA logs or incident reports were found to demonstrate that investigations are being conducted as per policy. This indicates a critical gap in the implementation of the practice's safety management system.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence of Action: Are there completed SEA forms, logs, or records showing the process in action? These must be anonymised.

Remediation Plans

Implement a system for consistently documenting all significant event and incident investigations using the established templates. Ensure all completed forms are securely stored and readily accessible for audit purposes, demonstrating the full lifecycle from reporting to action.

Evidence Documents

- /medicines management/scp-policy.pdf
- /management/significant-event-monitoring-analysis-template.pdf
- /management/notification-of-incidents.pdf

- /practice policies/accident-reporting-policy.pdf

Lack of documented higher-level safeguarding training for named Designated Safeguarding Leads.

Issue Description

The practice policies clearly outline the requirement for Designated Safeguarding Leads to undertake specific higher-level training. However, the provided documentation does not include evidence of this training for Dr. Sarah Khan (Children's DSL) or Dr. Ben Carter (Adults' DSL), such as completion certificates, dates, or levels. This absence of direct evidence makes it impossible to verify that the leads possess the current, appropriate expertise required for their critical roles, potentially impacting the quality and effectiveness of safeguarding responses.

Issue Details

Domain
Safe

Severity
Major

Criterion
Their specific higher-level training is documented and current.

Remediation Plans

The Practice Manager must provide verifiable documentation of current (within the last 2-3 years) Level 3 or higher safeguarding training for both Dr. Sarah Khan and Dr. Ben Carter. This documentation should include the training provider, date of completion, and level achieved. Implement a system to proactively track and update DSL training records, ensuring renewal before expiry.

Evidence Documents

- /safeguarding children/safeguarding-children.pdf
- /safeguarding adults/safeguarding-protocol.pdf
- /safeguarding adults/mhcc-gp-sg-policy.pdf
- /safeguarding adults/at-risk-adults-policy.pdf

Lack of documented logs for routine fire safety checks.

Issue Description

While the fire safety policy outlines the need for routine fire safety checks (fire drills, alarm tests, emergency lighting), no documented logs or records of these activities were found. This lack of evidence means the practice cannot demonstrate that these critical safety checks are being consistently performed, which is essential for ensuring the ongoing functionality of fire safety systems and staff preparedness.

Issue Details

Domain
Safe

Severity
Major

Criterion
Documented records of routine fire safety checks (fire drills, alarm tests, emergency lighting).

Remediation Plans

Implement a robust system for documenting all routine fire safety checks. This should include dedicated logbooks or digital records for weekly fire alarm tests, monthly emergency lighting checks, and annual fire drills. Ensure these logs are regularly completed, reviewed, and stored in an accessible manner.

Evidence Documents

- /health and safety/fire-safety-policy.pdf

Lack of documented ongoing Legionella control measure records.

Issue Description

The Legionella Management Policy outlines required control measures such as temperature checks and flushing of infrequently used outlets. However, there is no documented evidence, such as temperature logs or flushing records, available in the document system to demonstrate that these ongoing control measures are being consistently implemented. The policy's appendices for these logs are unpopulated. This indicates a significant gap in the practical application and record-keeping of Legionella control, directly impacting patient and staff safety.

Issue Details

Domain
Safe

Severity
Major

Criterion
Documented evidence of ongoing control measures (e.g., temperature checks, flushing logs) and actions taken in response to risk assessment findings.

Remediation Plans

Implement a robust system for recording all Legionella control measures, including daily/weekly temperature checks at sentinel points and regular flushing of infrequently used outlets. Ensure all records are accurately completed, dated, and signed by the responsible person. Store these records systematically in the document management system, making them readily accessible for audit and review. Train relevant staff on proper record-keeping procedures.

Evidence Documents

- /infection control/legionella-management-policy.pdf

Lack of documented process for monitoring workload and capacity metrics.

Issue Description

The reviewed documents imply an awareness of "increased workload" when engaging temporary staff, but there is no explicit documented process for systematically monitoring key workload and capacity metrics (e.g., appointment demand, consultation length, prescription volume, administrative tasks) against available staff capacity. Without this, it is difficult to proactively identify and address potential imbalances, leading to staff burnout, rushed consultations, and potential delays in patient care.

Issue Details

Domain
Safe

Severity
Major

Criterion
Monitoring of workload and capacity against available staff.

Remediation Plans

Establish a "Workload and Capacity Monitoring Procedure" that defines key metrics to be tracked, frequency of monitoring, responsible personnel, and how data will be used to inform staffing decisions and resource allocation. Implement tools or systems to facilitate this monitoring and ensure regular reporting to practice management and partners.

Evidence Documents

- /hr and recruitment/employing-agency-workers.pdf
- /hr and recruitment/locum-appointment-protocol.pdf

Missing documentation for fire extinguisher maintenance and servicing.

Issue Description

The fire safety policy states that fire extinguishers are regularly maintained, but no specific service records or certificates were found to evidence this. Without documented proof of annual servicing, there is no assurance that fire extinguishers are in proper working order and ready for use in an emergency, which could compromise the safety of patients and staff.

Issue Details

Domain
Safe

Severity
Major

Criterion
Documented records of equipment maintenance (fire extinguishers).

Remediation Plans

Obtain and file current service certificates for all fire extinguishers. Establish a system to ensure annual servicing is scheduled and documented, and that all service reports are retained and easily retrievable.

Evidence Documents

- /health and safety/fire-safety-policy.pdf

No direct evidence of staff Prevent Duty training completion found.

Issue Description

Although the Prevent Duty policy states that all staff are required to undertake Prevent training, and a 'Staff Skills Competencies Training Record' policy outlines how training records are maintained, no actual training matrix, log, or certificates demonstrating that staff have completed specific Prevent Duty training were found. This significant gap means there is no verifiable evidence that staff possess the necessary knowledge to identify vulnerable individuals or understand referral pathways.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence that relevant staff have been trained to identify individuals vulnerable to radicalisation and understand local referral pathways (Channel).

Remediation Plans

Immediately compile and make available a comprehensive training matrix or log that clearly lists all staff members, the date of their Prevent Duty training completion, and the training provider. Implement a system to track and ensure all relevant staff complete mandatory Prevent training and refreshers, and that this evidence is readily accessible for audit purposes.

Evidence Documents

- /safeguarding adults/new-national-prevent-referral-form.pdf
- /hr and recruitment/staff-skills-competencies-training-record.pdf

No documented evidence of significant event and incident discussions in practice meetings.

Issue Description

The practice policies state that incident findings and learning points should be discussed in clinical and partner meetings. However, no meeting minutes or other records were provided to verify that these discussions are regularly occurring, which is crucial for disseminating learning and fostering a safety culture.

Issue Details

Domain
Safe

Severity
Major

Criterion
Evidence of Discussion: Is there mention of SEAs/ incidents being a standing agenda item in meeting minutes (e.g., clinical, practice, or governance meetings)?

Remediation Plans

Ensure that significant events and incidents are a standing agenda item at relevant practice meetings (e.g., clinical, governance, partner meetings). Document these discussions in the meeting minutes, including key findings, agreed actions, and assigned responsibilities, to provide clear evidence of review and learning.

Evidence Documents

- /medicines management/scp-policy.pdf
- /management/notification-of-incidents.pdf
- /practice policies/accident-reporting-policy.pdf

Safeguarding Adults Policy requires urgent update and inclusion of critical external contact details.

Issue Description

The 'At-Risk Adults Policy' is significantly out of date, with its next review date having passed over 18 months ago. Crucially, it lacks specific, actionable contact details for external reporting to the Local Authority's adult safeguarding team, which is a critical procedural gap that could impede timely and effective safeguarding actions. While the Mental Capacity Act is referenced, there is no explicit mention of Deprivation of Liberty Safeguards (DoLS), which is a key component of adult safeguarding.

Issue Details

Domain
Safe

Severity
Major

Criterion
Existence, currency, and comprehensiveness of the practice's Safeguarding Adults Policy, ensuring it aligns with the Care Act 2014, local Safeguarding Adults Board (LSAB) guidance, and includes all required procedural elements for protecting vulnerable adults.

Remediation Plans

Immediately schedule a comprehensive review and update of the 'At-Risk Adults Policy'. Ensure the updated policy includes current and specific contact details (name, phone number) for the Local Authority adult safeguarding team. Explicitly incorporate and detail the principles and application of Deprivation of Liberty Safeguards (DoLS) within the policy. Establish and adhere to a strict annual review cycle for all safeguarding policies to ensure ongoing currency and

compliance.

Evidence Documents

- /safeguarding adults/at-risk-adults-policy.pdf

Significant gaps in clinical waste management documentation: missing contract and collection evidence.

Issue Description

While a comprehensive clinical waste protocol is in place, there is no evidence of a current waste disposal contract with a licensed carrier. Furthermore, no consignment notes or waste transfer notes were found to demonstrate regular and compliant waste collections. This indicates a critical breakdown in the practical implementation and verification of the waste management system, posing significant regulatory and safety risks.

Issue Details

Domain
Safe

Severity
Major

Criterion
A current, compliant process for managing clinical waste, including a valid disposal contract, evidence of collections (consignment notes), staff training records, and a comprehensive policy for safe storage, segregation, and timely disposal of all clinical and sharps waste.

Remediation Plans

Immediately secure a valid contract with a licensed clinical waste disposal company and ensure all contractual documentation is readily available. Implement a robust system for retaining all consignment notes/waste transfer notes for a minimum of three years, ensuring they are easily retrievable for audit purposes. Conduct an urgent review of the clinical waste protocol, updating it to reflect current practices and ensuring the review date is adhered to. Verify and document all

staff training on clinical waste management, including specific dates and content, and ensure these records are centrally accessible.

Evidence Documents

- /infection control/clinical-waste-protocol.pdf
- /hr and recruitment/training-policy.pdf
- /hr and recruitment/staff-skills-competencies-training-record.pdf