

Session 9: Learning from failed CQC Inspections

- Review key themes and points of failure from GP practices that have not passed CQC inspections
- Look at actual extracts from the CQC reports to learn from what is documented and publicly available (anonymised)

About this session: The content of this session is intended to provide general guidance based on our current understanding of CQC expectations. It should not be relied upon as definitive or exhaustive advice. As CQC approaches and areas of focus may change, practices remain responsible for their own compliance and governance arrangements.

Overall key themes from the Practices that failed a CQC inspection – note how many fall into the Safe & Well Led KLOE's!

1. Governance and leadership oversight

- A recurring theme was insufficient oversight of systems, risks and performance.
- Several practices had concerns in the well-led domain, often linked to incomplete monitoring, weak assurance processes, gaps in policies or unclear accountability for improvement actions.

2. Safe care and medicines management

- Medicine safety was a repeated area of concern, particularly around high-risk medicines, monitoring of long-term conditions, delayed or incomplete reviews and ensuring clinical records demonstrated appropriate assessment and follow-up.
- Vaccine or medicine storage records incomplete

3. Staffing, skills and clinical supervision

- Concerns related to supervision of clinical staff, oversight of advanced clinical roles
- Appropriate recruitment checks
- Mandatory training records,
- Lack of appraisals
- Resilience within the workforce.

4. Learning culture and incident management

- Better-performing or improving practices tended to show open learning cultures, clearer systems for reporting and investigating incidents, and evidence that lessons from complaints or safety events were being acted on.
- Weaker services often had less reliable arrangements for capturing, sharing or embedding learning.

5. Patient-centred, caring and responsive services

- Many reports included positive findings on staff kindness, compassion, dignity and respect.
- Even where overall ratings were lower, caring and responsive domains were often stronger than safe and well-led.
- Practices commonly received positive feedback where patients were involved in decisions, able to access appointments, and supported through appropriate referral or care pathways.

6. Access, continuity and responsiveness to local needs

- Access and responsiveness appeared as both a strength and a risk.
- Some practices demonstrated extended hours, urgent access, continuity of care and community engagement.
- Others had concerns around people being able to access services safely or delays in diagnosis and follow-up.

Conclusions we can draw from these themes

- Across all the CQC reports, patient-facing care was often described positively, but organisational assurance was not at the same standard.
- The most common risks related to:
 - Safe care,
 - Medicines management,
 - Staffing oversight
 - Governance.
- Practices that improved tended to show:
 - stronger learning cultures,
 - better incident management systems / processes
 - clearer monitoring of risks,
 - more consistent evidence that actions were embedded and sustained.

Governance and Leadership oversight

A dominant theme is weak governance, with leaders not having sufficient oversight of quality, safety, risk and performance.

Clear themes that systems were either not in place, not embedded, or not working effectively enough to identify and manage risks.

Leaders did not always have **oversight** of some processes and therefore failed to identify risks when assurance processes did not operate as intended.

E.g.

Backlogs of incomplete tasks were not appropriately monitored or managed.

- Significant events and reported concerns were not always recorded, investigated or reviewed effectively to **support learning and improvement**
- Significant events and complaints were not always thoroughly recorded, acted on and analysed.
- There was a log of significant events, however further improvements were required. For example, the completion of actions was not always clearly or consistently documented. We also identified incidents that were documented on a recording form, but not on the log.
- The practice did not have a matrix or tracking form for significant events and it was not always easy to see how oversight was maintained

Risk Management & Health & Safety

Gaps in risk assessment and follow-up, particularly around fire safety, legionella, health and safety action plans, emergency preparedness, premises risks, and evidence that identified risks had been acted on.

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

Risk assessments were not always supported with a clear record of actions taken.

- The practice lacked a robust assessment of, and provision for, emergency medicines held on site.
- No risk assessment to determine the range of emergency medicines held.
- We did not find all the emergency medicines we would expect to see.
- We also found there were no systems to ensure the defibrillator was regularly checked and fit for use

Emergency
Medicines

- ❖ limited evidence to show that the practice had its own policies and procedures for identifying and prioritising 'same day' care which meant people requiring urgent appointments may not always be identified and prioritised appropriately.
- ❖ No formal policy for assessing and prioritising appointments so that staff could safely and consistently direct patients to the appropriate clinician.

Urgent clinical
appointments
/ Triage

Risks to patients, staff and visitors were not effectively assessed, monitored or managed.

Health and safety risk assessments were not always accurate and managed in a way that provided appropriate reassurances that actions had been taken.

- ❑ Risk assessments were not always supported with a clear record of actions taken.
- ❑ We reviewed the water hygiene risk assessment and survey report undertaken on xx we noted a number of actions were required to improve safety. We could not find evidence of an action plan to respond to these concerns.
- ❑ there was only one fire marshal, staff were unsure who would fulfil this role if this person was not at the practice.
- ❑ Action plans for health and safety, fire and legionella risks assessments were not in place in the practice.
- ❑ Health and safety risk assessments were not always accurate and managed in a way that provided appropriate reassurances that actions had been taken
 - The practice health and safety risk assessment had a number of outstanding actions, including issues with fire safety which were also highlighted in the fire risk assessment
 - We were unable to find evidence of a recent fire evacuation drill.



Ardens CQC searches – why I keep mentioning them! Taken from actual CQC reports published

-  We found xxx patient's indicated a potential missed diagnosis. We reviewed the records for five patients and these all showed a significant deterioration in patients' eGFR levels (shows how well the kidneys are filtering). None of these records had been coded as CKD and all lacked the level of monitoring required.
-  We found that xx patients were identified as having a missed diagnosis of diabetes. This meant they had not received the necessary monitoring including, eye screening referrals and blood tests, thereby exposing them to the risk of harm.
-  We found for medicines subject to a MHRA alert, the required monitoring had not been undertaken. For example, where patients had been prescribed a combination of a medicine for cholesterol and one for high blood pressure, as this combination of medicines can increase the risk of healthcare complications. We identified xx patients on this combination of medicines and all patients required reviews. The five patient records we reviewed did not contain evidence that the risk of this combination of medicines had been discussed with the patient.
-  At this inspection, our search of patients with hypothyroidism who had not had thyroid function test monitoring for 18 months found that xx out of a total of xxx patients had not had the appropriate monitoring. We examined a sample of five records and found all were overdue required checks.



At this inspection we found a significant improvement in the healthcare monitoring for these patients, with xx identified as not having the required monitoring out of xxx patients prescribed these medicines. We examined five patient records and found that, whilst all had the required blood tests, four records did not indicate the creatinine clearance had been calculated.



Practice 2

Our clinical searches (date) showed that the process for monitoring patients' health in relation to the use of medicines was not always effective. For example, our searches indicated that out of xxx patients being prescribed medicines used to treat high blood pressure and heart conditions, xx had not had the required monitoring. We reviewed the records of x patients in more detail and found that none had up to date blood tests prior to issuing their prescription.



We found non-steroidal anti-inflammatory and anti platelet medicines were not always prescribed safely to patients over the age of 70. Out of xxx patients prescribed these medicines, we identified xx had not been prescribed the recommended medicines to reduce the risk of gastrointestinal irritation and bleeding. We reviewed x records in more detail and found all x patients were potentially at risk of this.



The practice told us they had a system for recording and disseminating safety alerts, however it was unable to demonstrate that all relevant alerts had been acted on. Our clinical searches showed that x patients out of xx, prescribed a medicine used to treat bladder problems, had not received necessary monitoring. In addition, there was no evidence to show they had been informed of the risks associated with taking the medicine.

Other Medicines Management

Medicine management arrangements did not ensure safe storage.

Patients did not always receive appropriate monitoring before repeat prescriptions were issued,
Prescription stationery was not stored securely.

Patients with long-term conditions were not always reviewed in line with current best practice guidance,
and some reviews were not completed in a timely manner.

We also reviewed patient group directions (PGDs), which allow specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber. We saw PGDs that had been signed by nurses, **after being signed** by the authorising GP. This meant that the nurse had not been authorised to administer medicines under PGDs

- We found Patient Group Directions (PGDs) were still not always authorised correctly

We found the practice had not carried out a risk assessment to determine the range of emergency medicines held. We also found there were no systems to ensure the defibrillator was regularly checked and fit for use

We found the **ambient room temperature** was not being monitored where medicines were stored, including those for use in an emergency, to ensure they remained effective and safe to use.

Fridge Temperature records demonstrated that temperatures had not been consistently recorded at the main site

Medicines Management – more!

The practice was not always prescribing in line with safety alerts about medicines and healthcare products. •

Test results were not always followed up appropriately in order to diagnose long term conditions.

We found medicines reviews did not always contain necessary information to support continued prescribing.

- Information was not always available to demonstrate what was considered as part of the review; whether interactions of prescribed medicines had been discussed and considered with the person; or include a record of potential risks and actions to be taken.

Unable to demonstrate they had improved oversight of non-medical prescribers and staff employed in advanced clinical practice.

The service shared with us documents outlining practitioners' scope of practice, but these had not been effectively implemented or monitored.

There are multiple concerns about safe prescribing and medicines oversight, including high-risk medicine monitoring, incomplete medicines reviews, unsafe or inconsistent storage, prescription stationery security, emergency medicines, PGDs, and failure to act consistently on safety alerts.

Staff Management including recruitment

Recruitment & Employment Checks

- DBS checks were not always completed for staff.
- Recruitment checks were not consistently carried out in line with regulations.
- Recording of employment checks could be improved, to include a documented explanation of any gaps in employment.

Vaccination & Immunisation Records

- Staff vaccination records were not maintained in line with current UKHSA guidance.
- Staff vaccinations not up to date.
- Not all staff could obtain evidence of vaccinations, as records were not always available.
- Central immunisation records did not include all recommended immunisations (e.g. tetanus, polio).

Staff Support & Engagement

- Staff did not always feel listened to or supported when raising concerns.
- Lack of staff engagement.
- Not all staff were aware of the Freedom to Speak Up (FTSU) Guardian, and this policy was not well known by staff

Training, Supervision & Staffing Capacity

- Not all staff had completed or were up to date with mandatory training.
- Staff in advanced clinical practice did not have formalised clinical supervision.
- Staffing levels not reviewed.
- Only one fire marshal; staff were unsure who would cover this role in their absence.

Staffing continued

- ❑ A strong theme is poor staff engagement and low confidence in leadership. Staff did not always feel listened to, supported or able to raise concerns without fear of retribution. There are also concerns about morale, wellbeing and internal communication
- ❑ Staff were not confident that concerns raised would be dealt with appropriately or effectively. We saw that the partnership did not work collaboratively with the staff team or with other partners,
- ❑ Leaders did not have a shared vision for the future of the service. Staff were aware of ongoing strategic disagreements in the senior leadership team and did not have confidence in the service's ability to improve
- ❑ However, some staff reported they felt unsure they had been heard and understood, particularly in relation to staffing pressures.
- ❑ Meetings for other groups of staff were less regular and for nursing staff in particular there were no team meetings.

Safeguarding

Non-clinical staff had not yet received safeguarding training to a level appropriate for their role.

One staff member had a DBS that had not checked the children's list as it had been applied for as adult workforce. We were told that this clinician did not see children, however there may be occasions when they come into contact with children. There was no risk assessment to support the decision.

However, not all staff were clear about the process to follow up on children and adults at risk who were not brought to their appointment.

The document identifies weaknesses in safeguarding processes:

- staff training gaps
- unclear processes for following up children and adults at risk who were not brought to appointments,
- inadequate systems to prevent abuse or protect service users.

Infection Prevention & Control

There was an IPC policy for all staff employed by the provider, however it had **not been adapted for use at this practice**. It lacked specific detail including named individuals and clarity about roles and responsibilities including ordering and waste management

Policies were not always personalised to the service.

An IPC audit had been completed and remedial actions had been identified. However, at the time of assessment, **not all actions had been completed**. For example, a lack of cleaning schedules and documentation for cleaning, including for clinical rooms.

The provider had not confirmed the immunisation status of all clinical staff to mitigate the risk to them and others of infection.

Final Thoughts

Prioritise preparation on the 'Safe' and 'Well Led' KLOES – once you are confident on those - move on to 'Effective' and 'Responsive'

Great care and great staff needs to be backed up by good systems and processes in the practice.

Be aware of the issues in using AI and other systems to manage processes – what assurance do you have that the product is working as intended? You can't 'just plug in and let it get on with it' – you will need a checking process that the system / product is working as required to ensure you are managing the risk e.g. sample audit / checks.

Passing a CQC inspection **is achievable** (although it has its challenges with their moving goal posts!) so stay up to date with what CQC require and make the necessary changes - before you get the email!

Make what's required for CQC part of your existing systems and processes in recruitment, clinical meetings, safeguarding, significant events, complaints, MHRA notices, audits, emergency care etc – work smarter not harder!

Don't put off CQC preparation – the more you do now - potentially the better your outcome will be.

Don't Forget

- When you get your CQC inspection email – give me a call and I will pop down and support you with preparation
- Previous 'Preparing for CQC' workshop recordings & slides here: [Preparing for CQC Inspections - Surrey and Sussex LMCs](#)
- Short Videos from GP practices - their top tips for CQC success here:
- [Insights from practices - Surrey and Sussex LMCs](#)



Reflection on today and the workshops – ideas for improvement before I run the next ones



What will you take away and implement or change in your GP Practice?



Please write in the chat