

# Care Quality Commission

## Inspection Evidence Table

**Dr Zuber Ahmed (1-532086925)**

Inspection date: 19 July 2019

Date of data download: 08 July 2019

### Overall rating: Inadequate

The practice has been rated as inadequate in the safe, effective, responsive and well-led domains, and requires improvement in the caring domain. Overall the practice is therefore rated as inadequate. There are breaches in the Health and Social Care Act (Regulated Activity) Regulations 2014 of regulation 12 (safe care and treatment), regulation 17 (good governance), regulation 18 (staffing) and regulation 19 (fit and proper persons employed). The practice has been placed into special measures as a result.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

### Safe

### Rating: Inadequate

The practice is rated as inadequate in the safe domain. Not all staff had been trained in safeguarding adults and children. The practice did not carry out all the required checks prior to recruiting new staff, and there was no evidence of on-going checks. The practice did not have assurance that safety checks were carried out. There were failings in the infection prevention and control process. There was no guidance for non-clinical staff on how to deal with medical emergencies. The competence of nurse prescribers had not been formally assessed. Some medicines were incorrectly stored. The significant event process was not well monitored or recorded. There were no significant event reviews and learning was not documented.

#### Safety systems and processes

The practice had gaps in their systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Not all staff had been trained in safeguarding. Of the five GPs regularly working at the practice we saw evidence of safeguarding children training for one of them and no evidence of them completing safeguarding adults training. We saw evidence that the advanced nurse practitioners had been trained in safeguarding children to level three. One had been trained to level two in safeguarding adults and the other to level one. There was no evidence of safeguarding training for the practice nurse. In addition, there was no evidence held of the healthcare assistant, the phlebotomist and chiropractor completing any safeguarding training. Most of the administration team had completed training but none was held for the practice manager. The practice manager told us they repeated safeguarding training every five years but they did not have a policy for this.</p> <p>There were no chaperone posters displayed in the clinical consultation rooms or the waiting area.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
<p>The practice manager told us they had never advertised for staff and always employed people they knew. They supplied us with their recruitment policy, which was undated, but we saw this was not followed.</p> <p>We looked at the personnel files for staff. The practice manager and the lead GP confirmed that all information held about staff was in their personnel files and they did not hold additional information, including electronic information.</p> <p>The clinical practitioner used to be a district nurse and approached the practice when they wanted a new job in 2015. The practice nurse worked for another practice in the building and approached them as they wanted a change in 2015. The advanced nurse practitioner had worked in the same practice and also</p>	

wanted a change in 2017. A family relative had not received a placement after completing their degree so the practice employed them and trained them as a healthcare assistant in 2018.

The clinical practitioner had started work in 2015. They had supplied a CV but this only included a job from June 1999 to November 2000 and it stated they were a student nurse before this. A reference had been provided from a work colleague dated 7 April 2015 but no previous employer had been approached. Evidence of a Diploma in Professional Studies in Nursing was held but no other professional registration checks had taken place.

The practice nurse started work in 2015. There was no work history and no references had been requested. Their previous employer had not been approached to confirm their employment or conduct. No photographic evidence of identity was held. A check of their professional registration was kept showing the expiry date as 31 December 2017. No further check had been completed.

The advanced nurse practitioner had also come from another practice. They had provided a work history but no reasons for leaving previous employment were noted. Previous employers were not approached and the recruitment checklist for references was noted that the practice clinical practitioner knew her and she was a previous work colleague of the practice nurse. There had been no check of the advanced nurse practitioner's professional registration.

While we were looking at the personnel files the practice manager brought us the CV for the healthcare assistant. They told us they had just given it to them on the day of the inspection. They had started work in June 2018. A DBS check had been obtained in January 2019. The CV indicated that the healthcare assistant had previously worked in healthcare establishments. No previous employer had been contacted for a reference or to confirm past employment details. A confidentiality statement had been signed 8 June 2018. Photographic evidence of identity was kept.

The practice employed a chiropractor. There was no work history provided and no references. A DBS check had been completed 7 May 2015 but it was not recorded if this was an enhanced DBS check or not. Photographic evidence of identity was held.

One of the reception team had a personnel file that contained very little information. They started work 1 January 2017. There was no photographic evidence of identity and no work history or references. A DBS check had been carried out. The practice manager told us they were a relative of the lead GP.

There were two salaried GPs. Photographic evidence of identity was held for both but neither had a work history, a check of their professional registration or references documented. A DBS check was in place for one of the salaried GP.

The practice had no records relating to immunisation of staff.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 17 July 2019	Yes
There was a record of equipment calibration. Date of last calibration: 12 February 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: October 2018	Yes
There was a log of fire drills. Date of last drill: 5 December 2018	Yes
There was a record of fire alarm checks.	Yes
There was a record of fire training for staff. Date of last training: various dates	Partial
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 28 November 2018	Yes
Actions from fire risk assessment were identified and completed.	No
<p>A fire risk assessment had been carried out for the building in November 2018. This was not specific to the practice and it had been arranged by the building management company. Some issues had been identified, for example there was no evidence of practical training for staff in the safe use of fire extinguishers and flammable items were lying loose in the ground floor cleaner's cupboard. The practice manager told us the building management company were dealing with the actions and as far as she was aware they had been completed. However, no evidence of this was held.</p>	
<p>We saw that all administrative staff except the practice manager had completed on-line fire safety training. There was no record of any clinician other than the clinical practitioner completing fire safety training.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	No
Health and safety risk assessments had been carried out and appropriate actions taken.	No
<p>The practice was located in a LIFT building that was managed by NHS property services. The practice manager told us the building management company was responsible for all premises and health and safety checks and the company held the evidence of these. Information from NHS property services had not been sought.</p> <p>The practice manager confirmed they did not carry out their own security or health and safety risk assessments. For example, they did not keep assurance that legionella checks were being carried out regularly or that their privacy curtains were periodically changed.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	No
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 7 July 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	NA
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>The practice did not request or record the Hepatitis B, MMR or chicken pox status of clinical or non-clinical staff.</p> <p>The lead staff member for infection prevention and control told us there had been no sharps injuries in the previous two years. However, we saw an incident form in the personnel file of a nurse stating they had a needlestick injury in November 2018. This had not been recorded as a significant event.</p> <p>We looked in four clinical consultation rooms. The window blinds in two of the rooms were visibly dirty. Two rooms also contained items with a build-up of dust on them. The trolley containing emergency equipment and medicines in one room was dusty and dirty. This contained an aero chamber and mask for children with asthma.</p> <p>There was no cold chain information for any of the medicine fridges. One of the medicine fridges was dirty. The infection control lead told us there was no cold chain policy and they would put one in place.</p> <p>Only one room contained clinical wipes. A GP told us they did not use wipes as there were none supplied in their room.</p>	

The infection control lead had completed an infection control audit 7 July 2019. This had a score of 100% compliance. The audit had not identified the issues we found. At the end of the inspection we asked the lead GP for a copy of the infection control audit. They told us they were in the process of completing one but one had not been completed recently. They said the only related audit was for handwashing. We saw the handwashing audit. It was recorded that the lead GP had been checked 3 June 2019 and other clinicians 17 July 2019.

The infection control lead told us they thought their role was only to carry out infection control audits. They were not aware of other aspects of the role.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	No
There was a process in the practice for urgent clinical review of such patients.	No
All staff had completed basic life support training in February 2019. Clinicians had been trained in how to identify patients with severe infections including sepsis. Reception staff had not received guidance in how to deal with medical emergencies; the practice manager told us they used their common sense.	

## Information to deliver safe care and treatment

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

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

Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

### Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.94	1.14	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	8.2%	8.3%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	5.02	5.03	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	3.16	3.31	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	No
<p>The advanced nurse practitioner and clinical practitioner were able to prescribe medicines. They told us they received clinical supervision from the lead GP but the lead GP told us they did not keep records of this.</p> <p>We looked at medicines stored in fridges. We saw that medicines and vaccinations were touching the back of the fridge. This had not been identified during medicine checks.</p>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	15
Number of events that required action:	15
<p>The practice did not keep a central record of significant events. To identify the number of significant events in the previous 12 months they had to search records for each month separately.</p> <p>There was a significant event form for each month and all significant events were recorded on the same form. We saw that the information on the forms was discussed in the following practice meeting and minutes were held for these. Details of the discussion were not included in the significant event form, just in the monthly meeting minutes. The action required was sometimes recorded on the form but this was not consistent.</p> <p>We saw three examples of the action required being a letter to be sent to the patient. We checked the records and, in all cases, there was no record of a letter being sent.</p> <p>Significant events did not have a review date. The practice manager told us they did not review them as when they had been actioned it was unusual for them to re-occur.</p> <p>The practice manager told us of an incident in the waiting room a few weeks earlier where a patient from their practice became unwell. An ambulance was called and they were advised not to move the patient so they put a screen around them. The practice manager told us they had not completed a significant event form for this incident.</p> <p>The clinical practitioner gave us examples of incidents. They told us they had been called out to see a distressed patient in a care home. A clinical intervention was needed and the patient had to be hospitalised. They reflected on this with the inspection team and identified that it had been a significant event which should have been shared with the wider team, as learning and safety issues for other staff members could have been identified. They told us they discussed incidents with the lead GP but they were not formally recorded as significant events.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
10 May 2019, patient became aggressive in the waiting room when he arrived for an appointment and found none had been booked. He later said he knew he had cancelled the appointment.	Discussed 15 May 2019 and minutes seen. It was noted that in the future the patient should not be given his own way and a letter needed to be sent to him as he had done things like this before. There was no record of a letter being issued. There was no review date. No learning outcomes had been identified.
7 May 2019, patient became abusive saying staff had put the telephone down on him. The line had been crackly.	Discussed 15 May 2019 and minutes seen. A warning letter had been issued previously and it was noted that a second letter should be sent. There was no record of a letter being issued. There was no review date. No learning outcomes had been identified.
7 January 2019, an agitated patient shouted abuse in the waiting room.	Discussed 16 January 2019 and minutes seen. A letter would be sent to the patient saying he had to see a male GP in future or use another practice. We saw an alert was put on the patient's records to this effect. There was no record of a letter being issued. There was no review date. No learning outcomes had been identified.

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

## Effective

## Rating: Inadequate

The practice is rated inadequate in the effective domain. One person had responsibility for disseminating new NICE guidance in meetings. There was no record of any discussion in the minutes we reviewed, going back to November 2018. There were several areas in QOF scores where the practice was below the CCG and national average. Audits were mainly for medicines and prescribing. There was no programme of improvement for other areas of the practice. Staff training was not well-monitored and there was no evidence held of some essential training for staff. There was no evidence of any training for the healthcare assistant or phlebotomist. Clinical support and appraisal for clinical staff was all informal with no records being kept.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was usually delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice manager told us the clinical practitioner received new guidance from the National Institute for Health and Care Excellence (NICE). If they felt other staff needed to know the information they discussed it at the monthly practice meetings. The lead GP also told us the clinical practitioner was responsible for new NICE guidelines. We checked the practice meeting minutes back to November 2018 and NICE guidance was not recorded as being discussed at any of them.	
The lead GP told us that in 2017-18 cancer reviews were not carried out. They told us reviews were all completed in 2018-19.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	2.11	1.18	0.77	Variation (negative)
The lead GP told us this high figure was due to prescribing by previous GPs, and they have a high number of patients in a care home. They told us there was a plan to review all newly registered patients on these medicines.				

## Older people

## Population group rating: Inadequate

Findings
<p>Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups.</p> <ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li> <li>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>The practice carried out structured annual medication reviews for older patients.</li> <li>We were told staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. However, evidence of this was not kept.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>

## People with long-term conditions

## Population group rating: Inadequate

Findings
<p>Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to below average data and a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups. The lead GP justified poor achievement of clinical outcomes measured by QOF as due to patients being of South East Asian origin and the high number of care home patients. No further explanation or measures to address this were provided.</p> <ul style="list-style-type: none"> <li>There was a significant negative variation for the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018). The lead GP told us there was a CCG initiative looking at this. We saw the practice's figure for 2018-19 had increased to 60%, but this figure was unverified.</li> <li>There was a tending towards negative variation for the percentage of patients with diabetes, on</li> </ul>

the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2017 to 31/03/2018). The lead GP told us their plan to improve included reaching more patients by using a personal care record as part of a project, and by using text message reminders. We saw the practice's figure for 2018-19 had increased to 65%, but this figure was unverified.

- There was a negative variation for the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2017 to 31/03/2018) The lead GP told us their plan to improve included the healthcare assistant carrying out basic checks and then a GP reviewing the patient. There was no evidence that the healthcare assistant was qualified to carry out these checks. We saw the figure for 2018-19 had increased to 67%, but this figure was unverified.
- There was a negative variation for the percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018). We saw the figure for 2018-19 had increased to 67%, but this figure was unverified.
- There was a significant negative variation for the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018). The lead GP told the practice had carried out staff training and the figure for 2018-19 had increased to 89%, but this figure was unverified.
- There was a significant negative variation for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less (01/04/2017 to 31/03/2018). The lead GP told us they had adopted a focussed approach and as a result the figure for 2018-19 had increased to 80%, but this figure was unverified.
- Although the practice told us they had a high number of patients in care homes, they had a below average number of patients between the ages of 65 and 85, and their patient over the age of 85 was in line with the CCG and national average.
- The practice told us the healthcare assistant carried out reviews of patients with rheumatoid arthritis. There was no evidence that they were qualified to carry out these reviews.
- There was no evidence that staff who were responsible for reviews of patients with long-term conditions had received specific training.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	54.8%	75.3%	78.8%	Significant Variation (negative)
Exception rate (number of exceptions).	4.5% (15)	7.1%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	62.6%	74.8%	77.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.5% (15)	5.9%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	63.0%	79.6%	80.1%	Variation (negative)
Exception rate (number of exceptions).	5.1% (17)	9.2%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	62.1%	76.6%	76.0%	Variation (negative)
Exception rate (number of exceptions).	0.5% (1)	3.7%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	38.3%	88.3%	89.7%	Significant Variation (negative)
Exception rate (number of exceptions).	1.2% (1)	6.9%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	67.4%	81.9%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	6.2% (23)	3.3%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.7%	92.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	4.1%	6.7%	N/A

**Findings**

Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups.

- The lead GP told us the practice was below the minimum levels for most childhood vaccinations for 2017-18 as they have a high number of patients from abroad who were not keen on vaccinations. They told us they sent reminders to patients and telephoned them but on occasions they still did not attend. The practice was unable to provide up to date figures for 2018-19.
- Not all staff had been trained in safeguarding children.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	86	95	90.5%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	68	94	72.3%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	69	94	73.4%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	76	94	80.9%	Below 90% minimum (variation negative)

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

## Working age people (including those recently retired and students)

Population group rating: Inadequate

### Findings

Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups.

- There was a negative variation for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018). The lead GP told us this was due to their low socio-economic population, and some patients from abroad would not attend. They said they carried out opportunistic screening and a Romanian interpreter was available at the practice each morning which could help. They told us their figure for 2018-19 had increased but this was not verified.
- Breast and bowel screening was below the CCG and national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Although patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74, there was no evidence that the healthcare assistant, who carried out some of these checks, had been trained.
- Patients could book appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	57.8%	71.5%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	53.2%	66.6%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	36.9%	52.5%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	50.0%	71.8%	70.2%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) <sup>(PHE)</sup>	40.0%	51.5%	51.9%	No statistical variation
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### People whose circumstances make them vulnerable

Population group rating: Inadequate

#### Findings

Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups.

- Not all staff had been trained in safeguarding vulnerable adults.
- The healthcare assistant carried out learning disability health checks. There was no evidence they had been trained for this role, and they also had no evidence of having completed training in safeguarding children or vulnerable adults.
- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

### People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

#### Findings

Although we saw some good practice in this area of the domain, the domain was rated as inadequate overall due to a breach of regulation regarding staffing that had not improved since the previous inspection. There was no evidence of staff keeping up to date with current guidelines. This impacted on all population groups.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

- Most of the non-clinical team had completed on-line dementia awareness training, but some of this had been completed over five years ago. We saw evidence of only two members of the clinical team completing dementia awareness training.
- The lead GP told us they were the dementia champion.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.5%	86.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	5.2% (4)	9.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	81.6%	88.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.3% (1)	6.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	77.3%	81.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (2)	4.8%	6.6%	N/A

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	452.0	531.6	537.5
Overall QOF score (as a percentage of maximum)	80.9%	95.1%	96.2%
Overall QOF exception reporting (all domains)	3.6%	4.8%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

We saw that audits carried out by the practice were usually medicine audits. We saw evidence of a Valproate audit in May 2018 that was repeated On 15 July 2019. We also saw some audits that had not yet been repeated, including one for hydrochlorothiazide (diuretic medication often used to treat high blood pressure and swelling due to fluid build-up).

We saw that some of the practice's QOF scores had improved in the previous 12 months. We did not see evidence of a formal plan to manage these improvements.

The lead GP provided evidence that they looked at improving the clinical quality of the practice, mainly around medicine management. However, the practice did not have an effective programme of improvement activity for other areas and had not identified that improvements required in non-clinical areas of the practice.

#### Any additional evidence or comments

The practice told us that for the year 2018-19 their QOF score had increased to 518 out of a maximum score of 559. This was 93%. This score was unverified.

#### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	No
The learning and development needs of staff were assessed.	No
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	No
Induction included completion of the Care Certificate for Healthcare Assistants employed since April 2015.	No
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	No
The lead GP told us they provided clinical supervision and held appraisals for the clinical practitioner,	

advanced nurse practitioner, practice nurse, healthcare assistant and phlebotomist. There was no record of this in their personnel files. The lead GP confirmed this was all informal and they did not keep any records, either paper based or electronic. They told us they did not record their continuing professional development (CPD) or training but they were aware of what training was required.

The lead GP told us the healthcare assistant, who had started work in June 2018, had not completed the Care Certificate for Healthcare Assistants. The healthcare assistant confirmed this. We saw the healthcare assistant was not included in the on-line training system and the only training recorded for them was basic life support in February 2019. The healthcare assistant told us they collected blood samples from patients and carried out new patient health checks, rheumatoid arthritis checks, diabetic reviews and learning disability health checks. There was no evidence they had been trained to carry out any of these procedures or checks.

The phlebotomist, who had worked at the practice since 2014, was not included on the on-line training system. The practice manager told us they had not activated it as they only worked one day a week. However, they told us they also worked on three other days as a notes summariser. Their personnel file was noted that they had completed hand wash and infection control training in July 2019 but there was no evidence of any completed training. There was no evidence of any training in phlebotomy and there was no evidence of any supervision or appraisal.

The practice employed a chiropractor and patients with relevant issues could be booked directly with the chiropractor instead of another clinician. Their personnel file was noted that they had completed venepuncture for receptionist training in June 2015 but no other training was recorded. They were not included on the on-line training system.

The practice manager told us they did not have an induction for new staff but there was an on-line training course on induction. They thought this included office procedures and confidentiality. We saw that some staff had completed the on-line training but this was not consistent.

We saw that most of the reception and administrative staff had had an appraisal in the previous 12 months. There was no evidence of an appraisal for the practice manager or any member of the clinical team, including the nurses, healthcare assistant and phlebotomist. The lead GP told us they carried out informal appraisals but did not document them.

The practice manager told us they did not have a training policy. They decided what training they thought was appropriate and they tasked staff with completing three to four on-line courses at each appraisal. We saw that the progress of training was not monitored until the next appraisal. We saw that one member of the reception and administrative team last had an appraisal 2 May 2018. This was noted that they had not given themselves enough time for training and they had not completed any on-line training for the last couple of years.

The practice manager told us the clinical practitioner had not been able to keep up to date with their mandatory training as they had been completing a master's degree. They said they had caught up in the previous two weeks. We looked at their training records. In the week prior to our inspection they had completed 39 on-line training courses, and 34 had been over two days. One of the reception and

administrative staff had also completed 17 training courses in the week prior to our inspection.

We informed the lead GP verbally that the healthcare assistant and phlebotomist must not work again until they had assurance that they were trained and competent to carry out their roles and had completed safeguarding training. We followed this instruction up by email and the lead GP responded to say they would not carry out any patient care function in the practice until they had the necessary assurance in place.

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	No
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Although patients had access to health checks there was no evidence that the healthcare assistant, who carried out some of the checks, had been trained to do so.	

The practice was in the process of setting up a carers' register. At the time of the inspection nine had been identified (0.16% of the patient population). Staff discussed changes to care and treatment with patients but could not demonstrate discussion with carers if this was appropriate.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	90.0%	95.5%	95.1%	Variation (negative)
Exception rate (number of exceptions).	0.6% (5)	0.4%	0.8%	N/A

#### Any additional evidence or comments

The lead GP told us they had managed this better during the year 2018-19 and the unverified figure for the year was 93%.

#### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

## Caring

## Rating: Requires improvement

The practice is rated requires improvement in the caring domain. There was no information about support groups on the practice website or in the waiting area. The practice did not have a carers' register. They had started to identify carers and had identified nine which was 0.16% of the practice population. The practice was unaware of local support for carers.

### Kindness, respect and compassion

**Staff usually treated patients with kindness, respect and compassion.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
The practice had a drop-in coffee morning in the building once a week. This was open to all, and not just their patients. The patient participation group usually attended and it was used to give some health information to patients and also help those suffering from loneliness.	

CQC comments cards	
Total comments cards received.	4
Number of CQC comments received which were positive about the service.	1
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0
NB the CQC comments box had been opened.	

Source	Feedback
CQC comments cards	One comment card said the patient felt listened to and staff were polite and understanding. Other cards said the service was good overall.
NHS Choices website	The most recent comment stated staff, including doctors, were rude, and not helpful.

## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5126	418	68	16.3%	1.33%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	80.3%	87.0%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	77.1%	84.8%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	91.4%	93.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	74.0%	81.8%	83.8%	No statistical variation

Question	Y/N
The practice carries out its own patient survey.	No

### Any additional evidence

The practice manager told us the patient participation group (PPG) carried out surveys “every now and again”. The PPG kept the results and took responsibility for the surveys and the practice manager told us they were not involved in them and did not monitor the results. The practice manager said a survey had been completed in 2017 and the PPG may have completed a more recent one but they were unsure as they did not get involved.

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Partial
The practice had interpreters available on-site so a lot of their patient population could access interpreters in a timely manner. Some GPs could also speak languages spoken by the patient population.	
The practice could not demonstrate that it provided carers with relevant information as they had only just started to compile a carers' register and had identified nine carers (0.16% of the practice population) to date.	

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	90.9%	91.2%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	No
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	No
There was no information about support groups on the website. Information about support groups was not available in the waiting area. The practice manager told us information leaflets would be sourced in other formats if required.	

Carers	Narrative
Percentage and number of carers identified.	The practice did not have a carers' register. The practice manager told us they had come across nine carers (0.16% of the practice population) but they were working on finding more. However, the practice manager was under the impression that care workers in care homes could be on the carers' register.
How the practice supported carers (including young carers).	The practice did not offer a service to carers as they were still working on a register. The practice manager had not heard of Oldham Carers' Centre.
How the practice supported recently bereaved patients.	Sympathy cards were sent to recently bereaved patients. GPs told patients about the coffee morning they held every Monday if they thought they may be lonely.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Inadequate

The practice is rated as inadequate in the responsive domain. The practice had designed a training programme so the clinical practitioner could verify a death to make the process quicker. However, evidence of their training was not kept. Some staff had completed training in dementia awareness but for some this was over five years ago. The system for prioritising requests for urgent appointments and home visits was unsafe. No action was taken in relation to survey results relating to telephone access. The practice told us they had had no complaints in the previous 12 months. The complaint we examined from June 2018 had not been responded to appropriately.

### Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 7pm
Tuesday	8am – 8pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 7pm
Saturday	Variable, for the chiropractor only
GP appointments available:	
Monday	8.30am – 12 noon and 1.30pm – 5pm
Tuesday	9am – 12.30pm and 1pm – 5pm
Wednesday	Morning – covered by a locum GP and 12.30pm – 3.30pm
Thursday	8.30am – 12.30pm and 1pm – 6.30pm
Friday	9am – 12.30pm and 1pm – 6.30pm
	NB extended hours appointments were available at a nearby practice in the evenings and during weekends.

Advanced nurse practitioner appointments available:	
Monday	9am – 12 noon and 2pm – 7pm
Tuesday	None
Wednesday	8am – 1pm and 2pm – 6pm
Thursday	8am – 1pm and 2pm – 6pm
Friday	8am – 1pm and 2pm – 6.30pm
Practice nurse appointments available:	
Monday	None
Tuesday	8.15am – 12 noon and 12.30pm – 4pm
Wednesday	8.15am – 12 noon and 12.30pm – 4pm
Thursday	None
Friday	None
Chiropractor appointments available:	
Monday	None
Tuesday	4pm – 7pm
Wednesday	None
Thursday	None
Friday	4pm – 6pm
Saturday	Variable

#### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5126	418	68	16.3%	1.33%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	92.4%	93.1%	94.8%	No statistical variation

#### Any additional evidence or comments

The lead GP and practice manager told us the practice was open on Saturdays for chiropractor appointments. When we asked for clarification of the times they said this was not consistent; they hoped to have appointments from 9am until 1pm in the future.

## Older people

## Population group rating: Inadequate

### Findings

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- The clinical practitioner had taken ownership of managing the end of life pathway for patients in care homes. They had designed a training programme for them to be able to verify a death. The lead GP told us they had trained the clinical practitioner to be able to carry out this role. We saw no evidence of this training. Following the inspection, the practice sent us a completed competency assessment tool documenting that the lead GP had assessed the competency of the clinical practitioner on 22 January 2019 and 24 June 2019. They told us that evidence of the training was held at the University.
- The clinical practitioner was responsible for elderly patients in care homes. All clinical supervision and support was informal and no records of supervision or appraisal were kept.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- Patients with multiple conditions could have their needs reviewed in one appointment. The practice manager told us the reception staff asked the practice nurse if they wanted to do this before booking patients in for appointments.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

## **Families, children and young people**

**Population group rating: Inadequate**

### **Findings**

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.

## **Working age people (including those recently retired and students)**

**Population group rating: Requires improvement**

### **Findings**

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on Tuesdays and until 7pm on Mondays and Fridays. Pre-bookable appointments were also available to all patients at additional locations within the area until 8pm during the week and also at the weekends.

## **People whose circumstances make them vulnerable**

**Population group rating: Inadequate**

### **Findings**

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- Not all staff were trained in safeguarding vulnerable adults.
- The practice held a register of patients living in vulnerable circumstances those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided longer appointments for patients with a learning disability.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Inadequate**

**Findings**

Although we saw good practice in this area of the domain, the domain was rated as inadequate overall due to some training not being evident, the unsafe system for prioritising requests for urgent appointments and home visits, a lack of action taken following poor survey results and the handling of complaints. This impacted on all population groups.

- Most non-clinical staff had completed training in dementia awareness but some of this was over five years ago. Two members of clinical staff had completed the training.
- Formal training had not been provided to staff about supporting patients with mental health needs.

**Timely access to the service**

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Partial
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Partial
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
<p>The practice manager told us that reception staff used their common sense when responding to requests for urgent appointments. They said there was no guidance for this and they felt the system was good as staff knew the patients. The practice manager told us that if they felt an urgent appointment was needed they would find the patient an appointment. Otherwise they would either be put on a cancellation list or be given the telephone number of the local 7-day GP access scheme.</p> <p>The practice manager told us that when a patient requested a home visit staff asked them the reason for the request. They told us that staff had not received training in how to prioritise a request but there may be occasion when they should call 999. They said staff used their common sense.</p>	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	53.9%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	67.2%	69.0%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	61.9%	67.4%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	64.7%	72.5%	74.4%	No statistical variation

Source	Feedback
CQC comments cards	Three of the four completed CQC comments cards mentioned that it was difficult to get an appointment at the practice.
NHS Choices	There were six comments on the NHS Choices website relating to visits to the practice between August 2017 and December 2018. One gave the practice a five-star rating and five gave the practice a one-star rating. All the one-star ratings mentioned that it was very difficult to get an appointment.

## Listening and learning from concerns and complaints

**Complaints were not used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	0
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	Not known
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

Y/N/Partial

Information about how to complain was readily available.	No
There was evidence that complaints were used to drive continuous improvement.	No
<p>The practice manager told us they had not had any complaints in the previous year. We examined the last complaint that had been received 25 June 2018. This had been acknowledged in writing by the practice manager. This was then noted that the lead GP had spoken to the patient and resolved the issues. There was no formal response and no record of the patient being informed how they could escalate the complaint.</p> <p>We saw no examples of learning from complaints.</p> <p>We asked reception staff for a leaflet explaining the complaints procedure. They gave us the practice booklet but could not find a complaints' leaflet immediately. The inspector had to wait for another member of staff who helped to locate the information on the computer. The practice leaflet told patients they could complain to the Patient Advice and Liaison Service (PALS) but the telephone number provided was incorrect.</p>	

## Well-led

## Rating: Inadequate

The practice is rated as inadequate in the well-led domain. Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care. The lead GP had not identified and was unaware of the issues identified during this inspection. The practice culture did not effectively support high quality sustainable care. The practice did not always act on appropriate and accurate information. We did not see evidence of systems and processes for learning, continuous improvement and innovation going forward.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
The practice manager was retiring in December 2019. They told us that staff had had a meeting and decided they did not want to recruit a new practice manager. The lead GP had been supernumerary since April 2019 and was in the process of looking at the systems in place so they could take over most of the practice manager role.	
Although staff told us that managers were visible and approachable we saw little evidence of support being provided to staff. Clinical staff in particular only had informal support.	
The lead GP had not identified and was unaware of the issues we identified during the inspection.	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No

The practice had a mission statement that was displayed on their website: “Here at the Sun Valley Medical Practice we aim to deliver consistent high-quality healthcare in partnership with our patients”. However, there was no strategy in place to provide high quality sustainable care.

## Culture

### The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	No
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Yes
The practice’s speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Partial
Staff told us the practice manager had an open-door policy and they felt able to contribute their ideas in practice meetings.	
The practice manager told us that no complaints had been made in the previous year. The most recent written complaint, made in June 2018, had not been responded to in writing so it was not clear if an apology was required or given. Some significant events were noted that patients had been written to. However, the practice was unable to supply us with any evidence of this so we could not see the response.	

## Governance arrangements

### The overall governance arrangements were not clear.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Partial
The lead GP told us they had set up a WhatsApp group to involve more patients who did not attend patient participation group (PPG) meetings. They told us thirty to forty patients were in the group. The lead GP was the administrator for the group and told us a lot of people had his mobile telephone number so he did not mind it being available to this group of patients. The practice manager told us the WhatsApp group was just for those going to meetings to send messages regarding meetings. They did not know if there was a protocol in place for this group.	

The clinical practitioner had been completing a master's degree and had been out of the practice for two days a week. They worked in silo, stating they had close contact with the lead GP only. They did not work closely with the other nurses or healthcare assistant. Significant events that they identified were not recorded as such and not discussed with the wider team.

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	No
<p>The practice manager showed us their disaster handling and business continuity plan dated 26 February 2015. This was brief and did not contain information about staff. They told us the lead GP may have another more up to date copy in their personal files but it was the 2015 copy they would use in an emergency. Later in the inspection the practice manager gave us an updated copy of the disaster handling and business continuity plan dated April 2019 and noted as version one. They said they had found it elsewhere on their computer. Not all staff were listed in the document and contact information was only held for GPs. The practice manager told us they did not keep a copy of the plan at home. The staff we asked told us they were not aware of any business continuity plan being in place.</p> <p>The infection control lead showed us the infection control audit they had carried out 7 July 2019. Although this had scored 100% they had not identified dirty areas within clinical rooms including a dirty medicine fridge.</p> <p>Some clinical audits had bene carried out but these were mainly medicine and prescribing audits. Other internal audits had not been carried out and the practice had therefore not identified the issues we found during the inspection.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	No
<p>The lead GP told us they had introduced a staff incentive scheme and gave bonus payments when they thought it appropriate. We saw meeting minutes that stated staff would receive a bonus due to their QOF scores improving for the year 2018-19.</p> <p>Other risks had not been identified and information held was not accurate. For example, a recent infection control audit had not identified issues and the significant event process did highlight where learning was required.</p>	

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

### The practice did not fully involve the public and staff to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	No
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Partial
<p>The practice had a PPG and approximately eight patients attended the monthly meetings. The practice manager told us the meetings were run by the PPG. We asked for the PPG meeting minutes and were told that the secretary stopped attending several months earlier so minutes had not been kept. The practice manager told us the PPG talked about the Monday coffee mornings* held and they had also talked about arranging a trip for members.</p> <p>The practice manager told us the PPG carried out surveys “every now and again” and they let patients who attended the coffee mornings fill in survey forms*. The PPG kept the results and took responsibility for the surveys and the practice manager told us they were not involved in them and did not monitor the results. The practice manager said a survey had been completed in 2017 and they may have done a more recent one but they were unsure as they did not get involved.</p> <p>Staff told us they were able to submit ideas during meetings but we saw no evidence of their involvement in planning the service.</p> <p>*NB the coffee morning was open to all, and not just for the practice’s patients.</p>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
<p>The lead GP told us of changes made to the practice to help improve their service. This included having additional nursing staff such as the clinical practitioner and having a chiropractor employed by the practice. However, the correct pre-employment checks had not been carried out for the new staff recruited and evidence of their having training for their roles was poor.</p> <p>Although we saw evidence that significant events were discussed in meetings learning did not form part of the discussion. We did not see evidence of learning from significant events being identified or shared.</p>	

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

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

### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England

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