

Care Quality Commission

Inspection Evidence Table

Dr Bhupinder Batra (1-496034730)

Inspection date: 03 July 2019

Date of data download: 16 August 2019

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

Safe

Rating: Unrated

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse safeguarded from abuse. However, safety was not a sufficient priority. The practice could not provide evidence of safeguarding training for all staff.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: At this inspection we reviewed staff files and found three members of staff were not trained to appropriate levels of safeguarding for their roles. One receptionist had completed safeguarding children level 1 but did not have any adult safeguarding training. There was no record of safeguarding adults and children training for a second member of the reception staff. At this inspection we spoke with the practice nurse. The nurse was not able to tell us what level safeguarding children training they had done. There	

Safeguarding	Y/N/Partial
was no evidence the nurse had completed Level 2 safeguarding children training required to fulfil their role. We spoke with the practice lead and asked for assurance that children safeguarding training would be done immediately. Following the inspection, the practice sent us evidence of completed Level 2 safeguarding training for the nurse. We saw evidence the nurse had completed adult safeguarding training.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence:	
<p>At our last inspection the practice did not have evidence of medical indemnity insurance for one of their nursing staff on file. The practice sent us evidence following that inspection to demonstrate that they contacted the relevant insurance company to arrange for this to be put in place.</p> <p>At this inspection we reviewed the indemnity for all clinical staff working at the service. The practice nurse who did not have a record of medical indemnity insurance on file at our last inspection now had evidence of registration with a professional body which provided indemnity cover.</p>	

Safety systems and records	Y/N/Partial
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a record of fire training for staff. Date of last training:	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection, there was no risk assessment in place for the storage of hazardous substances. The practice sent us an updated risks assessment following that inspection to include the safety instructions for hazardous products held on the premises.</p> <p>At the last inspection, the practice could not provide evidence that all staff had received fire safety training. At this inspection we reviewed the files of four staff members who had been employed since the last inspection and saw all staff had completed essential training in Fire Safety.</p>	

Infection prevention and control

The governance and audit process had improved to assure appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y ¹
Staff had received effective training on infection prevention and control.	Y ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 10 May 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	P ³
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	P ⁴
Explanation of any answers and additional evidence:	
<p>1 – At our last inspection the nurse could not find an infection prevention control (IPC) policy. No risk assessment had been undertaken. There was no evidence of IPC audits having been carried out. No hand hygiene audits had been undertaken. At this inspection there was an infection prevention control (IPC) policy in place. An IPC audit had been carried out by an external assessor in May 2019.</p> <p>2 – At our last inspection the lead for IPC had not received additional training which demonstrated competencies to fulfil the role. An update had been undertaken in 2016 which covered personal responsibilities for maintaining IPC within the role of a practice nurse. At this inspection we spoke with the practice nurse who was the IPC lead. We saw evidence that they had received some basic IPC training and was booked to attend an IPC lead training event on 22 July 2019.</p> <p>3 – Responsibility for infection control at the practice was allocated to a member of the nursing team. The practice used a checklist template to log any actions identified in the latest infection control audit. However, there was no prioritising of actions identified and no timeframe in place to ensure recommendations would be actioned and monitored.</p> <p>4 – Clinical waste: At our last inspection, there was no oversight to ensure health care waste was managed in line with guidelines. For example, sharps bins were available but there were no purple top bin for the disposal of specifically contaminated sharps. Staff we spoke with were unaware that clinical waste bags were required to be labelled in line with the Department of Health Technical Memorandum. At this inspection the practice had purple sharps bins in all clinic rooms. At this inspection we asked if waste bags were labelled. Staff told us waste bags were collected by the building management company cleaners and we were not able to check whether waste bags which were labelled in line with guidelines. Waste bags were stored in a locked storage area which was only accessible to cleaners employed by the building managers. The practice manager showed us email correspondence with the building managers requesting bin bags to be labelled in line with the Department of Health Technical Memorandum.</p>	

Risks to patients

The practice had started to take action to improve consistency in the way they managed systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
Comprehensive risk assessments were carried out for patients.	P
Risk management plans for patients were developed in line with national guidance.	P
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection, the practice did not have a paediatric pulse oximeter. At this inspection we saw the practice had obtained a paediatric pulse oximeter which was stored in the emergency trolley.</p> <p>At our last inspection there were inadequate arrangements to deal with a medical emergency. At this inspection the practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. At this inspection we saw evidence of sepsis training received by staff in May 2019.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
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.	P ¹
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y ²
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y ³
<p>Explanation of any answers and additional evidence:</p> <p>Emergency medicines and equipment: At our last inspection there were inadequate arrangements to deal with a medical emergency. The provider could not ensure that staff could care for patients in an</p>	

emergency. For example;

- The practice did not stock several of the recommended emergency medicines, for example those used for suspected meningitis. There was no risk assessment in place.
- A small cylinder of oxygen was held on site. There was not a risk assessment in place to assess if this should be sufficient during an emergency situation.
- The practice did not stock an Ambu bag (a manual resuscitator or "self-inflating bag", used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) should a patient require assistance in breathing.

1 – At this inspection we found recommended emergency medicines were stocked but PR chlorphenamine tablets had expired in June 2019. We checked the log of emergency medicines and saw the date of expiry was noted down but the medicine had not been removed. There was an alternative injectable medicine stocked.

2 – The practice sent us information following the inspection to demonstrate they now had the recommended emergency medicines, another oxygen cylinder and an Ambu bag in stock. At this inspection we saw the practice now had two oxygen cylinders although one of these was found to be under half full. We raised this with the practice manager during our inspection. At the last inspection the provider had not risk assessed access to the defibrillator which was shared with another practice in the building. At this inspection the practice had an agreement in place for sharing the defibrillator including arrangements for checking the working status. The practice had risk assessed accessing the defibrillator which could be accessed by staff in 60 seconds.

At our last inspection, the provider did not have a system to assure themselves that the contents of the doctor's bag held on the premises were appropriate and safe. At this inspection the practice had removed the bag of equipment and medicines stored by the locum GP from the premises.

Cold chain Maintenance: At our last inspection the systems for medicines that required refrigeration were not in line with current guidelines. For example;

- The practice had four fridges. We were told that only the fridge in the treatment room was used to store vaccines. However, we saw that one other fridge contained vaccines to be returned to the manufacturer. The temperature of this fridge was not monitored.
- For the main storage vaccine fridge there was no second thermometer as recommended by national guidance. Additionally, it was unclear if the thermometer was being reset appropriately. The practice told us after the inspection that they had ordered a second thermometer for the main fridge and implemented a cold chain policy.
- The nurse did not know the correct steps that should be taken if temperatures were outside of the recommended range and stated that the vaccines would be disposed of and did not state that the vaccines would be isolated and that the manufactures would be contacted for advice.

3 – At this inspection the cold chain was being managed in line with national cold chain guidance. We saw only one fridge was used to store vaccines. The practice had obtained a second thermometer for the main vaccine fridge in line with national guidance. There was a cold chain policy which included

Medicines management	Y/N/Partial
<p>guidance on storage of vaccines and a procedure for staff to follow in the event of a breach of the cold chain. At this inspection we spoke with the nurse who knew what to do if temperatures were outside of the recommended range. The nurse knew to contact the local Medicines Management and Pharmacy team for advice.</p> <p>Prescriptions storage: At our last inspection blank prescription forms were stored securely, however there was no records to account for the prescription stock held or those that were in use in line with national guidance. At this inspection we saw the practice kept a log of blank prescriptions which were kept locked in the stockroom. The practice had a protocol with instructions for staff to write down the serial numbers of blank prescriptions given to doctors. The practice had a prescription security policy in place.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y ¹
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection, the practice had some safety alerts in a shared folder on their computer system, however, they did not have the latest alerts such as the one relating to Sodium Valproate in women of childbearing age. They told us they circulated safety alerts to all clinicians, however, the regular locum GP we spoke with told us they did not receive these. The nurse was also not informed of safety alerts including those related to vaccines.</p> <p>1 – At this inspection there was an effective system to ensure all safety alerts were received and acted on. The practice had updated the safety alert policy. We saw examples of actions taken on recent alerts for example, regarding sodium valproate and fluoroquinolone antibiotics.</p>	

Effective

Rating: Unrated

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles. This was a concern identified at our last inspection.

	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.	Y
The learning and development needs of staff were assessed.	P
The practice had a programme of learning and development.	N
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.	
Explanation of any answers and additional evidence: The provider had not ensured that staff had received essential training appropriate to their roles. Previously we found staff had not received training in Health and Safety, Fire Safety, Infection Prevention and Control and Equality and Diversity. At this inspection we found there were still gaps in staff training. For example, of the four staff files we reviewed, three members of staff did not have training in safeguarding (adult and children) and information governance, three in basic life support and three did not have training in infection prevention and control (IPC). We identified new issues when we reviewed staff files: Not all staff had received annual refresher training in Basic life support or information governance training. Training records for one receptionist showed information governance training last completed in 2009 and no record of safeguarding training. There was no record of infection control for two members of reception staff. The practice nurse had not undertaken update training which covered responsibilities within the role of a practice nurse. For example, we looked at staff training records and found there was no record of safeguarding children for the practice nurse. The last update training in basic life support (BLS) was in 2017. There was no evidence of Mental Capacity Act training for the practice nurse. We spoke to the practice nurse who was not able to provide evidence of mandatory training completed.	

Consent to care and treatment

The practice was able to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y ¹
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection the practice was unable to show that it always obtained consent to care and treatment. Two members of the clinical team did not demonstrate through our discussion that they understood the principles of the Mental Capacity Act 2007, Gillick competency and Fraser guidelines. We reviewed the record for one patient who had a coil fitted and found that the patient's consent had not been documented.</p> <p>1 – At this inspection we asked staff to show us an example where consent had been obtained and recorded. The nurse showed us the patient record system and we saw a record of consent for a cervical smear and a record of consent for immunisation of a patient given by an adult with parental responsibility.</p>	

Well-led

Rating: Unrated

Leadership capacity and capability

Leaders could not always 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.	P
They had identified the actions necessary to address these challenges.	P ¹
Staff reported that leaders were visible and approachable.	Y
Explanation of any answers and additional evidence: At this inspection there were some positive developments, but we found that the provider did not have a comprehensive plan to address the lack of systems and processes in place locally to ensure the service operated safely and as intended, for example in relation to staff training.	

Governance arrangements

While the practice had made some improvements since our last inspection, we found the overall governance arrangements did not consistently ensure patient safety.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P
Staff were clear about their roles and responsibilities.	P
There were appropriate governance arrangements with third parties.	P
Explanation of any answers and additional evidence: At our last inspection, the overarching governance framework had not ensured that systems and processes were operating effectively. For example, <ul style="list-style-type: none">• Inadequate arrangements to deal with a medical emergency.• Clinical staff did not all have the appropriate professional indemnity medicines that required refrigeration were not stored in line with current guidelines and safety alerts were not always received and acted on.• There was no oversight of the practice's performance in relation to the Quality Outcomes Framework particularly around exception reporting.• Policies were not reviewed to indicate essential training required for staff to perform their role.• Consent to care and treatment was not sought in line with legislation and guidance and clearly recorded. At this inspection, the provider could not demonstrate that they had implemented actions to address all of the issues we told them they should take at the previous inspection on 20 February 2019. The provider had not ensured that processes were happening in line with their policies or legal	

requirements. For example, there was a staff training and development policy which required staff to attend mandatory training to ensure they remain competent in their role. There was still no record that staff have completed all those training details in the policy. This was a concern identified at our previous inspection.

At this inspection the provider had implemented a consent to treatment policy. Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented

At our last inspection there was no oversight of the practice's performance in relation to the Quality Outcomes Framework particularly around exception reporting. At this inspection it was still not clear how the provider used data to monitor and improve performance. Exception reporting figures in relation to the Quality Outcomes Framework (QOF) we saw were very low.

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.	P
There were processes to manage performance.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
Explanation of any answers and additional evidence:	
<p>At our last inspection there was inadequate access to, and challenge of performance by leaders and staff. There were significant failings in systems and processes for the management or sharing of data. For example;</p> <p>At our last inspection, we found there were no consistent 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. Some medical notes were clearly flagged; however, we also saw notes where concerns were not being flagged up as an alert. The lead GP and Deputy Practice Manager struggled to explain the process of following up on patients who did not attend appointments or had high A&E attendances and we were not shown examples to demonstrate this in action.</p> <p>At this inspection we spoke with the lead GP who showed us evidence of follow up of patients with high A & E attendances. We saw a record of searches for 'frequent flyers' performed by the deputy practice manager. The GP lead explained they would review patients identified from the search and arrange to call them and make a follow up appointment.</p> <p>Information on the practice's performance in relation to QOF was not completely understood by the practice. Published figures showed higher than average exception for depression; however, the practice was not aware of this.</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.	P
Our inspection indicated that information was accurate, valid, reliable and timely.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
Explanation of any answers and additional evidence:	
<p>At our last inspection, there was inadequate access to, and challenge of performance by leaders and staff. There were significant failings in systems and processes for the management or sharing of data.</p> <p>At our last inspection information on the practice's performance in relation to QOF was not completely understood by the practice. There were some areas where exception reporting was high, such as Depression 41% and cardio-vascular disease primary prevention was 50%. The Lead GP and practice manager were not aware of this as they told us they do not except patients who are eligible for treatment.</p> <p>At this inspection we discussed oversight of performance with the GP partner. They explained that the Deputy PM had made the depression and cardio-vascular disease exceptions. On the day of our inspection the Deputy PM was on leave and we were not able to speak with them. The GP Partner told us they had reviewed these QOF figures. We looked at figures to date and 2 patients had been excepted so far for Depression out of 394 patients and 4 patients out of 54 for Cardio Vascular disease.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	NP
Learning was shared effectively and used to make improvements.	P
Explanation of any answers and additional evidence:	
<p>At our last inspection, there was minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care was not understood.</p> <p>At this inspection, the provider demonstrated they supported the nurse to attend training, update sessions and practice nurse networks. However, there was limited evidence to demonstrate learning was shared with practice staff. Staff had not received essential training for their role.</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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.