

Care Quality Commission

Inspection Evidence Table

Little Lever Health Centre (1-1826317082)

Inspection date: 11 March 2020

Date of data download: 06 March 2020

Overall rating: Requires Improvement

Dr Jain and Dr Subramanian (Little Lever Health Centre 2) was inspected on 11 March 2020. It was rated requires improvement overall and requires improvement for each of the key questions. We found breaches of Regulation 12 (safe care and treatment), Regulation 16 (receiving and acting on complaints), Regulation 17 (good governance) and Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirement notices were issued in respect of these breaches.

In the past twelve months there had been major changes in practice staff both clinical and non-clinical which has had an adverse effect on the service. The practice now has a new practice management team but they have had no practice nurse for almost twelve months and the lead GP is now on long-term sick with no indication of a return date.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires Improvement

The key question safe was opened up for review on the day of the inspection because of concerns around medicines management and other safety checks. The key question safe was rated as requires improvement because the practice did not carry out the required health, safety and fire checks, there were gaps in the infection control process, there was no review of significant incidents to ensure learning had taken place, the system to manage safety alerts was not failsafe and there was insufficient clinical staffing with no intermediate planning.

Immediately following the inspection the practice sent in evidence that the concerns identified at the inspection had been reviewed and systems were being implemented to reduce any current risk.

For example, we were told that significant incidents would be regularly communicated, safety alerts would be disseminated and discussed and all actions in connection with risks would be identified and managed appropriately. Provided those systems were embedded in everyday planning the practice should be able to assure that future risk is suitably reduced. However, the rating has been given in keeping with the evidence found on the day.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	No
Staff who acted as chaperones were trained for their role.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Not all staff knew how to access the safeguarding policies. • There was no regular clinical attendance at local safeguarding meetings. • Although we were told that health visitors regularly attended the practice we saw no evidence of any discussions. • Staff who chaperoned were not aware they had to record their attendance in the patient's notes. • The practice did not routinely reconcile with other professionals regarding failed attendances or document in records if there were no safeguarding issues. 	

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.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a recruitment policy in place identifying requirements for new staff. However we saw that not all requirements had been adhered to. For example new DBS checks had not been requested for the two practice managers who were employed in March 2019. 	

- We saw gaps in employment histories with no explanation and reasons for leaving previous employments were not recorded where necessary.
- There was no employment history, references, DBS certificate or training information for the newly appointment regular locum GP.

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 March 2019	Yes
There was a record of equipment calibration. Date of last calibration: 21 March 2020	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: August 2019	Yes
There was a log of fire drills. Date of last drill: Unknown	Partial
There was a record of fire alarm checks. Date of last check: Weekly on Tuesdays last recorded 24/02/2020	Yes
There was a record of fire training for staff. Date of last training: Various	Partial
There were fire marshals.	No
A fire risk assessment had been completed. Date of completion: 6 March 2020	Partial
Actions from fire risk assessment were identified and completed.	Unknown
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We were told that fire drills were done by independent fire marshals and were not seen as the responsibility of the practice. • We were told that the last fire drill was before Christmas when means of escape and fire exits were checked. • We were told by the practice manager that any fire issues were the responsibility of NHS property services. • Not all staff had completed fire training. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 6 March 2020	Yes

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6 March 2020	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The health and safety assessment identified extension leads in the GP and practice manager's room were a fire risk and should be removed. There was no record of them being removed. No action plan had been put in place to monitor the improvements that were required. 	

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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 2 March 2020 (NHS Bolton basic risk audit)	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
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.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The infection control audit had been completed by a member of staff who had not undertaken infection control training since 4 January 2017. It was unclear what the results of the audit were. All practice rooms were covered by the audit and some areas for improvement were identified, for example: <ul style="list-style-type: none"> Curtains, rails and blinds were not all clean and dust free. There were items stored at floor level in patient waiting areas, the main office and in toilet facilities. Alcohol hand gel was not available in all rooms. Examination couches were not in a good state of repair. For one clinical room the score for the audit was 43%, but it was not clear how this had been calculated. For another there were 42 areas where there was either a concern or a question mark recorded against the relevant question. 	

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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
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.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was no practice nurse and the practice had been unable to secure one after the existing nurse left in June 2019. • The health care assistant was trained and available to administer vaccinations such as B12, flu, shingles and pneumonia. However, the practice chose not to use this resource and GPs administered all vaccinations. • Induction was not consistent. We saw three examples of full and comprehensive induction sheets available. However in the case of one of the practice managers, only generic induction had been completed. There was a comprehensive induction sheet available for locum staff, but no evidence that any had been completed for the locum GP. 	

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 had systems for the appropriate and safe use of medicines, including medicines optimisation. Not all systems were effective.

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) (01/01/2019 to 30/11/2019) (NHS Business Service Authority - NHSBSA)	1.24	0.93	0.85	Variation (negative)
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). (01/01/2019 to 30/11/2019) (NHSBSA)	3.2%	6.4%	8.4%	Significant Variation (positive)
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 (01/07/2019 to 30/11/2019) (NHSBSA)	6.87	5.52	5.56	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2019 to 30/11/2019) (NHSBSA)	0.62	2.17	2.07	Significant Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
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.	Not applicable
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

Medicines management	Y/N/Partial
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.	Partial
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.	No
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Not applicable
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	No
<p data-bbox="57 1216 807 1249">Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li data-bbox="108 1308 1477 1341">• There was no written policy for high-risk medicines and no regular searches were completed. <li data-bbox="108 1346 1501 1456">• There was no clarity on the process around high risk medicines and no evidence of overdue monitoring. However we checked the records of patients who were being prescribed high-risk medicines that would be considered high-risk (two different medicines) and found no concerns. <li data-bbox="108 1460 1501 1823">• A vaccination cold chain audit was undertaken on 2 March 2020 – all answers were completed with a “yes”. For example “items are stored away from the back and sides of the fridge and freezer compartment if it has one”. When we looked in the fridge we found that this was not the case. The bottom drawer had been removed and items were stored on the bottom of the fridge. The fridge was so full that items were touching both sides from top to bottom and also the back of the fridge. The audit stated that the fridge was less than 60% filled. The audit stated that the plug was enclosed to prevent tampering and was hard wired. When we looked we saw this was not the case and the fridge was simply plugged in to the wall with no protection. The practice told us that extra medicines were stored in the fridge on the day of the inspection as a temporary measure. <li data-bbox="108 1827 1353 1899">• Emergency medicines were not kept in line with recommendations and there was no assessment of how and where they could be obtained if required in an emergency. <li data-bbox="108 1904 1465 1937">• There were two defibrillators on site. One of them did not work but it had not been removed. <li data-bbox="108 1942 1390 2011">• We were told that daily checks were done of the fridge temperatures by the health care assistant when she was there and by a member of reception staff when the health care 	

Medicines management	Y/N/Partial
<p>assistant was not there. However, on the day of the inspection the fridge we looked at had not been checked.</p> <ul style="list-style-type: none"> There was no clinical audit or clinical review of the use of antibiotic medicines. The practice told us medicines were managed by the CCG. *There was no requirement for Patient Group Directions because there was no nurse in the practice. Patient Specific Directions (which are required when a health care practitioner undertakes vaccinations) were not in use. The practice told us the health care assistant did not undertake vaccinations because it would take too long to complete the necessary documentation. For that reason, she was not utilised in that capacity, and GPs completed vaccines, including flu, B12 and pneumococcus, on an "as and when" basis. 	

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:	*See below
Number of events that required action:	*See below
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw examples of ten significant incident reports that were provided by the practice dated between September 2019 and January 2020. Of the ten, only one resulted in a change. In all the others action was required by a third party. None of the reports demonstrated learning. There was no evidence of a system to demonstrate discussion and review. We saw examples of significant incidents recorded and discussed in practice meetings but no evidence of documented incidents having been completed for that incident. All reports were completed by one of the practice managers and not by the person involved or reporting the incident. 	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A missed home visit request. Serious incident. Patient died.	This was recorded as having happened because the GP forgot about a home visit. Learning was unclear, but a change was made to the clinic system so that home visits were more obvious. There had been no review of this significant event.
Practice received a discharged note for patient still in hospital	Hospital contacted. Nothing changed. Fault attributed to hospital.
Safeguarding incident.	Police contacted. Incident appears to have been documented because police did not arrive on time. Fault attributed to the police.
Patient seen at orthopaedic department and discharged with only one day of medicine (Co-codamol) causing upset to patient	Recorded as incident because patient was upset at not receiving medicine from GP practice. Fault attributed to hospital for only providing one day's medicine.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Email alerts were distributed by administration staff to clinical staff but there was no formal process to manage medicines and medical device alerts or to assure that appropriate action was taken when necessary. There was no evidence to demonstrate that the last three alerts had been actioned or viewed by the GP we spoke to. There was no standing agenda item on practice meetings to discuss medicine alerts and no read receipts on emails sent. 	

Effective

Rating: Requires Improvement

The practice is rated requires improvement in the effective key question. There was no system in place to ensure all clinicians were following NICE guidelines. The practice was performing below the local and national average for asthma and cervical screening. There was no evidence of any two-cycle audits and where repeat audits had been identified as necessary they were not completed. Training was not effectively managed and there was no documented evidence of formal supervision or peer review of clinical staff.

Immediately following the inspection the practice sent in evidence that the concerns identified at the inspection had been reviewed and systems were being implemented to reduce any current risk. For example a system to improve clinical audit and ensure appropriate staff learning, support and development.

Provided those systems were embedded in everyday planning the practice should be able to assure that future risk is suitably reduced. However, the rating has been given in keeping with the evidence found on the day.

Effective needs assessment, care and treatment

Patients' needs were usually assessed, and care and treatment was 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.	No
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.	Yes
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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence:	

- There was no system in place to ensure that clinicians followed evidence-based practice such as appropriate dissemination of patient safety alerts, discussion of NICE guidance updates or peer review and supervision. We saw no evidence of such discussion in practice meeting minutes.

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) (01/01/2019 to 30/11/2019) (NHSBSA)	0.84	0.88	0.72	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- 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.
- 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.
- The practice carried out structured medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- We saw that patients with long-term conditions were offered a structured review to check their health and medicines needs were being made. However, we did not see evidence of a formal system to monitor patient recall and review other than the Quality and Outcome Framework (QOF).
- Care for patients with the most complex needs were co-ordinated with other health and care professionals.

- Patients with unplanned admissions to hospital were contacted by one of the GPs after discharge. Home visits were undertaken by the primary care network specialist nurse if appropriate.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- An audit of patients with asthma and chronic obstructive pulmonary disease (COPD) had recently been done by an outside clinical company to identify any unmet needs. This was a single cycle audit.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring and adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients in this population group could also be referred to the health improvement worker assigned to the practice.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.3%	76.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	1.9% (4)	10.4%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.3%	77.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.6% (12)	7.1%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.7%	81.2%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.6% (12)	9.9%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	59.5%	74.6%	75.9%	Variation (negative)
Exception rate (number of exceptions).	0.6% (1)	4.6%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	81.8%	88.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	3.9% (4)	6.1%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	77.5%	83.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.4% (13)	3.0%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	84.6%	93.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	5.8% (4)	4.2%	5.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- The practice had met the minimum 90% for all four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- Young people could access sexual health and contraception at community clinics.
- Patients in this population group could also be referred to the health improvement worker assigned to the practice.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	12	12	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	29	29	100.0%	Met 95% WHO based target
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) (01/04/2018 to 31/03/2019) (NHS England)	29	29	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	29	29	100.0%	Met 95% WHO based target

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: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- The target for cervical screening was lower than required. The practice had been unable to recruit a practice nurse since the previous one left in June 2019. This meant there was no one at the practice to carry out cervical screening. Eligible patients were referred to the GP Federation extended hours service for cervical screening during the hours of 6.30pm to 8.30pm Monday to Friday or 9am to 1.30pm on Saturdays and Sundays.
- There was no female clinician at the practice, other than the health care assistant. Patients who wanted to consult with a female GP had to be seen at the extended hours or out of hours services.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients in this population group could also be referred to the health improvement worker assigned to the practice.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	71.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	64.3%	67.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	59.9%	52.7%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	47.8%	69.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	35.3%	47.0%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- Longer appointments were offered to patients when required, for example if they wished to discuss more than one issue.
- Patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. The GPs undertook all vaccinations in the absence of a practice nurse.
- The practice demonstrated that they had a system to identify people who misused substances.
- Patients in this population group could also be referred to the health improvement worker assigned to the practice.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

We saw good practice for patients in this population group. However, the issues that impacted the effective key question overall also impacted the patients in each of the population groups. For that reason all population groups have been rated requires improvement.

- Patients with mental illness, severe mental illness, and personality disorder were referred to the mental health worker provided by the primary care network. Clinics were undertaken on a weekly basis to provide health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Patients in this population group could also be referred to the health improvement worker assigned to the practice.
- Same day and longer appointments were offered when required.
- 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.

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 (01/04/2018 to 31/03/2019) (QOF)	94.1%	91.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.9%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	100.0%	90.6%	90.2%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	5.6%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	92.9%	92.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.7% (1)	5.0%	6.7%	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)	512.8	532.6	539.2
Overall QOF score (as a percentage of maximum)	91.7%	95.5%	96.7%
Overall QOF exception reporting (all domains)	2.6%	4.7%	5.9%

	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

- There was no evidence of any two cycle audits.
- There was no evidence of improvement demonstrated as a result of any clinical audit
- There was no evidence of improvement demonstrated as a result of any non-clinical audit

Any additional evidence or comments

- At the time of the inspection, the practice had commissioned an outside pharmaceutical company to undertake an audit of patients with asthma and COPD.
- We saw those audits had been completed but at the time of the inspection the practice was not able to demonstrate any improvements for patients or any action plan to determine improvements for patients in the future.
- The practice presented a sodium valproate audit which had been undertaken, identifying one patient taking this medicine. There had been no repeat audit undertaken and no evidence of any learning points.
- Clinical audit and/or patient consultation reviews were not a standing agenda item at meetings.

Effective staffing

The practice was unable to demonstrate that the skills, knowledge and experience of staff was appropriately managed.

	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.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care 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.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Not all staff were given protected time for learning. • Training was not up to date for all staff. Some staff had completed several training sessions in the fortnight prior to the inspection. This included one staff member completing 17 on-line training courses in one day. • The appraisals we looked at did not evaluate the competence or learning needs of staff members and did not opportunities for development. • There was no clinical support for the health care assistant at the practice. • Although induction programmes were in place they had not been completed for the two newest members of staff or the locum GP. • There was no documented clinical supervision for the locum GP. • There was no documented evidence of clinical peer review. 	

Coordinating care and treatment

Staff worked with other organisations to deliver care and treatment.

Indicator	Y/N/Partial
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The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
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.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Patients had access to a health improvement worker at the practice through the primary care network (PCN). Patients had access to a mental health worker at the practice through the PCN. Patients had access to an MSK worker at the practice through the PCN. Patients who required cervical screening were referred to the GP Federation extended hours service. 	

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	95.0%	95.5%	95.0%	No statistical variation

smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.5% (4)	0.6%	0.8%	N/A

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
Policies for any online services offered were in line with national guidance.	Yes

Caring

Rating: Good

This was a focussed inspection based on a quality change from an Annual Regulatory Review (ARR) and we did not inspect this key question. Therefore, the rating for this key question remains the same.

Responsive

Rating: Requires Improvement

The practice is rated requires improvement in the responsive key question. There was no consistent system in place to ensure that verbal and written complaints were documented, monitored and responded to. There was no practice nurse and the lead GP was on long term sick leave. There was one full time GP and a part time locum GP managing all patients at the practice and there was evidence that prevalence of expected diseases was low.

Immediately following the inspection the practice sent in evidence that the concerns identified at the inspection had been reviewed and systems were being implemented to reduce current risk. For example, the practice had begun a process to monitor verbal complains and were in the course of advertising for a practice nurse and a salaried GP. Provided those systems were embedded in everyday planning the practice should be able to assure that future risk is suitably reduced. However, the rating has been given in keeping with the evidence found on the day.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However services did not meet all 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a registered population of 2814. 6.5% of the population were over 75 years of age and 0.5% were over 90 years old.• There was a high incidence of smoking, COPD and diabetes.• There were increasing challenges of depression, anxiety, drug and alcohol abuse.• There was no practice nurse and the health care assistant undertook chronic disease management with support of the GPs.• The registered manager, who was a partner, was on long term sick leave leaving one partner to provide the support for chronic disease management. A temporary part time sessional locum GP also saw patients.• The assistant practice manager was on maternity leave and two practice managers undertook a job share role.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 8.00pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments were available at various times throughout each day. In addition:	
<ul style="list-style-type: none"> The practice provided a full range of GP consultations and management of long term conditions. However there was no female clinician for consultations and patients wishing to see a female clinician were referred to the GP Federation extended hours service. This meant they could not be seen during the hours of 8am and 6.30pm at their local practice. Patients could call or visit the surgery or book appointments on-line. Appointments were for 10 minutes and patients were asked to state if they required longer. Extended appointments were available until 8pm on a Tuesday. The website stated that patients had access to a practice nurse. 	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	96.3%	94.6%	94.5%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> We spoke to two patients who told us they were very happy with appointments and could get one whenever they needed. We received 49 comments cards from patients. They all contained some positive comments about the practice and the staff. Twelve comments cards mentioned appointments; seven provided positive comments but five commented on long waits when attending appointments, or difficulty obtaining an appointment within a suitable timeframe.

Older people

Population group rating: Requires Improvement

Findings
<p>Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.</p> <ul style="list-style-type: none"> The practice had a registered population of 2814. 6.5% of the population were over 75 years of age and 0.5% were over 90 years old.

- All patients had a named GP who supported them in whatever setting they lived. However, one of the GPs was on long term sick and this impacted some patients who were used to seeing that GP.
- 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. All home visit requests were triaged by a GP who made the decision whether a visit was necessary or not.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings

Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.

- Patients with multiple conditions had their needs reviewed by the health care assistant and then by one of the GPs. However, longer appointments were available for those with multiple conditions, when requested.
- The practice provided care coordination to enable patients with long-term conditions to access appropriate services.
- The practice arranged for all asthma patients and all chronic obstructive pulmonary disease (COPD) patients to be reviewed by an external company in the absence of the practice nurse. We saw this had been completed, but there was no documented outcome or action plan by the practice to demonstrate the next steps.
- 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.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.

- The practice contacted the parents or guardians of children due to have childhood immunisations. However, there was no evidence of a system to proactively follow up missed children's appointments in secondary care or for immunisation. There was no evidence that missed appointments were consistently monitored.
- There was limited evidence that the practice pro-actively identified and reviewed the treatment of newly pregnant women on long-term medicines. These patients were provided with advice on an ad-hoc basis.

- Staff were not utilised to carry out reviews for this population group. However, there was a weekly baby clinic with a GP. Only GPs carried out reviews for this patients in this population group.
- Young people could access services for sexual health and contraception at other services in the community.
- There was no practice nurse and all appointments were with a GP or the assistant practitioner/health care assistant. Patients needing to see a nurse were referred to the extended hours service provided by the GP Federation.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.

- The uptake for women being cervically screened was lower than average. Patients who were eligible or required cervical screening were referred to the extended hours service provided by Bolton GP Federation.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Continuity of care was provided via the two full time GP partners. With one of the GPs on long term sick, a regular locum was in place.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.

- There was a register of patients living in vulnerable circumstances, including travelers and those with a learning disability and people in vulnerable circumstances could register easily.
- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice told us they had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice told us they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

Although we saw some good practice in this population group, the issues that required improvement in the responsive key question impacted across all population groups.

- There was no evidence of a system for following up patients who failed to attend for administration of long-term medication.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- There was a mental health worker at the practice once a week provided by the GP Federation. The practice referred patients with mental health to this clinic where they were assessed and monitored.
- Heart disease, cancer and access to 'stop smoking' services were managed by the assistant practitioner who worked on a part time basis.
- Same day and longer appointments were offered when required.
- When patients were assessed to be at risk of suicide or self-harm we were told there were 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.

Timely access to the service

People were 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.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice was able to demonstrate that patients could access appointments quickly despite there being no practice nurse and a part time locum GP. • Only GPs made a decision as to whether a home visit was necessary or not. 	

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 (01/01/2019 to 31/03/2019)	80.8%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	65.3%	70.9%	67.4%	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 (01/01/2019 to 31/03/2019)	63.0%	69.5%	64.7%	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 (01/01/2019 to 31/03/2019)	66.5%	74.6%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	There were three negative reviews on NHS choices where patients were very dissatisfied with the service received. These had not been responded to by the practice. There were no positive responses posted.

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.	Unidentified
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence:	

- The complaints procedure stated that all complaints, written and verbal would be recorded. It also stated that where a complaint was made verbally a written record would be taken and a copy would be provided to the complainant.
- We were told there had been no complaints since the new practice managers were employed in March 2019. However, there was inconsistent evidence to support this.
- Both the practice managers and other staff we spoke to gave examples where patients had verbally displayed dissatisfaction about the service they received. For example, delays in receipt of prescriptions and long waits when attending for appointments. These had not been documented or monitored and were not discussed at practice meetings.
- We were told there had been no formal written complaints. However, the inspection team found a complaints file in the practice manager's room which demonstrated a continuous pattern of complaints between May 2018 and March 2019, the most recent being from 12 March 2019.
- Not all the complaints were responded to in accordance with the complaints policy. For example a verbal complaint was not responded to, one was not responded to in a timely manner, and one did not receive an appropriate response.

Well-led

Rating: Requires Improvement

The practice is rated requires improvement in the well-led key question. Governance was not effective. There were limited processes to manage risks. We saw no evidence of shared learning or any focus on improvements.

Immediately following the inspection the practice sent in evidence that the concerns identified at the inspection had been reviewed and systems were being implemented to reduce any current risk. For example, there was a standardised meeting agenda to discuss significant incidents, patient safety alerts, good prescribing, and other issues associated with good practice working. All members of staff would be involved in those meetings to ensure that communication was effective. Provided those systems were embedded in everyday planning the practice should be able to assure that future risk is suitably reduced. However, the rating has been given in keeping with the evidence found on the day.

Leadership capacity and capability

Not all leaders could demonstrate that they had all the necessary skills or capacity to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">The leaders were unaware of the term statutory notification, or the need to notify CQC in certain circumstances, for example the long-term sickness of the registered manager.Not all actions to address challenges had been taken. For example, there was no documented plan of who would undertake the role of registered manager whilst that person was on long term sick leave. A part time locum GP was in place to undertake clinical duties but there was no plan for their other roles.The remaining partner was the safeguarding lead, but the practice managers were responsible (according to clinical and non-clinical staff we spoke to) for all other lead roles. The practice managers had been in post for under twelve months and undertook a job share role. They could not demonstrate that all the necessary skills and capacity were in place to undertake all the roles. For example, they were not trained in lead roles for infection control or significant incident reporting and analysis. They were not both able to undertake searches on the clinical system to identify issues.There was no evidence of a leadership development programme or a succession plan. The GP we spoke to said they had no intention of retiring soon. There was no contingency in the event of the remaining partner requiring leave, other than to employ another locum in an emergency.	

Vision and strategy

The practice vision 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.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were told that the vision of the practice was to provide evidence based and patient focused care for all patients which was monitored through patient feedback. However, the practice could not demonstrate how this was monitored through patient feedback. There had been no patient evaluation to monitor if the absence of the practice nurse and registered manager (long term GP) had an adverse effect on the quality of care for patients. There was no documented action plan to show how the priorities would be achieved. For example, if patients wanted to see a nurse, they would be referred to the extended hours service provided by the Bolton GP hub. This service was not available between the hours of 8am and 6.30pm on Monday through to Friday. 	

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Partial
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.	No
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

Explanation of any answers and additional evidence:

- Not all staff had completed equality and diversity training.
- The practice could not demonstrate that all patients were given an apology and informed of any resulting action when things went wrong. For example, in the case of the missed home visit, although it was documented as a significant incident, we did not see any documented response to the patient's wife following the incident, explaining the reason for the error and informing what was being done to stop it occurring again. In addition, complaints were not always appropriately responded to.
- Safety and wellbeing of staff was not always considered, for example, where actions should have been taken to remove fire or health and safety risks.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Non-clinical staff	Happy working at the practice. Happy with the management in place
Non-clinical staff	Not being utilised to best of ability.
Non-clinical staff	Can seek support outside the practice when required
Non-clinical staff	Have done a lot of training very recently. One staff member completed 17 courses in one day.
Non-clinical staff	Made a suggestion in September for all non-clinical staff to cover each other, including referral letters. Not sure that has happened yet.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

- It was not clear who was taking the role of the registered manager whilst they were on long-term sick.
- The practice managers undertook a job share role, but they did not both undertake all areas of the post. It was not clearly set out which manager undertook which part of the role and who would cover which area when the other was not there.

Managing risks, issues and performance

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

	Y/N/Partial
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There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
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.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice could not assure that action was taken to make improvement or change when required. For example, there was no action plan to remove fire risks (extension leads) or improve areas of infection control that had been identified as requiring attention. There was no evidence that two-cycle clinical audits, or any internal audit was regularly undertaken. There was no long term documented action plan or protocol to cover the roles of the registered manager during long term sick leave or that of the practice nurse until a new one was in place. Although there was a record of significant incidents, there was no completed cycle demonstrating consistent discussion and review. 	

Appropriate and accurate information

The practice did not always use data and information to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was no evidence of completed two-cycle clinical audits. During our inspection we found inconsistencies in the systems to manage medical alerts, significant incidents and complaints. Actions were not taken when risks were identified, such as those identified during fire and health and safety assessments. The practice staff were not aware of the term statutory notifications or what constituted a statutory notification to CQC. The practice had not notified CQC that the registered manager was on long-term sick. 	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Verbal complaints were not documented and monitored to identify trends 	

Feedback from Patient Participation Group.

Feedback
We spoke with three members of the PPG who were very satisfied with the GP practice and the service received. However, they spoke on behalf of themselves as patients and not on behalf of the PPG. They said the PPG members were not reflective of the whole population. However, they said the practice was involved and updated the group on various issues, for example the fact that they were looking for a new nurse.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice could not demonstrate clinical audit was taking place. The practice could not demonstrate discussion, review and learning from significant incidents. 	

- The practice could not demonstrate that complaints/verbal comments were used to make improvements.

Examples of continuous learning and improvement

We found no examples of continuous learning and improvement.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework

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