

Inspection Evidence Table

Dr George Duru

(1-529384387)

Inspection Date: 16 May 2023

Overall rating: Inadequate

We last inspected Dr George Duru on 11 November 2016. The practice was rated good overall and in all key questions. At this inspection, on 16 May 2023, we found five breaches of regulation which resulted in the key questions of safe, effective, responsive, and well-led being rated inadequate, and caring being rated requires improvement. Overall, the practice is now rated inadequate.

Safe

Rating: Inadequate

At the last inspection on 11 November 2016, we rated the practice as good for providing safe services. At this inspection we rated the question inadequate. We identified several areas of concern including:

- Staff were not all trained in safeguarding.
- Recruitment systems were not effective and not in line with legislation.
- Infection prevention and control systems were not effective.
- Safety procedures such as for fire and health and safety were not adequate.
- Medicine management arrangements were not effective.
- Significant events were not used to learn and improve the practice when things went wrong.
- Safety alerts were not appropriately actioned.

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
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Y

There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	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.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had 2 safeguarding policies. They provided us with a 'Safeguarding Adults and Children Policy, The Duru Practice, 2022'. This policy did not name who the safeguarding lead was. It stated, "All staff will be given training on safeguarding at induction and at intervals thereafter as specified by role and national guidelines". The frequency was not recorded. The practice also had 'The Duru Practice Safeguarding Children, Young People and Adults Policy' which had been put in place by NHS Oldham Clinical Commissioning Group (CCG, now the Integrated Care Partnership), reviewed 19 October 2021, and personalised to the practice. This named the practice manager as the person responsible for notifying the CQC without delay about allegations of abuse where the harm is attributable to the practice, the deputy for reporting allegations, the Practice Designated Senior Manager, the deputy of the Designated Senior Manager, and the Nominated Senior Officer. The provider, practice manager and staff told us the lead was the lead GP. They were not named in either policy. The Duru Practice Safeguarding Children, Young People and Adults Policy gave information about the level and frequency of safeguarding training for staff. It stated safeguarding training would be repeated every 3 years as a minimum. The most recently employed non-clinical staff member who started work in February 2023 had not received safeguarding training. The nurse practitioner last had safeguarding training in November 2016. The practice manager said they reminded staff to complete training. The lead GP told us they engaged in local safeguarding procedures. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Where staff members had been employed from abroad no checks were made on their right to work in the UK. We saw no evidence one staff member had the right to work in the UK, and the practice manager confirmed they had not asked for evidence during the recruitment process. Following the inspection, the practice manager asked the staff member for evidence of their right to work, and we saw evidence of their right to live and work in the UK. We examined staff personnel files as part of our inspection. We saw gaps in the employment history of two staff members who had been employed in the past year, and there was no explanation of these gaps. The practice manager told us they did not keep any interview notes. 	

- Checks on the professional registration of clinical staff were not routinely carried out. There was no evidence of a check for 2 clinicians, 1 had been checked in 2016 and 1 checked in 2017. There was no evidence 1 clinician was qualified for their role.
- We checked a reference received for a recently employed staff member. This did not indicate the employer the reference was from, the dates of employment, the date it was completed or who completed it. In addition, the practice included the applicant's address on the reference form with no indication the staff member had agreed to this.
- Evidence of staff vaccination was not routinely kept. Some evidence was kept in personnel files, but this was on an ad hoc basis. There was no evidence of vaccination for the most recently employed clinician. Staff told us they had not been asked to provide evidence of their immunisation status.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment: 16/02/2022	N
There was a fire procedure.	Partial
Date of fire risk assessment: 09/12/2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice manager was the fire warden and had received training. They worked 30 hours a week and told us a non-clinical staff member was the deputy fire warden. The deputy had not received training. • The practice provided us with their Fire Safety Policy, dated 2022. This stated it was the responsibility of the practice manager to make sure staff were trained at induction and at regular intervals. The frequency was not recorded. The lead GP had not received training since August 2019 and another member of the clinical team who had worked at the practice since 2014 had no record of training. The most recently employed non-clinical staff member who started work in February 2023 had not completed the fire safety training allocated to them, but they had received fire safety awareness as part of their induction. The policy stated, "We have designated a responsible person for fire safety". It did not name the responsible person. • The practice was located in a large building managed by NHS Property Services. A fire risk assessment had been carried out by the management company who had completed the actions required. The practice had a Health and Safety Policy 2022. This included "The fire warden carries out a fire risk assessment of the premises and reviews it regularly". This did not happen. We saw the fire risk assessment for the practice, noted that it had been carried out by the practice manager on 7 March 2019. This was not a risk assessment, but a statement saying the existing fire safety measures were adequate and all staff had received adequate training. 	

- The practice had recorded a significant event in October 2022 as they recognised people were wedging open a fire door. The learning points were “never prop open a fire door”. During our inspection we observed a staff member prop open a fire door and leave it.
- The practice manager had carried out a health and safety risk assessment, titled “Activities undertaken within the Duru Practice”, on 16 February 2022. These listed types of hazards, for example slips and trips, but did not include an assessment of each room to identify risks. The practice health and safety policy stated, “All staff will be given training on health and safety at induction and at regular intervals thereafter”, and it said training was on the electronic training system. We saw no training on health and safety had been allocated to any staff to complete, and we saw no evidence of any staff member being trained.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out.	Y*
Date of last infection prevention and control audit: 31/01/2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	NA
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice provided us with their infection control policy, dated 2022. This did not include the name of the infection control lead. We were told the practice nurse, who worked 4.5 hours a week, was the lead. The policy stated it was the practice manager’s responsibility to “ensure that staff are trained at induction and at regular intervals” and went on to say they would “ensure all staff receive infection prevention and control training every 3 years”. We examined the training records held on the practice’s electronic system and within personnel files. We found no evidence of infection control training for the lead GP, and no evidence of training for another member of clinical staff since 2015. The most recently employed non-clinical staff member, who started work in February 2023, had not completed infection control training. Another non-clinical staff member was last trained over 3 years ago. • The infection control lead had carried out an audit on 31 January 2023. It stated the practice was 100% compliant. The audit stated, “Staff have attended recent up to date infection control training” but this was not accurate. The audit stated, “Infection control is a recurrent agenda item at practice meetings”. We saw the minutes of the 3 most recent practice meetings, from August 2022, October 2022, and April 2023. Infection control was not an agenda item in any of these meetings. The audit stated, “Clinical staff are up to date with relevant vaccinations (records available)” but we saw records were not held. • We checked the equipment in the room used by the healthcare assistant. We found 93 hypodermic needles that were past their expiry date of 1 March 2023. 	

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.	N
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our inspection of 11 November 2016, we found the locum pack, used to give essential information to locum GPs, did not contain sufficient guidance. We said, "The provider should review the GP locum pack to ensure all appropriate information is included, for example current local telephone numbers and up to date practice information". At this inspection the practice manager told us there was no locum pack and they told locum GPs verbally when they started what the processes were. 	

Information to deliver safe care and treatment

Staff had most of 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial

Explanation of any answers and additional evidence:

- A rejected referral had resulted in a referral being missed and the practice recording a significant event. This had occurred in May 2022. One of the actions was for a log of rejected referrals to be kept. The lead GP told us this was kept but non-clinical staff and the practice manager told us no log was in place.
- The lead GP told us they managed test results unless they were abroad, then a deputising GP managed them. They said they did some every day and caught up at the weekend if needed. They told us they did this the previous weekend; they were behind due to the CQC inspection but would catch up afterwards. We reviewed outstanding results and 56 were from before the previous weekend. The earliest one was 7 days prior to the date we checked.

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	1.13	0.97	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	6.5%	6.5%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)	4.39	4.44	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	198.0‰	185.5‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	3.60	0.78	0.56	Significant variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	8.8‰	7.2‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	N
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. 2	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Nursing staff did not have the appropriate authorisations to administer medicines:</p> <ul style="list-style-type: none"> • Patient Group Directions (PGDs) are signed to allow certain healthcare professionals to administer specified medicines to patients. The practice provided us with the PGDs they held, and we examined a sample of 7. • On 3 of the PGDs we examined the practice nurse had signed after the authorising GP. They were therefore not authorised to administer the medicine. • We saw that 1 PGD was signed by the healthcare assistant and the practice nurse, but neither had dated it. Healthcare assistants cannot work under a PGD. The practice nurse and practice manager told us they used PGDs for the healthcare assistants and did not use Patient Specific Directions (PSDs). <p>As part of our inspection, a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice:</p> <ul style="list-style-type: none"> • The records we examined provided evidence that the majority of patients prescribed Disease-modifying antirheumatic drugs (DMARDs) had been monitored appropriately. DMARDs are prescribed to suppress inflammation and help to prevent joint damage for patients with rheumatoid arthritis. 	

- We reviewed 5 medicine reviews. These were all single code entries. The outcomes of the reviews, or if monitoring was up to date, had not been recorded.
- The practice provided us with an antibiotic review carried out by a clinical pharmacist in February 2023. The audit highlighted several issues. Feedback included that patients were routinely being prescribed antibiotics following a telephone request via non-clinical staff, with no direct discussion with the GP, and this could lead to inappropriate prescribing.
- The lead GP told us they did not carry out any formal clinical supervision for members of the clinical team, so no records were kept. However, they told us the non-medical prescriber only worked on the days the lead GP worked, and they did check all their prescribing.

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.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	N
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	Unclear
Number of events that required action:	Unclear
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had 4 recorded significant events in the past year. Details of these were held in their electronic system, and 2 of them were also held in a significant event file. The practice manager told us they may not record all significant events. They told us of an incident in the reception area when a child had a medical emergency. They said this was not recorded as a significant event. They told us about several times when patients had been aggressive. They said these were not recorded as significant events and no data was kept of the occurrences. The practice’s Violence and Aggression policy 2022 states “If an incident occurs, we ensure that the member of staff involved completes the incident reporting form as soon as possible, in line with local policy”. • The practice provided us with their significant event policy, dated 2022. This stated it was the responsibility of the practice manager to “ensure that staff are trained at induction and at regular intervals so that they are aware of the principles of significant events”. Records showed no staff had received this training, including the lead GP and practice manager. 	

- We saw the meeting minutes from the last 3 practice meetings, in August 2022, October 2022 and April 2023. The minutes of August 2022 mentioned a significant event. This event was not held in the electronic system or in the significant event file. The practice manager told us they held the details separately as it was ongoing. The significant event was from May 2022 and was related to a rejected referral. Although it was ongoing the practice had decided a log should be kept of rejected referrals. This had been referred to in meeting minutes, but discussions with staff and the practice manager found a log was not being completed. The August 2022 minutes stated the patient would be invited to the practice for an explanation and an apology from the lead GP. This had not yet occurred.
- The minutes of October 2022 included details of a significant event discussion. The significant event form stated that fire doors were being propped open. The learning points were “never prop open a fire door”. During our inspection we observed a staff member prop open a fire door and leave it. Learning from the event was not embedded.
- The following practice meeting was in April 2023. No significant events were discussed but there had been 2 recorded since the previous meeting. The practice manager told us they did discuss significant events at other times, but they did not keep a record of these discussions.

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

Event	Specific action taken
November 2022. A flu vaccination was given to a patient who had already received the vaccination by the pharmacy.	The lead GP and vaccine manufacturer were contacted, and it was established that there was no patient harm. The electronic notes of the patient had not been checked prior to vaccinating and the learning points were that this was human error and notes should be ‘quadrupled checked’.
June 2022. An incorrect patient went into a nurse consultation after being called from the waiting area.	It was found the patient was registered at a different GP practice in the building and had answered to the incorrect patient’s name. The learning point was to check the GP practice of the patient when calling them for a consultation. The waiting area is used by several GP practices.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice manager told us they emailed safety alerts, including The Medicines and Healthcare products Regulatory Agency (MHRA) alerts, to clinicians. They then printed them and kept them in a file so they could be referred to. • The practice was unable to demonstrate that all relevant safety alerts had been responded to. Our clinical searches found that 8 patients were prescribed a combination of the medicines amlodipine and 	

simvastatin 40mg or more. The MRHA alert of 2014 stated the maximum recommended dose of simvastatin co-administered with amlodipine or diltiazem is now 20 mg per day. We examined the records of 5 of these patients. None of their records had been noted that they had been informed of the risks involved in taking these medicines against the guidance. Following the inspection, the lead GP told us they had spoken to these patients, amended their dose, and would repeat appropriate checks.

Effective

Rating: Inadequate

At the last inspection on 11 November 2016, we rated the practice as good for providing effective services. At this inspection we rated the question inadequate. We identified several areas of concern, including:

- Clinicians were not always up to date with current guidance.
- A Statement of Intent had been in place with no evidence of consultation.
- A delayed referral had not been actioned in a timely way.
- Blood tests were not always repeated at appropriate intervals.
- We saw 33 cases of potentially missed diabetes diagnoses.
- We saw over-prescribing of asthma inhalers.
- Childhood vaccinations were below target.
- There was no programme of targeted quality improvement.
- Training was not well-managed and several staff had not completed essential training
- Staff appraisals were not routinely carried out.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not 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.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	N
The practice prioritised care for their most clinically vulnerable patients.	N

Explanation of any answers and additional evidence:

- Our clinical searches showed that clinicians were not routinely kept up to date with current guidance. We saw patients were prescribed the medicines amlodipine and simvastatin 40mg or more which was against guidance. Practice meetings where new guidance could be discussed were irregular, with the most recent being in April 2023, October 2022, and August 2022. No records of other informal meetings were held. Documented clinical supervision was not provided for clinical staff.
- The practice provided us with an example of a Statement of Intent in place. This was a statement by the lead GP that they had seen a patient on a given date and the patient was expected die within the following few days. It was a statement that they could issue a medical certificate of cause of death. The lead GP had been on annual leave on the given date and told us they had not carried out any consultations during this time. The patient's medical records did not show a consultation had taken place.
- We saw an example of a referral being made for a patient. The referral had been rejected and this was not realised until the patient contacted the practice over 5 weeks later. There was a further delay, and the patient was not referred until 17 weeks after the initial date. At the time of our inspection safeguards had not been put in place to stop this happening again.
- Our examination of patients' records found several examples of patients where blood tests had not been repeated at the appropriate intervals. We saw one where the patient had not had their required tests since 2017. Following the inspection, the lead GP told us they had unsuccessfully asked the patient to attend 6 times. They had now stopped their prescriptions being on repeat, meaning they had to contact the practice for their medicines, hoping that would prompt contact.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients with a learning disability were offered an annual health check.
- The practice assessed and monitored the physical health of people with severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Our searches found that 33 patients had a potential missed diagnosis of diabetes. A delayed diagnosis can lead to diabetes-related complications. We reviewed the records of 5 of these. All 5 had not had an appropriate follow up. We saw 3 patients had diabetes but were not coded as such, and 2 should have had a blood test to confirm if they had diabetes but this had not been carried out in a reasonable timeframe. Following the inspection, the lead GP told us they would review the 33 patients.
- Our searches found 31 patients had been prescribed 12 or more Short-acting beta-agonists (SABA) inhalers in the past year. We reviewed the records of 5 of these patients. We found 4 patients had been prescribed 12 to 14 inhalers. The asthma reviews for these patients had not identified over-use of inhalers. We saw 1 patient had been prescribed 28 inhalers in the past year and their asthma review had noted that their condition was well-controlled. Following the inspection, the lead GP told us they had reviewed this record and they felt it was over-ordering and not poor asthma control. The National report into asthma deaths has identified that increased usage of SABA inhalers is associated with an increased risk of death from asthma.
- Our searches suggested that 32 patients with asthma had had 2 or more courses of rescue steroids in the last year. We reviewed the records of 5 of these. None of these had been followed up to check their response to treatment within a week of their exacerbation. Guidance from The National Institute for Health and Care Excellence (NICE) states a follow up should take place within 48 hours of exacerbation.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	53	59	89.8%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	53	88.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e.	44	53	83.0%	Below 90% minimum

received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	53	88.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	69	75	92.0%	Met 90% minimum

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>

Any additional evidence or comments

We asked the practice for their latest unverified childhood immunisation data. The practice manager told us they had tried different ways of improving their childhood vaccination rates, such as being flexible with appointment times, but they found it “impossible”.

The unverified data provided by the practice on the day of the inspection showed:

- 46% of children had been given a 3rd diphtheria, tetanus, and pertussis (DTaP) vaccine before the age of 8 months. The target was 95%.
- 75% of children were given their 1st dose of measles, mumps, and rubella (MMR) vaccine aged 12 to 18 months. The target was 95%.
- 76% of children and 1 to 5 had 2 MMR vaccine doses and a DTaP and polio booster. The target was 95%.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	55.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	58.9%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/09/2022 to 30/09/2022) (UKHSA)	63.2%	N/A	80.0%	Below 70% uptake

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	60.0%	52.0%	54.9%	No statistical variation
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Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
<p>We asked the practice to supply us with 2 completed clinical audit cycles.</p> <ul style="list-style-type: none"> We saw an audit of the compliance with the valproate pregnancy prevention programme dated September 2022. This identified a patient for whom there was no record of the risks of taking the medicine being discussed with them, and where a pregnancy prevention programme may be required. It was recorded this audit would be repeated in 6 months to check compliance. The practice manager told us this had not been repeated to check the safety of patients receiving the medicine as no pharmacist was available. We saw an audit on antibiotic prescribing dated February 2023 looking at a week in October 2022. It indicated this was not the first audit. The audit identified some improvement, but stated there was some incorrect and some over-prescribing. Feedback from the pharmacist who carried out the audit included that patients were routinely prescribed antibiotics following a telephone request via non-clinical staff, with no discussion with a GP. Our review of 5 patients with asthma who had 2 or more courses of rescue steroids in the last year, found 3 of these were prescribed rescue steroids following their history being taken by a non-clinical staff. The lead GP told us they carried out some audits themselves to use in their appraisal. 	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	Partial
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice manager told us that new staff had a 3-month probation period. They had fire training then completed other training. They told us the probation period was not formal and it was not documented. We looked at the personnel file of the most recently employed non-clinical staff member who started work in February 2023. No details of an induction programme were in their personnel file and there was no indication they had passed their probation, even though they started work over 3 months ago. The practice manager told us that all evidence of staff training was in an electronic system except for the lead GP and nurse practitioner. Their training was mainly in their personnel files although they had set them up to complete training on the electronic system. We checked the training records of all staff and found it was not well-managed. There was minimal evidence of training in the personnel files of the lead GP and the nurse practitioner. The practice manager told us they regularly reminded staff, including the GP and nurse practitioner, to log on to their training and complete the required courses, and this was documented in 2 of the 3 meeting minutes we reviewed. Most non-clinical staff, except the staff member who started work in February 2023, were up to date with training such as safeguarding, infection control, fire safety and Information Governance. The most recently employed non-clinical staff member had completed 26% of their required training. The electronic records showed the lead GP had completed 2% of their required training. However, their personnel file provided evidence they were up to date with safeguarding training. We saw no evidence they had been trained in infection prevention and control, fire safety, the Mental Capacity Act, Information Governance and equality and diversity. The electronic records showed the nurse practitioner had completed 38% of their required training. There was no record of safeguarding training on their electronic record but there was evidence in their personnel file that safeguarding adults and children training had been completed in September 2018. There was no record of it being repeated since. We saw no evidence they had been trained in fire safety, Information Governance or equality and diversity. They completed training in infection prevention and control in 2015 but there was no evidence it had been repeated. 	

- The practice manager told us they were very busy, and it was difficult to fit training in as there was no spare time.
- We saw staff appraisals were not routinely carried out. One clinical staff member started work in 2018 and their only appraisal had been in December 2022. Another clinical staff member started work in November 2021 and their only appraisal had been in May 2023, the week prior to our inspection. We saw other non-clinical staff members also had an appraisal the week prior to our inspection. We saw 1 had started work in August 2018 and this was their first appraisal. We saw a staff member had an appraisal in May 2018 and their next was in May 2023, 5 years later. Another had not had an appraisal since April 2017. The practice manager had their only appraisal in December 2022, 4 years after they started work.
- The nurse practitioner was a close family member of the lead GP. Following our inspection in November 2016 we told the practice, “The provider should have a transparent process in place for the supervision and appraisal of all clinicians”. The lead GP told us at the time that they were considering an alternative arrangement for the nurse practitioner’s supervision. We saw they had an appraisal with the lead GP for the period 15 April 2016 to 16 April 2017, but this was undated. Their next appraisal was December 2022 and the lead GP had carried out both of these.

Helping patients to live healthier lives

Staff were not always 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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Patients had access to appropriate health assessments and checks.	Partial
The practice supported national priorities and initiatives to improve the population’s health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice could refer patients to a focused care worker who regularly attended the practice and visited patients at home. The focused care worker worked holistically with the patient and their family to 	

assess their situation and bring together agencies which could improve the outcome for the patient. This could involve helping with benefits, housing issues, schools, and providing practical support. The lead GP told us they had no formal documented meetings with the focused care worker, but they did discuss patients.

- Our clinical searches found that some patients at risk of developing a long-term condition such as diabetes did not always receive additional support and care. Our clinical searches identified 33 patients with a potential missed diagnosis of diabetes. We looked at a sample of 5 of these patient records. We saw 3 had diabetes but had not been diagnosed or coded, so had not been referred for appropriate checks such as for eye screening. For 2 patients a repeat blood test was required. There was no evidence they had been invited for these blood tests within the appropriate timeframe.

Consent to care and treatment

Evidence of the practice always obtaining consent to care and treatment in line with legislation and guidance was not always available.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Unknown
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a Mental Capacity Act policy dated 2022. This stated, "All staff will be given training on the Mental Capacity Act at induction and at regular intervals thereafter". The electronic system showed that 2 staff members, the practice nurse and a nurse who had started work the week of our inspection, had completed training. In addition, we saw evidence in their personnel file that the nurse practitioner had completed training in 2014. There was no record of any other staff member being trained; the practice manager told us they were aware of the requirement, but it had not been done. The Duru Practice Safeguarding Children, Young People and Adults Policy which had been put in place by NHS Oldham Clinical Commissioning Group (CCG, now the Integrated Care Partnership) stated "At present, all clinical and professionally registered staff must complete Mental Capacity Training and Deprivation of Liberty Safeguards (DoLS) as part of the mandatory e-learning pack". This had not been adhered to. • We asked to review a selection of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. The lead GP said they only had one such decision in place. They told us this had been put in place by the hospital and they did not hold a copy of it for us to review. They told us they were looking at having a system, so they would have a copy of any DNACPR decisions on their records. 	

Caring

Rating: Requires improvement

At the last inspection on 11 November 2016, we rated the practice as good for providing caring services. At this inspection we rated the question requires improvement:

- A patient had been asked to register with a new practice when they made a complaint.
- There were no internal patient surveys, and the NHS website was not checked for patient comments. This was a missed opportunity to identify where improvements could be made.
- The website did not contain information about support groups, including for carers or the bereaved.
- Confidentiality could be an issue in the reception area.

Kindness, respect and compassion

Staff usually treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Practice staff had attended an Oldham Central Primary Care Network (PNC) training session on transgender health in May 2023.• The practice manager told us they had the Pride in Practice Gold award. The LGBT Foundation Pride in Practice programme worked with GP practices to ensure that all lesbian, gay, bisexual and trans people had access to inclusive healthcare that understood and met the needs of communities.• We saw an example of a patient being asked to register with a different GP practice as a result of them making a formal complaint about the lead GP.	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	78.2%	80.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	74.9%	80.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	89.9%	90.9%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	65.7%	63.2%	72.4%	No statistical variation

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Any additional evidence

The practice manager told us they did not carry out their own patient surveys and they did not check the NHS website to see if patients had made any comments or suggestions about their practice.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	81.8%	87.6%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	N
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had access to British Sign Language interpreters and used a telephone interpreter service when patients did not speak English as a first language. The practice manager told us larger print leaflets could be accessed if required and information on the website could be translated. Due to the practice being on the same floor as other GP practices in a large building they were unable to keep patient information leaflets in the waiting area. This was in line with the policy of the building management company. Some leaflets, mainly clinical leaflets, were in consultation rooms for clinical staff to distribute to appropriate patients. 	

Carers	Narrative
Percentage and number of carers identified.	The practice manager told us they had 72 carers registered. This was 1.8% of the practice population.
How the practice supported carers (including young carers).	The practice manager was unaware of any young carers. They told us carers were offered a health check. Some information for carers was available on the practice website.
How the practice supported recently bereaved patients.	The focused care worker could provide support if required.

Privacy and dignity

The practice did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was no dedicated private room available, but staff would find an unoccupied room or quiet area if this was required for a patient.• The practice was one of 5 GP practices on a floor of a large building. The reception desks were in a row next to each other. We observed telephone calls from patients being taken by staff on the reception desk, but we noted identifiable information was not given while we observed. However, when patients were at the reception desk confidentiality was difficult due to the proximity of other patients.	

Responsive

Rating: Inadequate

At the last inspection on 11 November 2016, we rated the practice as good for providing responsive services. At this inspection we rated the question inadequate:

- Appointments were difficult to access unless patients could get through on the telephone or attend the practice.
- Only on the day appointments were available.
- Complaints were not handled appropriately and there was a lack of transparency in complaints' handling.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice manager told us they had not done any analysis of the needs of the local population, but the Integrated Care Partnership (ICP) sometimes provided them with information. • The times of appointments were flexible to meet the needs of patients. The lead GP amended the times of their surgery when required, and the practice nurse, who was contracted to work 4.5 hours a week, started their surgery at 7.30am to meet the needs of those going to work. • All staff except the lead GP had completed training in the Accessible Information Standard. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm

Thursday	8am – 6.30pm
Friday	8am – 6.30pm
GP Appointments available:	
Monday	8am – 1.20pm and 4pm – 6.30pm
Tuesday	8am – 1.20pm and 4pm – 6.30pm
Wednesday	8am – 1.30pm and 4pm – 6.30pm
Thursday	8am – 1.30pm and 4pm – 6.30pm
Friday	8am – 1.30pm and 4pm – 6.30pm
Nurse appointments	
Monday	none
Tuesday	7.30am - 1pm
Wednesday	10am – 12.30pm
Thursday	12.30pm – 1.30pm
Friday	none

Further information about how the practice is responding to the needs of their population

- A new practice nurse started work the week of our inspection. When trained, they would be working 30 hours a week and available Monday to Friday.
- Appointments were available via an enhanced service in the same building as the GP practice. These were 6.30pm until 8pm Monday to Friday and 9am until 5pm on Saturday.
- Patients had a named GP who supported them in whatever setting they lived.
- Parents or guardians calling with concerns about a child were usually offered a same day appointment when necessary. Where this was not possible paediatric appointments were available as an enhanced service in the area so children could be seen daily.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

Access to the service

People were usually able to access care and treatment in a timely way but some issues were identified.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	N
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice manager told us access by telephone was their biggest complaint from patients. However, they held no data about the number or trend of these complaints. Appointments could only be made by telephone or by attending the reception desk. However, the website stated appointments could be accessed online. The practice manager told us this was incorrect. Appointments could only be made on the day, and routine appointments for a convenient day in the future were not available. The practice manager told us that when the appointments for each day were full, patients who stated their need was urgent went on a message book for the lead GP. The lead GP triaged these patients and booked them an appointment if they deemed it appropriate. 	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	42.2%	N/A	52.7%	No statistical variation

The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	48.3%	45.5%	56.2%	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 (01/01/2022 to 30/04/2022)	62.5%	48.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	72.3%	63.9%	71.9%	No statistical variation

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.	Unclear
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw no evidence of learning from complaints. There was no data about the number of complaints, the types of complaints received, and any areas of improvement required following complaints. The Complaints Policy 2022 stated, "The practice manager is the person who will handle the receipt, communication to complainant, the recording of the detail, investigation, and distribution of any finding from the complaint". However, the practice manager told us they dealt with verbal complaints and the lead GP dealt with all written complaints. The practice manager told us there had been no written complaints in the last year. We examined the last 2 written complaints, both handled by the lead GP: <ul style="list-style-type: none"> A written complaint dated 7 March 2022 was regarding care provided by the lead GP. The lead GP investigated the complaint and responded in writing on 11 April 2022 stating they had reviewed the care and they were satisfied with it. The letter included "I hope you will reflect on 	

contents of letter and see that your care needs have not been neglected in any way". The response letter did not contain information on how the service user could escalate their complaint.

- A written complaint dated 27 April 2022 was regarding a missed telephone consultation and attitude from staff and the lead GP. The lead GP investigated the complaint and responded in writing on 5 May 2022. The lead GP acknowledged the telephone consultation had been missed, stating others had been missed by a locum GP on the same day. They disagreed with the patient's comments about them and stated they were sure the appropriate decision and treatments were given. They also asked the patient to register with another GP practice, stating the doctor-patient relationship had been damaged. The response letter did not contain information on how the service user could escalate their complaint. The practice's complaints policy stated, "the person making the complaint is entitled to have confidence that their care and treatment will not be affected as a result of making a complaint".
- The complaints policy stated, "All staff will be given training on handling complaints at induction and annually thereafter". Most staff had received training, but this had not been completed by the lead GP.
- The practice manager told us they dealt with all verbal complaints, and they did not record these anywhere other than the patient records. We saw that since the written complaints documented above, 3 further complaints were recorded on the electronic system, with 2 of these recorded as being written. The practice manager told us these were all verbal complaints, and they included them on the electronic system as they were trying to move to the electronic system, but they were mostly unrecorded.
- We saw the minutes of the last 3 practice meetings, in August 2022, October 2022 and April 2023. The October 2022 minutes stated there had been no formal complaints, but patients were still unhappy with the telephone lines. There was no recorded discussion about complaints in the other 2 meetings.

Well-led

Rating: Inadequate

At the last inspection on 11 November 2016, we rated the practice as good for providing well-led services. At this inspection we rated the question inadequate. We identified several areas of concern, including:

- A lack of governance and monitoring.
- Ineffective systems and processes.
- Leaders had not identified the risks we found during the inspection.
- Poor performance had not been identified and acted on.
- Policies were not followed and did not contain enough information to provide relevant guidance.
- There were no formal systems for managing risks.
- Information such as from complaints was not recorded and acted on to drive improvement.
- Staff were unsure about raising concerns about patient care and did not know of improvements made following patient feedback.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders were not always aware of the risks, issues, and challenges in the service.• Although the lead GP and practice manager told us about the challenges they had faced, they had not identified the issues we found during the inspection.• There was no leadership development programme; appraisals were not routinely held so conversations about staff development were rare.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Prior to the inspection we asked the practice for their mission statement. They told us their mission statement was, "The Duru Practice is here to deliver a comprehensive range of health care services to our patients as stipulated in the Primary Medical Services Contract. We aim to treat investigate and follow up our patients to the best that we can according to the National and Local guidance provided by NHS England. Our goal is to be safe and improve lives both young and old. We are committed to treating our patients with respect irrespective of their age, sex, ethnic origin, social-economic class". The practice had a Personal, not Primary, Medical Services contract.• The practice had a different mission statement on their website: "A holistic approach is at the heart of everything we do. We aim to provide a high quality of healthcare, backed by an efficient and effective service, responsive to patient demand and accessible to all".• Not all staff were aware if the practice had a vision for the future, and we saw no evidence of a vision or strategy during the inspection or during our discussion with the lead GP and practice manager.• Staff reported that their views were listened to but not always acted on.• Patients were not consulted about aspects of the practice.	

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.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
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.	N
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	N
The practice encouraged candour, openness and honesty.	N
The practice had access to a Freedom to Speak Up Guardian.	Y*
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Some staff feedback reported that staff were unsure it would be welcomed if they raised concerns about safe patient care. • We saw examples of poor performance, in that some staff did not complete required training, sometimes for several years. This had not been acknowledged during the infrequent appraisals and there were no arrangements in place to make improvements. • The lead GP investigated and responded to complaints about them with no input from anyone else at the practice and no independent scrutiny. • We saw an example of a significant event where a discussion in August 2022 had highlighted that a meeting with the patient would be held and an apology made. This had not occurred at the time of the inspection. • Not all staff were aware that there was a Freedom to Speak Up Guardian. • Not all staff, including the lead GP, had undertaken training in equality and diversity. 	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Explanation of any answers and additional evidence: The arrangements for governance were not clear and did not operate effectively. Examples of this included:	
<ul style="list-style-type: none">• The practice manager worked 30 hours a week. They told us there was no deputy, but staff could contact them at any time by telephone if they needed advice.• Staff meetings were irregular. The 3 most recent staff meetings were in August 2022, October 2022, and April 2023.• The practice leaflet was available on the practice website. This contained outdated information; opening hours and surgery hours were incorrect; the practice nurses had changed, and it gave details of a walk-in centre that no longer existed.• The practice had 2 safeguarding policies. One did not name the safeguarding lead and the other named the incorrect staff member. Staff were not trained in line with the policy.• Recruitment checks were not carried out in line with the safeguarding policy.• The infection control policy did not name the infection control lead. Staff were not trained in line with the policy.• Although an infection control audit had been carried out in January 2023 it had failed to identify areas of concern.• Complaints were not carried out in line with the complaints policy.• Other training was not carried in line with practice policy.	

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.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice supplied us with their undated business continuity and recovery plan. This stated, “Every staff member will receive training relating to responding to incidents and events at least on an annual basis”. No staff member had been trained. • There were no formal effective processes in place to manage risks. Although an infection control audit had been carried out this was not accurate. There was no effective health and safety risk assessment. • There was no quality improvement programme in place. The practice manager told us a clinical pharmacist had carried out some prescribing audits, but they had left so no others would be carried out until a new pharmacist started work. • The practice manager managed the Quality and Outcomes Framework. This was an award and incentive programme for GP practices. • The performance of staff was not assessed or challenged. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The system of recognising, recording, monitoring, and learning from significant events, learning events and complaints was not effective. 	

- Complaints were not routinely recorded, and formal complaints had been investigated and responded to by the person the complaint was about. Performance information was therefore not available, so staff and management were not held to account.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

The practice did not involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	N
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice manager told us they collected patient's responses to the NHS Friends and Family Test. We saw their collated responses. These had not been formally discussed by the practice and there was no evidence they had been used to improve the service. The practice manager told us they did not have a Patient Participation Group (PPG) and they had not had one since they started work in November 2018. The practice had a virtual PPG at our inspection in November 2016, and this had been used for gathering feedback from patients, carrying out surveys and putting action plans in place following the national GP patient survey. The practice manager stated they were thinking about having a PPG as a collective with the other GP practices in the building but at the time of the inspection nothing was in place. 	

- As part of the inspection, we asked staff for their feedback about the practice. Not all staff felt their views were acted on. In addition, staff were unable to give us any examples of changes made as a result of patient feedback.

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.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw no examples of continuous learning and improvement. • There was no formal process in place to assess clinical or non-clinical staff. • Staff appraisals were not high priority at the practice. There was a gap of 5 years between the appraisals of the nurse practitioner. The practice nurse had their first appraisal the week prior to our inspection, 18 months after they started work. The practice manager had their first appraisal 4 years after they started work. We saw 3 members of the non-clinical team had had an appraisal the week prior to our inspection. For 1 of these it was their first appraisal and they had worked at the practice nearly 5 years. For another there had been a 5-year gap between appraisals. We saw 1 staff member last had an appraisal 6 years ago. • Complaints were not routinely recorded or discussed so there was no evidence of learning. We saw an example of a significant event where learning was required. In October 2022, staff had been reminded not to prop open fire doors. During our inspection we observed this was still happening. 	

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. 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.