

# Care Quality Commission

## Inspection Evidence Table

**Dr Philip Olufunwa (1-489369890)**

**Inspection date: 11 August 2022**

### Overall rating: Not rated

We carried out this inspection to follow-up a warning notice issued after our previous inspection on 1 April 2022. We focused specifically on recruitment processes; assessment and mitigation of environmental risks; readiness for medical emergencies; clinical oversight; the management of patients with long-term conditions; staffing levels and medicines management. We did not rate any key questions at this inspection.

### Safe

### Rating: Not rated

#### Safety systems and processes

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
Explanation of any answers and additional evidence:  The practice was in the process of completing all necessary recruitment checks including retrospective checks for staff in post where necessary. This had not yet been completed.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 20/09/2021 Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence:  The practice provided the same partial evidence in relation to fire safety procedures that had been presented at the previous inspection in April 2022.	

The landlord had commissioned health and safety and fire safety risk assessments for the building as a whole but it was not always clear from these who was responsible for carrying out recommended actions. For example, the fire risk assessment referred to some clinical areas of the practice being outside the scope of the assessment. The practice could not assure us that all relevant fire risks within the clinic had been appropriately assessed.

Following the inspection, the practice submitted its own fire risk assessment (dated 16/08/2022) which identified areas for action, for example staff training and when these would be completed. This also clarified the practice and landlord's respective responsibilities in relation to fire safety.

## 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.	Y
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	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We were told that the practice had recently not had sufficient doctors available on the staff rota to provide enough appointments to meet patient needs. Reception staff told us they had to regularly advise patients with primary care needs to contact the '111' service or attend an urgent care centre. Staff told us that working at the practice was stressful in these circumstances and was a contributing factor to staff turnover.</li> <li>The day after the inspection, the practice provided assurance that one of the regular doctors had returned from leave and they were providing clinical sessions.</li> <li>At the time of our inspection the practice had just secured the services of an experienced interim practice manager who would be available two days every week at the practice to support the existing staff team.</li> <li>We reviewed the stock of emergency medicines, the emergency equipment and the monitoring procedures in place and found these were now satisfactory.</li> </ul>	

## 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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.69	0.59	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	7.5%	8.8%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.57	5.57	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	142.5‰	57.8‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.71	0.46	0.59	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	15.0‰	4.8‰	6.8‰	Variation (negative)

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
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Y
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.	Y
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. <sup>2</sup>	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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> <ul style="list-style-type: none"> <li>At our previous inspection, we noted that the practice was prescribing above average levels of hypnotic and psychotropic medicines. The practice had not yet investigated the reasons for this.</li> <li>The practice had improved its monitoring of patients prescribed higher risk medicines. We checked the records for patients prescribed a type of immunosuppressant (methotrexate) and for patients prescribed specific medicines to affect blood pressure (ACE inhibitors or angiotensin II). This had improved although we found some instances where the appropriate monitoring was overdue in the case of ACE inhibitors or angiotensin II.</li> </ul>	

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

The practice did not have an effective 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.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	0
Number of events that required action:	0
Explanation of any answers and additional evidence: The practice had a system to learn and make improvements when things went wrong but this had only recently been introduced. The practice had not fully responded to the concerns we identified at the previous inspection in April 2022.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a system for recording and acting on safety alerts and we found that the practice had now fully implemented a recent alert on the prescribing of citalopram (a medicine used to treat low mood or panic attacks). This had improved since our previous inspection.</li> <li>• However, we found that the practice was not consistently implementing all recent alerts. For example, that the practice was not consistently prescribing mirabegron (a medicine used to treat the symptoms of an overactive bladder) in line with current guidelines.</li> </ul>	

## Effective

## Rating: Not rated

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.

### Management of people with long term conditions

#### Findings

We saw evidence of improvement of management of some long-term conditions since our previous inspection in April 2022. However, there were 34 patients diagnosed with diabetic retinopathy whose blood sugar levels were not well controlled. We reviewed ten of these patients and seven were overdue monitoring. In three cases the patients had not responded to invitations and were likely to have left the area but this had not been satisfactorily investigated prior to this inspection.

#### Effective staffing

**The practice was not always able 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.	Y
The practice had a programme of learning and development.	Y
There was an induction programme for new staff.	Y
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>The practice had experienced some staff performance issues. We were told that these had now been resolved. These issues had contributed to a period of high staff turnover. Staff we spoke with told us they did not yet have confidence in the new management team.</li><li>The lead GP told us they provided regular supervision and oversight for members of the clinical team. They had not yet started documenting this although it was a concern we identified at the previous inspection.</li></ul>	

## Responsive

Rating: Not rated

### Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	N
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	Y
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)	Y
Explanation of any answers and additional evidence:  The practice did not always have effective arrangements in place to cover clinician absence and this impacted on the ability to offer timely access to appointments.	

## Well-led

Rating: Not rated

### 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.	Partial
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• At this inspection, we found that the practice had made some improvements but it had not fully acted on the findings of the previous inspection.</li><li>• Staff reported that the lead GP was approachable but that practice management arrangements had been insufficient to provide them with appropriate support to carry out their roles effectively.</li><li>• However, the lead GP had a clear and realistic plan to expand clinical and managerial leadership at the practice. They had sought external support to help secure the future of the service and had also engaged the NHS commissioning team about planned changes to the NHS contract. This was a significant development since our previous inspection. We were assured that there was a clear succession plan and this was being implemented.</li></ul>	

### Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
The practice had continued to experience high managerial and administrative staff turnover since our previous inspection. Staff told us they were expected to take over the responsibilities of departing staff members with little notice and without adequate preparation or support. For example, one person told us they were now responsible for the administration of 'two-week wait' referrals but had not been trained or supported to implement a monitoring process to ensure that these patients received and attended their specialist appointment.	



The new incoming interim practice manager provided evidence to show that additional training had been given on referrals the week after the inspection.

## Managing risks, issues and performance

### There were 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.	Y
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
There were gaps in some policies, procedures and documentation, for example in relation to recruitment. The lead GP was confident that they had secured additional management support to complete a thorough review but this was not yet complete.	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
We saw evidence that the practice had made some but not all the necessary improvements to address the concerns identified at our previous inspection. The practice had identified a change of ownership as the main driver for longer term improvement and was in the process of merging with another partnership.	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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