

# Care Quality Commission

## Inspection Evidence Table

**Dr Anita Sharma (1-501039840)**

**Inspection date: 22 April 2021**

### **Overall rating: Inadequate**

The overall rating for this practice is inadequate.

Dr Anita Sharma was placed into special measures following an inspection on 14 June 2019. The practice was removed from special measures and rated good in all key questions following an inspection on 7 February 2020.

We carried out a focused inspection on 20 January 2021. This was following a Transitional Monitoring Approach (TMA) assessment where possible risks to patient safety had been identified. Although a rating was not awarded following the focused inspection breaches of regulation were identified. We issued warning notices in respect of breaches of Regulation 12 (safe care and treatment) and Regulation 17 (good governance), and a requirement notice in respect of a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Since the January 2021 inspection the practice manager had left and a new practice manager had been appointed in February 2021.

This inspection, on 22 April 2021, was a full comprehensive inspection. The practice had informed us in writing prior to the inspection that the actions required, detailed in the warning notices and requirement notice, had been complied with and completed. Our findings contradicted this. We have rated the practice as inadequate in the key questions safe, effective and well-led, requires improvement in the key question responsive, and good in the key question caring. We found continued breaches of Regulations 12 (safe care and treatment), 17 (good governance) and 19 (fit and proper persons employed).

The practice has been placed into special measures and further enforcement action has been taken.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

# Safe

# Rating: Inadequate

The practice is rated inadequate for providing safe services. We identified several areas of concern including: clinical staff were not correctly authorised to administer certain medicines; some patients prescribed high risk medicines were not being appropriately monitored; checks on the competence, training and experience of clinical staff were not routinely undertaken prior to them working at the practice; not all pre-recruitment checks were carried out; some significant event forms had been misplaced and full investigations had not been carried out.

## Safety systems and processes

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

| Safeguarding  | Y/N/Partial |
|---|-------------|
| There was a lead member of staff for safeguarding processes and procedures.   | Yes         |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff.  | No          |
| There were policies covering adult and child safeguarding which were accessible to all staff.   | No          |
| Policies and procedures were monitored, reviewed and updated.   | No          |
| Partners and staff were trained to appropriate levels for their role.   | Partial     |
| There was active and appropriate engagement in local safeguarding processes.  | Yes         |
| The Out of Hours service was informed of relevant safeguarding information.   | Yes         |
| There were systems to identify vulnerable patients on record.   | Yes         |
| Disclosure and Barring Service (DBS) checks were undertaken where required.   | Partial     |
| Staff who acted as chaperones were trained for their role.  | Yes*        |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.  | Yes         |
| Explanation of any answers and additional evidence:   |             |
| Staff had a good understanding of safeguarding and knew how to access the policy for more in-depth information. We asked the practice for their policy for safeguarding children and vulnerable adults. The policy supplied to us was headed 'South Chadderton Heath Centre, Dr Sharma Safeguarding Lead'. The information in the policy related to a different GP practice, with lead roles assigned to GPs in the other practice. |             |
| Evidence of safeguarding training was supplied for the majority of staff, but no evidence of training for the practice manager was held.  |             |

| Safeguarding  | Y/N/Partial |
|---|-------------|
| <p>We saw evidence that Disclosure and Barring Service (DBS) checks were held for staff. However, the pharmacist, who saw patients face to face unsupervised, held a standard, not an enhanced, DBS check.</p> <p>*One staff member told us they did not currently chaperone. They said they had not been trained at this practice but had been trained previously. We saw chaperone training was one of 54 training courses they completed over a period of two days, two weeks prior to the inspection.</p> |             |

| Recruitment systems   | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).   | Partial     |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.   | No          |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.   | No          |
| <p>Explanation of any answers and additional evidence:</p> <p>At the inspection of 20 January 2021 we found gaps in the systems for recruiting new staff. At this inspection we examined the files of staff who had started work since 20 January 2021. We found appropriate action had not been taken.</p> <p>The recruitment policy had been updated 4 February 2021. The policy gave comprehensive guidance to follow when recruiting staff, including having a full employment history, reasons for leaving previous employment when relevant, obtaining references covering five years of previous employment usually from the previous two employers and obtaining documentary evidence of professional registration. It also stated a satisfactory health declaration was required.</p> <p>We found that not all staff who had been recruited since our previous inspection had provided a full employment history. Evidence of professional registration was not routinely requested; the practice had no evidence that the pharmacist had ever been registered (NB our subsequent checks found a current provisional registration). References were not always sought in accordance with the practice's recruitment policy. Up to date registration information was not held for all locum GPs. Health declarations were not held in the personnel files we examined.</p> <p>The newly appointed practice manager had found that no evidence of staff vaccination was maintained. Although this was not in place at the time of the inspection, we saw evidence a system was in place to monitor this and staff had had blood tests to determine their immunity.</p> |             |

| Safety systems and records  | Y/N/Partial |
|---|-------------|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: 15 October 2020   | Y           |
| There was a record of equipment calibration.<br>Date of last calibration: 3 March 2021  | Y           |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.   | Y           |
| There was a fire procedure.   | Y*          |
| A fire risk assessment had been completed.<br>Date of completion: 13 April 2021   | Y           |
| Actions from fire risk assessment were identified and completed.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>*The practice manager told us they had identified the need for more fire wardens. The current fire warden finished work mid-afternoon daily and they were aware that other staff who had received fire warden training had since left. The practice manager had been previously trained as a fire warden and intended to have updated training and take on the role.</p> <p>Not all staff had received training in fire safety.</p> |             |

| Health and safety  | Y/N/Partial |
|--|-------------|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: N/A  | N           |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: N/A   | N           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice manager showed us the file from NHS Property Services that included details about the safety of the building. However, they had not been able to locate any health and safety risk assessments for the area of the building specifically used by the practice. The practice manager told us they intended to carry out a health and safety risk assessment but did not say when.</p> <p>During the inspection we observed an oxygen cylinder stood against a trolley in the reception area. It was not appropriately secured.</p> |             |

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were usually met.

|  | Y/N/Partial |
|--|-------------|
| There was an infection risk assessment and policy.   | Yes*        |
| Staff had received effective training on infection prevention and control.   | Partial     |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 9 March 2021   | Y           |
| The practice had acted on any issues identified in infection prevention and control audits.  | NA          |
| There was a system to notify Public Health England of suspected notifiable diseases.   | Y*          |
| The arrangements for managing waste and clinical specimens kept people safe.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>*The practice supplied us with their infection control risk assessment that had been updated 2 February 2021. The policy stated the infection control leads were the lead GP and the practice nurse. The practice nurse told us they were not the lead and that they were a locum practice nurse working two sessions a week.</p> <p>The infection control policy did not include all the required information. It did not include information about what training was required and the appropriate intervals between training, or the management of outbreaks of communicable diseases and the reporting of notifiable infections to Public Health England (PHE). It also did not include details of infection prevention and control professionals in the area. Relevant staff told us they were aware of the system for notifying PHE.</p> <p>Evidence was not held of all staff receiving training in infection prevention and control. These staff included the practice manager, both locum GPs and the pharmacist who gave injections to patients. Some staff told us additional in-house training in infection prevention and control was provided at the beginning of the Covid-19 pandemic. The practice had made changes to the premises as a result of the Covid-19 pandemic. Patients were asked to only attend the practice if requested to do so by the practice.</p> |             |

## 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. | Partial     |

Explanation of any answers and additional evidence:

Although the lead GP told us there was cover for staff, for example if they were on annual leave, this was not corroborated by other staff. There were four staff members on the administration and reception team; two for reception, a secretary and a senior administrator. The practice manager explained that the senior administrator was able to cover all other roles but there were not enough suitably trained or experienced staff to cover for them.

We saw evidence that all staff except the two long-term locum GPs had received sepsis training.

We saw a recent example of a patient with a potentially serious illness telephoning the practice for an appointment in the morning. They were given a telephone appointment for later in the afternoon and a GP had not been made aware of the seriousness of the request. A significant event had been raised.

**Information to deliver safe care and treatment**

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

|   | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | 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.     | Y           |
| There was a documented approach to the management of test results and this was managed in a timely manner.                                      | Y           |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.  | Y           |

Explanation of any answers and additional evidence:

We saw that the lead GP actioned test results. These were up to date on the day of the inspection.

## Appropriate and safe use of medicines

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

| Indicator  | Practice | CCG average | England average | England comparison       |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)   | 0.79     | 0.88        | 0.76            | 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). (01/01/2020 to 31/12/2020) (NHSBSA)                                       | 12.8%    | 7.9%        | 9.5%            | 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 (01/07/2020 to 31/12/2020) (NHSBSA) | 4.87     | 4.27        | 5.33            | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)  | 159.2‰   | 183.3‰      | 127.0‰          | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)   | 0.37     | 0.95        | 0.67            | 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           |
| 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).                               | N           |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.           | N           |
| 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           |

| Medicines management  | Y/N/Partial |
|---|-------------|
| 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.   | N           |
| 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           |
| 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 PHE guidance to ensure they remained safe and effective.   | Partial     |
| <p>Explanation of any answers and additional evidence:</p> <p>At the inspection of 20 January 2021 we found gaps in the cold chain records of the fridge used to store vaccines. At this inspection we saw evidence that the concerns had been acted on. A new system was in place to ensure the fridge temperature was checked and details recorded daily.</p> <p>We were made aware of an incident in late 2020 where vaccinations had been left out of the vaccination fridge for an unacceptable period. Several staff members confirmed that a significant event had been raised, but information on this could not be found at the practice. Meeting minutes where the significant event had been discussed could also not be found. We discussed this with the lead GP. They told us they had no records of the significant event, but they had checked with the pharmacy and the supplier and the vaccines had not been returned. The provider told us they knew the vaccines had not been put in the fridge and used, but at the time of the inspection they had not requested the vaccine batch numbers to check patients had not been given this vaccine. Following the inspection the provider found the vaccines in the vaccine fridge They were annotated "Do not use".</p> <p>At the inspection of 20 January 2021, we found that not all clinicians were appropriately authorised to administer certain medicines. At this inspection we found appropriate action had not been taken, and medicines were still being administered by unauthorised clinicians.</p> <p>A Patient Specific Direction (PSD) is a written instruction, signed by a prescriber, to allow medicines to be administered to a named patient. The prescriber must assess each patient. Patient Group Directions (PGDs) are signed by a prescriber to allow healthcare professionals to administer specified medicines to a group of patients. We found the pharmacist had signed a number of PSDs and PGDs. The lead GP told us this was because they administered flu vaccinations and nasal flu vaccines, then said they may have been asked to sign them because the Care Quality Commission (CQC) were attending. Pharmacists are able to work under PGDs, so a PSD is not required.</p> <p>We examined two of the PSDs for the pharmacist. They had been signed by the pharmacists and the lead GP in March 2021. We checked these against the patient records and found the vaccinations had been given in January 2021. They were therefore not valid.</p> |             |



We examined the PGD file. We saw that locum GPs had signed PGDs. Locum GPs do not require a PGD because they are authorised prescribers.

Of the PGDs we examined we saw that the pharmacist was named on three separate PGDs for the flu vaccine. The lead GP had authorised one of these in February 2020 and two in November 2020. On each occasion the pharmacist was added on 27 January 2021. The GP had not countersigned these additions, so the pharmacist was not authorised to administer the vaccines. In addition, we saw that on five occasions the practice nurse was added to a PGD between five and 12 months following authorisation by the lead GP. As found during the inspection of 20 January 2021, they were not authorised to administer these vaccines.

As part of the inspection a number of set clinical record searches are 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.

Of the five patients prescribed Methotrexate (an immunosuppressant) there was no evidence that three patients had all the required monitoring. Of the five patients prescribed Azathioprine (an immunosuppressant) there was no evidence that one had the required monitoring. Of the seven patients prescribed Lithium (used to treat mood disorders) there was no evidence that six had all the required monitoring. We looked at the number of patients prescribed ACE inhibitor or Angiotensin II receptor blockers (used to treat high blood pressure, heart and kidney problems). We saw that these were prescribed for 392 patients, and there was no evidence that 59 of these had all the required monitoring carried out.

Following our meeting with the lead GP to give feedback on the inspection, we emailed the lead GP to ask them to let us know what action had been taken following these findings. We asked for a response by 5pm the following working day. They told us they could not give a response due to other commitments and the earliest they could respond would be four working days later. On 29 April 2021 the lead GP sent us a response. This stated that all patients who required monitoring had been contacted and relevant appointments had been made. They sent us documentation of their learning points which included a shared care protocol being in patients' notes and blood tests results being recorded in patients' notes irrespective of where the blood tests were carried out.

We saw that medicine reviews had been noted as being completed, but a record of what the reviews consisted of was not routinely recorded.

Following the inspection the lead GP sent us new policies they had put in place around the monitoring of high risk medicines. These had been put in place following the inspection.

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

The system to learn and make improvements when things went wrong was not effective.

| Significant events  | Y/N/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:  | 6*          |
| Number of events that required action:  | 6*          |
| Explanation of any answers and additional evidence:   |             |
| <p>The staff we spoke with were aware of how to raise concerns and we saw the system for recording significant events (SEAs). We saw that SEAs were discussed in meetings and areas of learning were recorded.</p> <p>Although we were provided with a spreadsheet detailing SEAs from 2017, we found not all SEAs had been recorded. A SEA had been raised in late 2020 as vaccines had been left out of the fridge for an unacceptable period. Details of the SEA could not be located and at the time of the inspection it was not known what had happened to the vaccines. The lead GP told us they had not been returned to the pharmacy or the supplier. Although the lead GP told us they had not been used they were unable to provide evidence of this and a check against vaccinated patients had not been made.</p> <p>During an interview with the lead GP as part of the inspection they made us aware of another significant event from January 2021. This had not been recorded on the SEA spreadsheet and no documentation was in the SEA file we examined.</p> <p>We saw SEA documentation from June 2020 where a patient had telephoned the practice asking for an appointment for a potentially serious illness. They had not been prioritised and received a routine GP telephone call. In April 2021 this happened again. SEAS were discussed in meetings and learning disseminated.</p> |             |

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

| Event   | Specific action taken  |
|---|--|
| <p>April 2021. A patient telephoned the practice in the morning with potentially life-threatening symptoms. They were given a telephone appointment for later in the afternoon. The patient then attended the surgery and an ambulance was subsequently called.</p> | <p>This was discussed in a staff meeting. Staff were informed they must ask patients how long they had had the symptoms and a GP must be informed of this urgently. It is noted in the meeting minutes that the patient was advised to call 999 by reception staff but they refused. The likelihood of the incident being repeated is noted as unlikely.</p> |
| <p>June 2020. A patient telephoned the practice with potentially life-threatening symptoms. They were given a routine GP telephone appointment. When the GP telephoned them an urgent hospital admission was arranged.</p>  | <p>This was discussed in a meeting. Reception staff were told they must ask patients how long they have had the symptoms and a GP must be informed immediately.</p>  |

| Safety alerts  | Y/N/Partial    |
|--|----------------|
| <p>There was a system for recording and acting on safety alerts.</p>   | <p>Partial</p> |
| <p>Staff understood how to deal with alerts.</p>   | <p>Partial</p> |
| <p>Explanation of any answers and additional evidence:</p> <p>We were told that all safety alerts were distributed to all relevant staff. Some staff received alerts directly by email.</p> <p>As part of the remote searches carried out by the CQC GP specialist advisor the responses to two Medical and Healthcare products Regulatory Agency (MHRA) alerts were checked.</p> <p>Five patients had been prescribed Amlodipine and Simvastatin of 40mg or more. For two of these patients there was no explanation in their records and no evidence they had been informed of the risks. Following the inspection the lead GP told us these two patients had been contacted and their medicine changed. We also looked at the alert for Februxistat and risk in those with major cardiovascular disease. We found one relevant patient on this medicine and there was no evidence they had been informed of the risk.</p> |                |

## Effective

## Rating: Inadequate

The practice is rated inadequate for providing effective services. We identified several areas of concern including: the on-going clinical needs of patients were not managed consistently due to required monitoring not always taking place; patients with poor mental health had consultations with a pharmacist who had not provided evidence of being sufficiently trained; patients with potentially missed diagnoses were found; no formal checks were carried out on the competence of clinicians.

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed in a safe way. Care treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

|  | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice.                             | Partial     |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | No          |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.               | No          |
| We saw no evidence of discrimination when staff made care and treatment decisions.   |             |
| Patients' treatment was regularly reviewed and updated.  | No          |
| There were appropriate referral pathways to make sure that patients' needs were addressed.   | Yes         |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.                               | Partial     |

#### Explanation of any answers and additional evidence:

Although information about current evidence-based practice was issued to clinicians we found this was not always followed. An example is that patients had been prescribed potentially dangerous medicine combinations with no documented explanation or evidence patients had been informed of the risk.

As part of the inspection a number of set clinical records searches are 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. We found examples of required monitoring not taking place.

Reception staff had been directed to book patients experiencing symptoms such as anxiety and depression, post-traumatic stress disorder, suicidal thoughts or any psychiatric problem to the pharmacist who worked at the practice. However, no evidence was held or had been sought to confirm they had experience or training in these areas. The provider told us they did not hold anything in writing

about their training, qualifications or experience in mental health. We saw an example of the pharmacist having a consultation with a patient suffering discomfort following an operation. There was no evidence in the patient records that infection had been excluded. The provider told us their role was to supervise the pharmacist, but they said they had not kept any supervision records.

## Older people

## Population group rating: Inadequate

### Findings

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The majority of administrative staff had received dementia training. However, evidence was not held of clinical staff receiving this training.
- Health checks, including frailty assessments, were usually offered to patients over 75 years of age. However, the practice manager told us these had not been carried out as often during the Covid-19 pandemic, and the low number of hours worked by the practice nurse and healthcare assistant had also impacted on this.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. However, not all clinical staff had been correctly authorised to administer these vaccinations.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- The practice told us patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, we found that some required monitoring had not taken place. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Our checks found examples of potentially missed diabetes diagnoses.

| Long-term conditions  | Practice   | CCG average | England average | England comparison                   |
|---|------------|-------------|-----------------|--------------------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020)<br>(QOF)                                  | 86.9%      | 78.2%       | 76.6%           | Tending towards variation (positive) |
| PCA* rate (number of PCAs).   | 17.0% (39) | 9.5%        | 12.3%           | N/A                                  |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020)<br>(QOF) | 92.0%      | 89.2%       | 89.4%           | No statistical variation             |
| PCA rate (number of PCAs).  | 16.3% (17) | 7.1%        | 12.7%           | N/A                                  |

| Long-term conditions   | Practice   | CCG average | England average | England comparison       |
|--|------------|-------------|-----------------|--------------------------|
| The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020)<br>(QOF)     | 88.0%      | 81.2%       | 82.0%           | No statistical variation |
| PCA rate (number of PCAs).   | 3.8% (3)   | 4.0%        | 5.2%            | N/A                      |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020)<br>(QOF)            | 75.8%      | 63.8%       | 66.9%           | No statistical variation |
| PCA rate (number of PCAs).   | 23.3% (40) | 9.4%        | 15.3%           | N/A                      |
| The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020)<br>(QOF)               | 77.6%      | 70.3%       | 72.4%           | No statistical variation |
| PCA rate (number of PCAs).   | 3.6% (14)  | 6.1%        | 7.1%            | N/A                      |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020)<br>(QOF) | 93.6%      | 92.1%       | 91.8%           | No statistical variation |
| PCA rate (number of PCAs).   | 6.0% (3)   | 3.6%        | 4.9%            | N/A                      |

|  |          |       |       |                          |
|--|----------|-------|-------|--------------------------|
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 83.6%    | 73.1% | 75.9% | No statistical variation |
| PCA rate (number of PCAs).   | 4.1% (7) | 7.5%  | 10.4% | N/A                      |

### Any additional evidence or comments

On the advice of Public Health England (PHE) the practice had paused in-house spirometry and asthma reviews during the Covid-19 pandemic. They told us patients were given advice on how to chart peak flow readings.

As part of the searches carried out by the CQC GP specialist advisor some patients with a potential missed diagnosis of diabetes were identified. Some patients had been advised they were diabetic and received diabetic medicine, but their records were not coded as them being diabetic. This meant they were not recalled for standard diabetic checks.

## Families, children and young people

## Population group rating: Inadequate

### Findings

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- The latest verified childhood immunisation data is shown below. The practice provided up to date information that over 90% of one and two-year olds had received the required vaccinations and 83% of children had received their pre-school vaccinations. These figures are unverified.
- The practice contacted the parents or guardians of children due to have childhood immunisations. In addition, if a parent missed a vaccination appointment, they received a telephone call.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Staff had the appropriate training to carry out reviews for this population group.
- Young people could access services for sexual health and contraception.

| Child Immunisation   | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 45        | 46          | 97.8%      | Met 95% WHO based target        |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)  | 34        | 36          | 94.4%      | Met 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. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)  | 33        | 36          | 91.7%      | Met 90% minimum                 |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)   | 34        | 36          | 94.4%      | Met 90% minimum                 |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)  | 38        | 40          | 95.0%      | Met 95% WHO based target        |

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

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

## Population group rating: Inadequate

### Findings

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- The practice told us they had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Repeat medicines could be ordered on-line.
- The practice's website indicated patients could book appointments on-line. However, staff told us appointments were booked by telephone.



| Cancer Indicators  | Practice | CCG average | England average | England comparison       |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/09/2020) (Public Health England) | 71.8%    | N/A         | 80% Target      | Below 80% target         |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)   | 65.1%    | 65.6%       | 70.1%           | N/A                      |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)   | 61.4%    | N/A         | 63.8%           | N/A                      |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)  | 100.0%   | 91.7%       | 92.7%           | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)  | 71.4%    | 54.1%       | 54.2%           | No statistical variation |

#### Any additional evidence or comments

The most recent verified data is shown above. We checked the current cervical screening data as part of the inspection. The unverified data shows that 70% of 25 to 49 year olds and 81% of 50 to 64 year olds were up to date with their cervical screening.

#### People whose circumstances make them vulnerable

#### Population group rating: Inadequate

#### Findings

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice employed a healthcare assistant with experience of end of life care.
- The practice referred relevant patients to a substance misuse service.
- The practice was a Homeless Friendly practice. However, not all staff were aware that patients without an address could register as a permanent patient.

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

**Population group rating: Inadequate**

**Findings**

Although we saw some good practice in this population group it is rated inadequate due to concerns identified overall in the effective key question. These impacted on all population groups.

- Reception staff had been directed to book patients experiencing symptoms such as anxiety and depression, post-traumatic stress disorder, suicidal thoughts or any psychiatric problem with the pharmacist who worked at the practice. However, no evidence was held or had been sought to confirm they had experience or training in these areas.
- Of seven patients prescribed a named medicine for mood disorders, six had not received the required monitoring.
- Patients could self-refer to Health Minds and Healthy Young Minds. These support services could help with concerns such as difficulty sleeping, low mood, depression, stress and panic attacks.
- Same day and longer appointments were offered when required.
- The majority of administrative staff had received dementia training. However, evidence was not held of clinical staff receiving this training.

| <b>Mental Health Indicators</b>   | <b>Practice</b> | <b>CCG average</b> | <b>England average</b> | <b>England comparison</b> |
|---|-----------------|--------------------|------------------------|---------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 96.2%           | 79.8%              | 85.4%                  | No statistical variation  |
| PCA rate (number of PCAs).  | 0.0% (0)        | 9.1%               | 16.6%                  | N/A                       |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>  | 91.7%           | 79.1%              | 81.4%                  | No statistical variation  |
| PCA rate (number of PCAs).  | 0.0% (0)        | 4.8%               | 8.0%                   | N/A                       |

## Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

| Indicator                                      | Practice | CCG average   | England average |
|--|----------|---------------|-----------------|
| Overall QOF score (out of maximum 559)         | 548.44   | Not Available | 533.9           |
| Overall QOF score (as a percentage of maximum) | 98.1%    | Not Available | 95.5%           |
| Overall QOF PCA reporting (all domains)        | 5.3%     | Not Available | 5.9%            |

|  | Y/N/Partial |
|--|-------------|
| Clinicians took part in national and local quality improvement initiatives.  | Y           |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Y           |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.                               | Y           |

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

At the inspection of 20 January 2021, we found a gap in the monitoring of urgent referrals made to secondary care. At this inspection we saw the practice had carried out an audit to ensure all referrals had been made at the required time. This had been repeated and the lead GP told us regular checks would be made. Results were positive.

The practice had carried out an audit on babies attending their eight-week assessment. This had been re-audited on 8 April 2021 and no appointments had been missed.

## Effective staffing

The practice was unable to demonstrate that all 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.  | Y           |

|  |         |
|--|---------|
| Staff had protected time for 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. | Partial |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.         | 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:

A pharmacist had been working at the practice for two days a week. Reception staff had been provided with a list of which patients he could have consultations with based on their symptoms. The practice did not hold and had not sought evidence of the pharmacist's skills, knowledge or experience. They held evidence of their Master of Pharmacy, and some other training certificates, but not enough information to determine they could safely perform their given role.

The lead GP told us they reviewed the work of the pharmacist after each surgery, but they told us they had not kept any record of this, and they had no records of any supervision.

We asked the lead GP how they checked the competence of clinicians, such as the regular GP locums. They told us they had not done this, but they intended to bring in a system to check random consultations within the following two weeks.

We saw that evidence was held of administrative staff completing mandatory training. There was no evidence of the practice manager completing all the required training, including safeguarding children and vulnerable adults, infection prevention and control and fire safety. They explained that they had been in post since February 2021 and other urgent work had taken priority. However, they told us they had completed the training previously in other employment and they would complete the required training as soon as possible. Although there was a system to monitor training, we saw that training was not always effective. One staff member told us they had not completed a specific training course at this practice. We checked their training records and found it was one of 54 training courses completed in two days, two weeks prior to the inspection.

Clinical staff had received training in safeguarding children and vulnerable adults. There were gaps in evidence of other mandatory training for clinical staff such as the long-term locum GPs and the pharmacist.

The practice manager had been in post since February 2021. The majority of administrative staff had received regular appraisals and the new manager was in the process of booking staff in for appraisals. New administrative staff had a period of induction with regular meetings with the manager.

### Coordinating care and treatment

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

| Indicator   | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y           |
| Patients received consistent, coordinated, person-centred care when they moved between services.                    | Y           |

### Helping patients to live healthier lives

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

|  | Y/N/Partial |
|--|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.  | Y           |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health.  | Y           |
| 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:<br><br>The practice manager explained that although health assessments usually took place some had been delayed due to the Covid-19 pandemic. In addition, the practice nurse and healthcare assistant worked a small number of hours and this had impacted on the ability to carry out some checks. The practice told us they were in the process of recruiting a new practice nurse who would start during May 2021. |             |

## Consent to care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y           |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.       | Y           |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.                   | Y           |

# Caring

Rating: Good

## Kindness, respect and compassion

Staff 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.  | Y           |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.   | Y           |
| Explanation of any answers and additional evidence:   |             |
| <p>The administrative staff we spoke with were knowledgeable about their patient population and the help available to them in the local area. We were told about assistance provided during the Covid-19 pandemic. Administrative staff had gathered information so they could direct patients to the most suitable source of assistance.</p> <p>Items for a local food bank were collected by the practice. The practice also had a period poverty scheme and had free sanitary products available in the toilets. Staff, the patient participation group (PPG) and patients also contributed to a period poverty charity both personally and by raising money through book sales at the practice.</p> |             |

## National GP Survey results

| Indicator   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)                   | 87.6%    | 85.7%       | 88.5%           | 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 (01/01/2020 to 31/03/2020) | 82.8%    | 84.6%       | 87.0%           | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their   | 93.8%    | 93.8%       | 95.3%           | No statistical variation |

| Indicator   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)                          |          |             |                 |                          |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020) | 85.8%    | 76.6%       | 81.8%           | No statistical variation |
| Question  |          |             |                 | Y/N                      |
| The practice carries out its own patient survey/patient feedback exercises.   |          |             |                 | Y                        |

#### Any additional evidence

The practice had carried out a patient survey in March 2021. This had a response rate of 75% and patients responded positively to the questions asked.

#### 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           |
| Explanation of any answers and additional evidence:  |             |
| Administrative staff were knowledgeable about services in the local area and were able to direct patients to the most appropriate service for their needs. |             |

#### National GP Survey results

| Indicator  | Practice | CCG average | England average | England comparison       |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020) | 86.7%    | 89.8%       | 93.0%           | 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.   | N*          |
| Information about support groups was available on the practice website.   | Y           |
| Explanation of any answers and additional evidence:   |             |
| *Leaflets were not available due to the Covid-19 pandemic. However, information was available on the practice's website and the practice was able to supply patients with the information they required for their needs. The information could be printed individually for patients or sent to them by email. |             |

| Carers  | Narrative  |
|---|--|
| Percentage and number of carers identified.                 | 81 carers had been identified, which is 2.4% of the practice population  |
| How the practice supported carers (including young carers). | Staff told us that carers' health checks were usually carried out, but these had not been as often due to the Covid-19 pandemic. |
| How the practice supported recently bereaved patients.      | Recently bereaved patients were referred to a bereavement service in the area if required.                                       |

## Privacy and dignity

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

|  | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Y           |
| Consultation and treatment room doors were closed during consultations.  | Y           |
| 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.   | Y           |

## Responsive

## Rating: Requires improvement

The practice is rated requires improvement for providing responsive services. This is due to complaints not being adequately managed.

### 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. | Y           |
| 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           |

| Practice Opening Times  |  |
|---|--|
| Day   | Time   |
| Opening times:  |  |
| Monday  | 8am - 6.30pm   |
| Tuesday   | 8am - 6.30pm   |
| Wednesday   | 6am - 6.30pm   |
| Thursday  | 8am - 6.30pm   |
| Friday  | 8am - 6.30pm   |
| Appointments available:   |  |
| Monday  | GP 9am – 12.30pm and 3pm – 6.30pm<br>Nurse 8am – 12 noon |
| Tuesday   | GP 9am – 12.30pm and 3pm – 6.30pm                        |
| Wednesday   | GP 6am – 12 noon and 2pm – 6pm<br>Nurse 2pm – 6pm        |
| Thursday  | 9am – 12.30pm and 3pm – 6pm                              |
| Friday  | 9am – 12.30pm and 3pm – 6pm                              |
| Patients were also able to pre-book appointments at a choice of three locations in the Oldham area outside these times. Appointments were available Monday to Friday 6.30pm – 8pm and 10am – 2pm Saturday and Sunday. |  |

## Older people

## Population group rating: Requires improvement

### Findings

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- The practice employed a healthcare assistant with experience of palliative care.
- Palliative care meetings where patients were discussed with a multi-disciplinary team had been paused. The practice manager told us they were in the process of setting these up again.
- Care and treatment for people with long-term conditions was coordinated with other services.

## Families, children and young people

## Population group rating: Requires improvement

### Findings

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- The practice nurse started at 8am one day a week and worked until 6pm on another day so school age children did not need to miss school.
- An appointment was kept free each day for children under the age of five years.

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

**Population group rating: Requires improvement**

**Findings**

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- The practice was open from 6am one day a week.
- Pre-bookable appointments were available at three locations in the area between 6.30pm and 8pm Monday to Friday and between 10am and 2pm during the weekend.

**People whose circumstances make them vulnerable**

**Population group rating: Requires improvement**

**Findings**

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- Although staff were unaware of a homeless register, the practice manager told us homeless patients did attend the practice and they were able to permanently register. Not all staff we spoke with were aware of this.
- Translation services were available for patients who did not speak English as a first language. Deaf interpreters were also available.

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

**Population group rating: Requires improvement**

**Findings**

Although we saw some good practice in this population group it is rated requires improvement due to concerns identified overall in the responsive key question. These impacted on all population groups.

- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Priority appointments were available when necessary for those experiencing poor mental health.
- Reception staff had been directed to book patients experiencing symptoms such as anxiety and depression, post-traumatic stress disorder, suicidal thoughts or any psychiatric problem to the pharmacist who worked at the practice. However, no evidence was held or had been sought to confirm they had experience or training in these areas.

## Access to the service

### People were usually able to access care and treatment in a timely way.

National GP Survey results

|   | Y/N/Partial |
|---|-------------|
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages).   | Y           |
| Patients were able to make appointments in a way which met their needs.   | Y           |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).   | Y*          |
| There were systems in place to support patients who face communication barriers to access treatment.  | Y           |
| Patients with urgent needs had their care prioritised.  | Partial     |
| The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.   | Partial     |
| <p>Explanation of any answers and additional evidence:</p> <p>The reception team had been given a list of patients who could be booked with the pharmacist directly. The list included conditions such as anxiety and depression, suicidal thoughts, post-traumatic stress disorder and general health enquiries. However, they did not hold and had not sought any evidence him being suitably trained to give advice on these conditions.</p> <p>We saw two examples of patients with the same potentially life-threatening condition being booked in for a routine telephone appointment. Significant events had been raised following these.</p> <p>*From the beginning of the Covid-19 pandemic all patients requesting an appointment with a GP received a telephone call from the GP. If it was felt that a face to face appointment was required, the GP invited them to the surgery.</p> <p>The practice's website gave information on health conditions and services available in the area.</p> |             |

| Indicator   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020) | 80.4%    | N/A         | 65.2%           | No statistical variation |

| Indicator  | Practice | CCG average | England average | England comparison       |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)          | 59.3%    | 57.2%       | 65.5%           | 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 (01/01/2020 to 31/03/2020) | 56.5%    | 57.2%       | 63.0%           | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)  | 68.1%    | 63.7%       | 72.7%           | 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.   | Unknown |

|  | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available.   | Y           |
| There was evidence that complaints were used to drive continuous improvement.  | N           |
| Explanation of any answers and additional evidence:  |             |
| <p>The practice provided us with a copy of their complaint's policy dated 4 February 2021. This stated all complaints should be directed to the practice manager. It also stated that the CQC Responsible Individual had overall responsibility for complaints. Meeting minutes from 4 February 2021 document that staff were informed all complaints should be directed to a named member of the administrative team and passed to the lead GP if they could not be dealt with by the administrative team member. This contradicted what was stated in the policy dated the same day.</p> <p>The meeting minutes of 4 February 2021 stated there had been no complaints. However, we saw evidence that a complaint was made in writing dated 29 January 2021. The minutes of the following meeting on 4 March also did not mention this complaint. Handwritten on the top of this complaint letter was "Coming to see me [date provided]". Nothing else was recorded and there was no evidence kept of any conversation with the complainant or any final response.</p> |             |

We saw another complaint dated 12 February 2021 that was received by email. A complaint form was completed that indicated the patient was happy. There was no record of any conversation with the patient or any final response.

The practice manager confirmed that they had dealt with these complaints in person and no written response had been made.

We asked about other complaints made in the previous 12 months. The practice was aware of four complaints. However, they could only find documentation of complaints from the year 2017-2018. They could not locate any other complaints so there was no evidence any complaints had been dealt with in a satisfactory manner.

We saw no examples of learning from complaints.

## Well-led

## Rating: Inadequate

The practice is rated inadequate for providing well-led services. We identified several areas of concern including: the practice had not made the improvements required following the inspection of 20 January 2021; significant events and complaints information was missing so the practice could not be sure appropriate action had been taken; there was no Freedom to Speak Up Guardian; some policies were inaccurate, lacked the required detail, or were not being followed; there was no system to identify staffing risks; the required training of clinical staff was not monitored; the issues found during the inspection had not been identified by the practice. In addition, the practice has previously been rated inadequate and placed into special measures. The improvements they made following that inspection were not sustained.

### 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.  | Partial     |
| Explanation of any answers and additional evidence:   |             |
| The practice had been rated inadequate following an inspection in June 2019. The practice was rated good in February 2020 but following an unrated inspection on 20 January 2020 further warning notices and a requirement notice were issued. This inspection found that not all the breaches of regulation brought to the attention of the lead GP in January 2021 had been rectified. Further areas of concern were found that the practice had been unaware of. |             |
| The lead GP told us about a succession plan that would be in place within the following six months. Our subsequent enquiries found that the information we had been provided with was inaccurate.   |             |

### Culture

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

|   | Y/N/Partial |
|---|-------------|
| Staff reported that they felt able to raise concerns without fear of retribution.     | Y           |
| 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 had access to a Freedom to Speak Up Guardian.   | N       |
| Staff had undertaken equality and diversity training.  | Partial |
| Explanation of any answers and additional evidence:  |         |
| <p>The staff we spoke with told us they felt well-supported by the practice manager. However, we also heard that returning from annual leave could be stressful as there was not the staffing capacity for all jobs to be covered during these times.</p> <p>We saw that some records of complaints and significant events had gone missing within the practice, with no evidence being held of relevant discussions taking place. We could not therefore be assured that the requirements of the duty of candour were being met. In particular, the practice had not fully investigated the location of vaccinations that had been left outside the vaccine fridge so there was no assurance they had not been administered to patients.</p> <p>The practice did not have a Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian gives independent support and advice to staff who want to raise concerns. Some staff had not heard of a Freedom to Speak Up Guardian and the lead GP was unsure if they had one.</p> <p>Some staff had completed training in equality and diversity. However, there was no evidence of training for practice manager, practice nurse, pharmacist or either of the long-term locum GPs.</p> |         |

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

| Source           | Feedback  |
|------------------|---|
| Staff interviews | The administrative staff we spoke with told us they worked well as a team. The more experienced team member was always willing to help other staff who felt able to approach them when required. We also heard that the new practice manager was very supportive and understood the issues caused by staff shortages. |

#### 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 were appropriate governance arrangements with third parties.          | Y           |

Explanation of any answers and additional evidence:

Some of the information on the website, such as policies, was out of date. The website also stated the practice employed a specialist palliative care nurse. This staff member was employed as a healthcare assistant.

Although we saw policies were being updated, they were not always correct. The practice nurse was listed as being one of the infection prevention and control leads but they were not aware of this. Sufficient information was not detailed in the policy for infection control and the detail in the safeguarding policy referred to another GP practice. Other policies were not being followed, including the recruitment policy and complaints policy.

We examined the records of significant events held at the practice. However, the provider made us aware of other significant events that had taken place. They were unable to provide evidence of these being recorded or investigated.

## 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           |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | N           |

Explanation of any answers and additional evidence:

We did not find evidence that comprehensive assurance systems were in place. A CQC GP specialist advisor carried out a number of clinical records searches. We found examples of patients not having all the required monitoring and examples of patients prescribed potentially dangerous combinations of medicines. The lead GP was not aware of this.

Following our inspection of 20 January 2021, the lead GP had not monitored the improvements required. The same breaches of regulations were found during this inspection, and there were no quality improvement initiatives.

The lead GP told us they did not currently formally monitor clinical staff, but they intended to put a system in place in the following two weeks.

**The practice had some systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

|  | Y/N/Partial |
|--|-------------|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.  | Y           |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.  | Y           |
| There were systems in place to identify and manage patients who needed a face-to-face appointment.   | Y           |
| The practice actively monitored the quality of access and made improvements in response to findings.   | N           |
| There were recovery plans in place to manage backlogs of activity and delays to treatment.   | Partial     |
| Changes had been made to infection control arrangements to protect staff and patients using the service.   | Y           |
| Staff were supported to work remotely where applicable.  | Y           |
| Explanation of any answers and additional evidence:  |             |
| <p>The practice had carried out a risk assessment of staff needed and supported staff who were required to shield to work from home during the Covid-19 pandemic.</p> <p>The practice manager had only been in post since February 2021. They told us the quality of access had not yet been monitored but this would be put in place.</p> |             |

**Appropriate and accurate information**

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

|   | Y/N/Partial |
|---|-------------|
| Performance information was used to hold staff and management to account.   | N           |
| There were effective arrangements for identifying, managing and mitigating risks.   | N           |
| Staff whose responsibilities included making statutory notifications understood what this entails.  | Y           |
| Explanation of any answers and additional evidence:   |             |
| <p>There was no formal monitoring of clinical staff. The lead GP told us they would put this in place, but at the time of the inspection there was no evidence of using performance information to hold staff to account. There was no evidence of mandatory training for all clinicians.</p> |             |

The lead GP had not identified risks found during this inspection. We saw that a pharmacist had unaccompanied consultations with patients for a variety on symptoms but there was no evidence he was trained for this or was working within his competency.

## Governance and oversight of remote services

|   | Y/N/Partial |
|---|-------------|
| 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           |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y           |
| The practice advised patients on how to protect their online information.                           | Y           |

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

**The practice involved 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.   | Y           |
| The practice had an active Patient Participation Group.  | Y           |
| Staff views were reflected in the planning and delivery of services.   | Y           |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.   | Y           |
| Explanation of any answers and additional evidence:  |             |
| <p>We saw the practice had carried out a patient survey in March 2021. This had a 75% response rate and results were positive.</p> <p>There was an active patient participation group (PPG). The PPG had not been as active as normal during the Covid-19 pandemic, but they had started to have on-line meetings. The PPG was involved in charity work and helped with social isolation, for example by arranging cooking classes on-line. Exercise classes had also been arranged.</p> |             |

## Continuous improvement and innovation

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

|  | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement.   | N           |
| Learning was shared effectively and used to make improvements.   | N           |
| Explanation of any answers and additional evidence:<br><br>We saw no examples of continuous learning and improvement.<br><br>Prior to this inspection we received assurance from the lead GP that they had taken the action required to be compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that this was not the case.<br><br>A number of complaints and significant events had gone missing so evidence of any required learning was not available.<br><br>We found that information provided to us during the inspection was sometimes conflicting. This included the employment status of the pharmacist. The pharmacist contacted us to tell us they had left the practice, but the practice told us they were completing some training then returning. In addition, we found that the succession plan described by the lead GP was not accurate. |             |

## 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 CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- $\%$  = per thousand.