

# Care Quality Commission

## Inspection Evidence Table

**Heston Practice (1-4829977258)**

**The Great West Surgery (1-4829976965)**

Inspection date: 6 December 2018

Date of data download: 4 December 2018

## Overall rating: Inadequate

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

### Safe

**Rating: Inadequate**

#### 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.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	No
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	No
There was active and appropriate engagement in local safeguarding processes.	Yes
Systems were in place to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	No
Disclosure and Barring Service (DBS) checks were undertaken where required	Yes
Staff who acted as chaperones were trained for their role	Yes
There were regular discussions between the practice and other health and social care	Yes

Safeguarding	Y/N/Partial
professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Clinical staff were trained to an appropriate level for their role. However, two newer members of the administrative staff had not yet received safeguarding training. These staff members were, on occasion, working alone on reception and at least one had been in post for two months.</li> <li>• The practice had a system to alert staff to patients known to be at risk of abuse. However, there was no separate register of these patients to facilitate regular review.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who required medical indemnity insurance had it in place.	Yes

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: November 2018	Yes
There was a record of equipment calibration. Date of last calibration: November 2018	Yes
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure in place.	Yes
There was a record of fire extinguisher checks. Date of last check: December 2018	Yes
There was a log of fire drills. Date of last drill: Not known	No
There was a record of fire alarm checks. Date of last check: December 2018	Yes
There was a record of fire training for staff. Date of last training:	Yes
There were fire marshals in place.	Yes
A fire risk assessment had been completed. Date of completion: June 2017	Yes
Actions from fire risk assessment were identified and completed.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Staff were unable to recall whether there had been a fire drill. We were told that this was the responsibility of the property management company to organise given that multiple services were provided from the premises at Heston. Staff were clear about the fire evacuation procedure and the assembly points at both the main and branch sites.</li> <li>A copy of the fire risk assessment was held at the practice. We were told that the property management company was responsible for implementing the recommendations. However, some of the recommendations were clearly marked for the attention of the occupying tenants (for example, overloaded power sockets). The managers could not provide evidence that the practice had responded to all of these recommendations.</li> </ul>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: Not seen	No
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Not seen	No
Explanation of any answers and additional evidence:	

We were told that the property management company had conducted appropriate premises and security risk assessments but the practice did not hold a copy which they could show us during the inspection. The practice staff did not record their own health and safety monitoring checks.

The provider submitted a copy after the inspection of the risk assessments carried out by an external security firm in relation to the provision of security to the special allocation service. This did not include a more general assessment of the environmental risks faced by practice staff or patients and the wider safety of the premises.

## Infection prevention and control

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

	Y/N/Partial
An infection risk assessment and policy were in place.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit: None seen	No
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
The responsibility for infection control across the main and branch sites had recently been allocated to a member of the nursing team. They had not yet carried out an infection control audit and the practice could not show us any previous audit.	

## 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.	No
There was an effective induction system for temporary staff tailored to their role.	No
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	No
There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No
Explanation of any answers and additional evidence:	

- The practice had not reviewed recent guidelines on managing sepsis with clinicians and staff. Receptionists had not been given guidance on identifying deteriorating or acutely unwell patients. The receptionists told us they would bring any patients they considered to be seriously unwell to the immediate attention of the clinicians on duty. There were times when the reception staff worked alone at the branch surgery. They told us that in this event, they would call an ambulance in line with practice policy. All staff had completed basic life support training.
- We were concerned that the centralised and regional management teams were not adequately assessing risks to staff and patient safety. For example, the branch practice was located in a multipurpose centre. When the provider had originally taken on the contract, there were several corporate tenants occupying the building. Aside from a pharmacy on the ground floor, the building was now occupied solely by the branch practice. Staff told us they felt at risk in this quiet environment, particularly working alone on reception or alone in the practice in the evening.
- In response to staff concerns, the managers had re-circulated the existing lone working policy to staff. The provider had also recently engaged an external security company to provide a security guard and further security risk assessments. The management had not carried out any wider risk assessment of patient and staff safety in the light of changes, staff concerns or following recent incidents of aggression involving patients of the special allocation service which operated from the branch practice.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	No
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The management of test results was tracked through the electronic records system. Staff told us that results were not always managed in a timely way with backlogs of around 250 items having recently built up due to a lack of GP and administrative capacity. The provider had recently increased the number of GP sessions and had appointed a lead GP (full-time) who had cleared the most recent backlog. The GP lead told us they planned to train the administrators to be able to take some of the administrative workload involved in processing test results away from the GPs. This action was still in the planning stage with no detailed action plan or timetable for implementation.</p>	

## Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process in place for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures in place 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.	No
For remote or online prescribing there were effective protocols in place for verifying patient identity.	N/A
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.	No
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	No
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance	Yes



Medicines management	Y/N/Partial
to ensure they remained safe and effective.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Prescription stationery was securely stored and only accessible to staff members. The practice did not have a system to track prescription stationery by serial number.</li> <li>• The provider checked relevant qualifications and training when appointing or recruiting independent medical prescribers but systems for ongoing supervision and monitoring of relevant competencies had lapsed.</li> <li>• The provider was not systematically carrying out structured medicines reviews with patients who were prescribed multiple medicines. Patients and staff reported some disorganisation in the provision of repeat prescriptions leading to delays for patients.</li> <li>• Staff told us that workflow requests (including changes to patients' medicines) were not always acted on promptly with backlogs building up. We were told that this was improving following an increase in GP staffing. On the day of the inspection, there were around 50 'tasks' waiting to be cleared on the electronic records system.</li> <li>• The practice did not carry out audits of prescribing including the prescribing of controlled drugs or antibiotic prescribing. It received benchmarking data from the clinical commissioning group but had not actively reviewed this or developed any action plan in response. The newly recruited lead GP told us this sort of quality monitoring was part of their job role and something they were planning to introduce.</li> <li>• The practice did not have emergency medicines at the branch site (The Great West Surgery) to deal effectively with anaphylaxis. There were local monitoring arrangements in place to check emergency medicines at both the main and branch sites. However, the provider had not responded, for example, to local requests to replace an expired medicine.</li> </ul>	

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

### The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	6
Number of events that required action:	6
<p>Explanation of any answers and additional evidence:</p> <p>There was an incident reporting system with any incidents being reported by email to the regional and central management teams. The provider had recently appointed a lead GP who told us they saw their role as including local leadership for incident reporting, feedback and learning.</p> <p>We saw evidence that concerns raised by staff had not always been acted on in a timely way. For example, there had been several incidents involving the special allocation service at the branch site. Staff had raised safety concerns in writing but had not received a timely, direct response to indicate that these concerns were being taken seriously. We received an action plan in relation to this service after requesting more information following the inspection.</p>	

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

Event	Specific action taken
Delay in ordering expired paediatric pads for the defibrillator	The ordering process had been changed to enable alternative suppliers to be used and a back-up set of pads had been ordered.
Power cut led to practice closing two hours early	Staff liaised with patients to rearrange appointments. Business continuity plan followed to ensure premises and equipment were secured. Practice was able to reopen the following day.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	Not monitored
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians received safety alerts electronically. The practice did not have an effective system for ensuring that these were acted on. The newly appointed lead GP had identified this as a risk and had recently run a search to identify female patients of childbearing age who had been prescribed a medicine with known risks in pregnancy. The search had identified some patients in this 'at risk' category and their treatment had now been reviewed. The lead GP told us they intended to improve</p>	

the practice systems for acting on safety alerts but had not yet developed an action plan to put this in place.

## Effective

## Rating: Inadequate

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice largely relied on individual clinicians (and patients) to instigate reviews and update treatment as appropriate. The quality and outcomes framework (QOF) triggered the practice to invite patients with longer term conditions for review towards the end of the financial year but the practice had high exception reporting rates for this programme, potentially reducing its reliability as a recall mechanism. The lead GP and managers told us they did not know why exception reporting rates were so high and we were unable to ascertain if these rates were justified.</li><li>• The lead GP told us that reviews and care planning were not yet being systematically carried out for older patients and patients with longer term conditions.</li></ul>	

## Older people

## Population group rating: Inadequate

### Findings

- Clinicians had access to an appropriate tool to identify patients aged 65 and over living with moderate or severe frailty. Those identified as being frail had a clinical review.
- However, there was little evidence of a systematic and proactive approach to meeting this population group's needs. For example, the practice did not routinely offer annual health checks or medication reviews to older patients and had not reviewed rates of polypharmacy (that is, where patients may be at risk of adverse effects associated with taking multiple medicines).
- The practice did not routinely provide follow-up after hospital discharge.

## People with long-term conditions      Population group rating: Inadequate

### Findings

- The practice could not demonstrate that it was systematically providing patients with long-term conditions with a structured annual review to check their health and medicines needs were being met. The lead GP told us this was an area for improvement.
- The practice tended to score highly on the quality and outcomes framework for its management of long-term conditions. However, the practice also recorded consistently high exception reporting rates for these indicators. The lead GP and managers told us they did not know why exception reporting rates were so high and we were unable to ascertain if these rates were justified.
- For patients with the most complex needs, we were told that the GPs worked with other health and care professionals to deliver a coordinated package of care. The practice had introduced care planning for patients with diabetes but did not routinely use written care plans for patients with other longer-term conditions. There were monthly multi-disciplinary team meetings to which the local community nurse representatives were invited.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk. The practice scored below the national average for the proportion of these patients who were treated appropriately.

## Any additional evidence or comments

The standard CQC performance analysis was unavailable for this practice. The following data was obtained from the 2017/18 Quality and Outcomes Framework results published by NHS Digital.

## Diabetes indicators

**The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	89.0%	76.1%	78.8%
Exception rate	27.3%	7.6%	13.2%

**The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	83.7%	76.5%	77.7%
Exception rate	37.2%	7.8%	9.8%

**The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	87.1%	77.3%	80.1%
Exception rate	23.8%	7.9%	13.5%

## Other long-term conditions

**The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	73.8%	77.3%	76.0%
Exception rate	13.3%	3.0%	7.7%

**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 (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	94.9%	88.3%	89.7%
Exception rate	33.9%	17.4%	11.5%

**The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	85.6%	82.5%	82.6%
Exception rate	18.2%	3.7%	4.2%

**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 (01/04/2017 to 31/03/2018)**

	Practice	CCG average	England average
	71.9%	88.6%	90.0%
Exception rate	6.6%	4.7%	6.7%

**Families, children and young people**  
**Indequate**

**Population group rating:**

#### Findings

- Childhood immunisation uptake rates for the two-year old cohort were below the World Health Organisation (WHO) targets. The practice was able to supply vaccines suitable for vegetarian and vegan patients.
- The practice had arrangements in the form of standard templates to identify and review the treatment of newly pregnant women on long-term medicines. The practice had recently carried out a review of female patients of child bearing age who had been prescribed a higher risk medicine.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and the clinicians would liaise with health visitors when necessary.

Child Immunisation	Practice	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)	92.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018)	80.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018)	82.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018)	82.4%	Below 90% minimum

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

**Population group rating:**

### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had high exception reporting rates for cervical screening. The staff told us this was due to cultural factors. There was a paper-based system to check that results were received for all tests taken and that any abnormal results were followed up.

**People whose circumstances make**



**them vulnerable**  
**Inadequate**

**Population group rating:**

### Findings

- Individual clinicians liaised with relevant professionals to provide coordinated end of life care. The practice had not reviewed whether it was providing end of life care in line with current best practice and did not routinely develop care plans with these patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had identified patients who were carers including young carers and maintained a register. However, some staff were unclear about what they could offer carers, for example, in relation to priority for appointments.
- The practice was commissioned to run a special patient allocation service from The Great West Surgery. We found that this service was not being run safely. Staff training needs had not been assessed; staff said they did not feel supported in providing the service and had been vulnerable to attack. Staff did not have access to clear protocols about operating the service. There had been several incidents within the last six months involving challenging behaviour.
- The provider had identified the special patient allocation service as a risk and had recently engaged an external security firm to provide a security guard at The Great West Surgery.

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

**Population group rating:**

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing opportunistic access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. The practice was not systematically calling these patients for a review.
- The practice did not have a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice was unable to explain the high exception rate reporting for some mental health indicators which undermined their performance monitoring.

## Any additional evidence or comments

### Mental Health Indicators

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 (01/04/2017 to 31/03/2018)

	Practice	CCG average	England average
	74.4%	89.9%	89.5%
Exception rate	41.8%	10.1%	12.7%

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018)

	Practice	CCG average	England average
	100.0%	93.1%	90.0%
Exception rate	6.0%	6.0%	10.5%

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018)

	Practice	CCG average	England average
	84.0%	76.4%	78.5%
Exception rate	0%	8.2%	6.6%

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	534.7	540.6	537.5
Overall QOF clinical exception reporting	23.1%	8.0%	10.1%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No

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

- The lead GP was developing an audit programme and had conducted first stage cycles of six clinical audits. The lead GP had also started to hold meetings with the clinical staff to review performance and identify areas for improvement.
- For example, the lead GP had carried out the first stage audit of the management of diabetes care within the practice. In contrast to the practice's published performance for diabetes on the Quality and Outcomes Framework, the audit had showed that the practice was not performing as well as other practices in the area with a similarly diverse population. The results had been discussed in a clinical meeting and the practice was using a dashboard tool provided by the clinical commissioning group to monitor its adherence to good practice guidelines. The lead GP planned to repeat the audit periodically in 2019.

## Effective staffing

The practice was 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	No
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	No
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence:	
The provider had a programme of mandatory training which was monitored.	
Staff views about opportunities for training and development were more mixed. Administrative members of staff told us that they had not received induction training despite requesting this since joining the practice. These members of staff were expected to work alone on reception. Administrative staff also told us they felt insufficiently prepared and supported to provide the special allocation service.	
Some staff members told us they felt more positive since the appointment of a lead GP and thought this would drive better clinical team working and development opportunities locally.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams	Yes

and organisations, were involved in assessing, planning and delivering care and treatment.	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	No
Patients received consistent, coordinated, person-centred care when they moved between services.	No
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence that individual GPs coordinated the care provided to patients and liaised with other professionals and with each other.</p> <p>However, there were some organisational barriers to the provision of coordinated care including recent examples when 'workflow tasks' (including letters from other professionals) had become backlogged on the electronic records system which had led to delays.</p> <p>The practice had an opportunistic approach to care planning for patients which potentially reduced opportunities to coordinate care. For example, only three patients had been listed on the palliative care register although thirty seven patients had died over the previous year. Some patient complaints and concerns related to experiences of poor coordination.</p> <p>The provider had recently appointed a lead GP. The lead GP told us they planned to review and improve clinical systems in place for planning and coordination.</p>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The health care assistant had recently qualified and was able to provide health care support and advice.</li> <li>• The practice was participating in a local scheme to identify patients at risk of developing diabetes.</li> <li>• The clinicians were aware of local social prescribing opportunities.</li> </ul>	

### Any additional evidence or comments

#### Smoking Indicator

The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months

	Practice	CCG average	England average
Exception rate	97.0%	96.1%	95.1%
	1.0%	0.8%	0.8%

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

# Caring improvement

Rating: Requires

## Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: The practice provided care to a diverse population of patients. Staff were committed to providing care that respected patients' rights, beliefs, preferences and individual autonomy and were able to provide examples.	

CQC comments cards	
Total comments cards received.	12
Number of CQC comments received which were positive about the service.	4
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	3

Source	Feedback
Comment cards	Patients were consistently complimentary about the capability and competence of the clinical staff at the practice.
Comment cards	Patients consistently described the staff as kind and helpful.
Staff interviews	When asked what they thought the practice did well, staff singled out the regular GPs for providing patient-centred care.



## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9029	418	105	25%	1.2%

Indicator	Practice	CCG average	England average
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 (01/01/2018 to 31/03/2018)	79%	85%	89%
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 (01/01/2018 to 31/03/2018)	80%	83%	87%
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	90%	93%	96%
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	71%	80%	84%

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

### 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

### National GP Survey results

Indicator	Practice	CCG average	England average
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 (01/01/2018 to 31/03/2018)	83%	90%	93%

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	No
<p>Explanation of any answers and additional evidence:</p> <p>The most recent national patient survey results showed that the majority of patients were positive about the quality of their experience, in particular patients reported high confidence and trust in their healthcare professional. However, the practice's results were consistently below the local and national averages for overall patient experience.</p> <p>The practice website was undergoing redevelopment. It did not yet contain information about local support groups but did include information about common health conditions and the services provided by the practice. The website included a translation facility.</p>	

Carers	Narrative
Percentage and number of carers identified.	51 (<1%)
How the practice supported carers.	We were told that carers had priority access to appointments and were advised about local carers services. Not all staff were clear about this however.
How the practice supported recently bereaved patients.	Responsible GP provided support and signposting to specialist bereavement services.

## 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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

## Responsive

## Rating: Inadequate

### Responding to and meeting people's needs

### Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	No
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had extended its opening hours in addition to providing more GP sessions by opening on Saturday morning. The Saturday appointments were proving popular with patients.</li> <li>*The practice used locum GPs to fill the staff rota and this reduced the practice's ability to provide continuity of care to patients who valued this. The practice did not have a plan in place to address this issue.</li> <li>In the 2018 national GP patient survey, 27% of practice patients reported being able to see or speak to their preferred GP when they would like to. This compared to the CCG average of 48% and the national average of 50%.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Saturday (Heston Practice only)	8am-12.00pm
Appointments available:	
Monday	8.30am-6pm
Tuesday	8.30am-6pm
Wednesday	8.30am-6pm
Thursday	8.30am-6pm
Friday	8.30am-6pm
Saturday	8.30am-11.45am



## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9029	418	105	25%	1.2%

Indicator	Practice	CCG average	England average
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	92%	93%	95%

### Older people

### Population group rating: Inadequate

#### Findings

- We found that staff were committed to providing a caring service to all patients. However, the provider had not actively considered how it might be more responsive to the particular needs of this population group.
- The practice offered a range of primary care services targeting older patients, for example the flu, shingles and pneumococcal vaccinations.

### People with long-term conditions

### Population group rating: Inadequate

#### Findings

- We found that staff were committed to providing a caring service to all patients. However, the provider had not actively considered how it might be more responsive to the particular needs of this population group.
- The practice liaised regularly with the local community nursing team to discuss and manage the needs of patients with complex medical issues.

## **Families, children and young people**

### **Inadequate**

**Population group rating:**

#### **Findings**

- GP and nurse appointments were available outside of school hours.
- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Practice policy was to offer parents or guardians calling with concerns about a child a same day appointment when necessary. However, patients reported difficulty in getting through to the practice by telephone.

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

### **Population group rating: Inadequate**

#### **Findings**

- The practice had adjusted its opening hours to ensure nurse and GP appointments were available outside working hours.
- Pre-bookable appointments were available to all patients at other practices within the area during the evening and at weekends at several 'GP hub' locations in Hounslow. The number of these appointments available to practice patients was capped.
- Patients reported frustration with the appointments system and difficulty in getting through to the practice by telephone while at work.

**People whose circumstances make them vulnerable**  
**group rating: Inadequate**

**Population**

**Findings**

- The practice did not hold up to date registers of patients living in vulnerable circumstances including homeless people and travellers. It was not clear how it used the registers it did hold, for example of patients with a learning disability to respond to their needs.
- The practice provided a special allocation service to patients who presented with challenging behaviour. The service was not sufficiently well organised to be responsive to their needs. For example, we were concerned at the number of recent incidents which had involved a police call out. The provider was aware of these incidents and, after the inspection, provided us with further information about actions it had taken. Actions included securing a security guard, circulating the lone-worker policy to staff and booking 'breakaway training' for staff. (Breakaway training is used to enable staff to escape from direct physical confrontation).
- We remained concerned that the provider had not carried out a more fundamental review to include a robust root cause analysis of incidents; an updated training needs assessment for staff and a review of the protocols underpinning the service. The actions taken were not sufficient to demonstrate that this service was meeting these patients' needs and was not exposing staff and other patients to unnecessary risk.

**People experiencing poor mental health (including people with dementia)**  
**Population group rating: Inadequate**

**Findings**

- We found that staff were committed to providing a caring service to all patients. However, the provider had not actively considered how it might be more responsive to the particular needs of this population group, for example the practice did not systemically utilise advance planning with patients with dementia.
- Staff interviewed had a good understanding of how to support patients with mental health needs.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.



## Timely access to the service

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

#### National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff at the branch site reported a lack of GP clinical cover. There had been occasions when the allocated GP was absent at short notice resulting in the cancellation of patient appointments. The issue was exacerbated by a lack of communication between the management and staff working at the practice. For example branch practice staff were not always informed if a doctor was going to be unable to attend.</p>	

Indicator	Practice	CCG average	England average
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	40%	70%	70%
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	48%	66%	69%
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	60%	67%	66%
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	58%	69%	74%

#### Any additional evidence or comments

The practice had been issued with a contractual breach notice in October 2018 for providing insufficient GP appointments to meet the needs of the practice population. Since then it had increased the number of GP sessions provided by offering nine additional GP sessions at Heston Practice. Registered patients were able to attend either site.

Source	Feedback
Comment cards	Patients commenting in advance of the inspection were critical of the appointment system. Five of the twelve comments we received were critical of the telephone line. This was corroborated by staff during the inspection who told us that patients might be queued on the telephone for 45 minutes to an hour at busy times of the day. The telephone system recorded activity data including call waiting times.

## Listening and learning from concerns and complaints

**Complaints were listened and responded to. Complaints were not used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	19 written complaints
Number of complaints we examined.	19
Number of complaints we examined that were satisfactorily handled in a timely way.	19
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	No
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <p>Since the inspection we have received concerns from two patients who have independently reported difficulty in being able to report a complaint after being told that no manager was available on site. The provider monitored complaints and monitored themes. However, despite consistent themes around appointment availability and difficulty accessing the service by telephone the provider did not act to increase clinical capacity until it was issued with a breach notice by the service commissioner. There was also a consistent theme around producing timely prescriptions and referrals. The regional manager told us that they had identified a need for additional administrative capacity and were in the process of recruiting more administrative staff. The response seemed slow given consistent staff and patient complaints and concerns.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Acutely unwell child and parent arrived at practice at 3.30pm to be told there were no available appointments. They were advised to attend urgent care or A&E by reception staff. This advice was not in line with practice policy which was to alert the GP on duty to the case.	Staff were reminded of appropriate policy. It was unclear from the analysis of complaints why staff had not followed normal policy ie if this was due to a lack of training or knowledge or if there were other stress factors in play on the day.

<p>The practice failed to implement a referral which led to a six month delay. The patient experienced stress and loss of earnings as a result.</p>	<p>The practice accepted it had made a mistake and apologised to the patient. It was unclear from the analysis of complaints why the referral had been missed and whether any actions had been put in place to reduce the risk of recurrence.</p>
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## Well-led

## Rating: Inadequate

### 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.	Yes
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	No
There was a leadership development programme in place, including a succession plan.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The provider had recently recruited a new senior management to lead improvement across its primary care services. This manager had identified a lack of local clinical leadership as a problem and had recruited a locum lead GP who had knowledge of the area and the service. Staff we interviewed were positive about these changes. Staff views were more mixed views about the approachability of management.</li><li>• Senior managers and the lead GP were clear about the challenges they faced, had updated the corporate risk register and were developing plans and priorities to improve. The provider could demonstrate that it had increased the availability of GP appointments at the Heston Practice site and staff told us this was now making a difference.</li><li>• However, we were concerned that some risks, for example staff concerns around the safety of the special allocation service had not yet been effectively addressed. The provider was taking action to improve security but these actions had not been clearly communicated to staff.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy in place to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: <p>The provider had recently reviewed its values and produced an 'operational handbook' which included</p>	

information about the provider's organisation structure, strategy and governance arrangements. The strategy for the Heston practice and branch site focused on putting in place better clinical leadership, capacity and engaging staff to improve morale and foster a positive culture.

These were positive developments but we found that the provider did not have a detailed strategy or business plan for example to address the lack of systems and processes in place locally to ensure the service operated safely and as intended, for example in relation to repeat prescribing.

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	No
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Explanation of any answers and additional evidence:	
<p>The local management arrangements were confused. The provider had a regional management structure but it was unclear who was responsible for managing the practice day to day. Some staff told us their practice manager had left the company while others said this person was still working as their responsible manager but they no longer attended the practice or branch sites day to day.</p> <p>Following the inspection, the provider informed us that the deputy practice manager had day to day control over practice management. However on the day of inspection, we did not see evidence that the deputy practice manager had the authority in practice to effect change or improvements.</p>	

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

Source	Feedback
Staff interviews	<p>Staff were committed to providing a high quality service to patients. They consistently told us the quality of clinical care provided was excellent and something they were proud of.</p> <p>However, staff expressed disappointment about the continuing disorganisation evident within the practice in relation to providing timely prescriptions, referrals and appointments and the impact on patient experience. The telephone system was a source of frustration to staff as it had been inadequate for many months.</p>

## Governance arrangements

## The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:  Some administrative staff members were unclear about roles and responsibilities. They told us they had not received induction training and did not have access to clear protocols to govern activity. As a result unnecessary mistakes were occurring and they had to ask clinical colleagues for advice on how to complete basic administrative tasks.	

## 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 in place which were regularly reviewed and improved.	No
There were processes in place to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
Explanation of any answers and additional evidence:	
<p>The provider maintained an active risk register for the service.</p> <p>The practice had responded effectively following a recent power cut and had successfully put its major incident plan in place. However, staff told us they were not well prepared to deal with other types of incidents, for example those arising from the special allocation service and had not had appropriate training. Staff had raised concerns in writing to the management but had not received a direct response and we were concerned that actions taken were insufficient.</p> <p>The practice was not managing all risks (for example in relation to medicines management). We noted that staff had raised concerns about some of these issues (expiry of emergency medicines) and had received no response. When we raised this with the managers, they acknowledged that there had been a communications gap but were confident that the recent senior appointments would drive change and improvement. The lead GP (who had been appointed on a locum basis) was developing a programme of audit and clinical oversight but it was too soon to see the impact of this.</p> <p>We saw evidence that the provider had responded to external drivers of change (for example, inspection results). However, the provider could not produce evidence that it proactively identified and responded to risks and assessed the impact on safety and quality.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes

Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:  Clinical information was available to support patient care. The practice however could not explain why its exception reporting rates were consistently very high on the Quality and Outcomes Framework. We could not ascertain if these exception reporting rates were justified during the course of the inspection. The lead GP was aware of the high exception reporting rates but had not yet investigated what was causing this.	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	No
Staff views were reflected in the planning and delivery of services.	No
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	No
Explanation of any answers and additional evidence: The provider could point to improvements it had made to address patient concerns. We noted that for example concerns about access to the service had been apparent for several months before action was taken. The commissioner had become involved and had issued a breach notice following patient complaints.  Shortly after the inspection, we were contacted by patients who wished to make a complaint to the practice (branch site) but were unclear how to do so as there was no manager available on site. They said that staff had directed them to contact CQC to complain.  The provider had identified effective staff engagement as one of its priorities. It had recently produced an operational handbook outlining the values, strategy and structure of the organisation for staff and other stakeholders. The practice held staff meetings and the provider circulated a monthly electronic newsletter to staff.	

Feedback from Patient Participation Group.

Feedback
The practice did not have an active patient participation group at the time of the inspection.

### Continuous improvement and innovation

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



	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
The lead GP was implementing changes to improve the scope for learning, continuous improvement and innovation. They were doing this by instituting clinical meetings, more opportunities for clinical supervision and a programme of audit. It was too soon to see results from this activity.	

**Glossary of terms used in the data.**

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