

Care Quality Commission

Inspection Evidence Table

Shepherds Bush Medical Centre (1-572837698)

Inspection date: 22 January 2019

Overall rating: Inadequate

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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	N
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	N
Systems were in place to identify vulnerable patients on record.	N
There was a risk register of specific patients.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	N
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	N

- We found evidence there is a lack a fundamental understanding around the safeguarding of vulnerable people and staff we spoke with were not always clear about what was a safeguarding

Safeguarding	Y/N/Partial
concern:	
<ul style="list-style-type: none"> The practice did not provide evidence of a system to safety net and protect children for whom there are safeguarding concerns, to ensure they are regularly reviewed. Although we saw safeguarding alerts had been placed on the electronic records of some children at risk, a systematic review had not been conducted between 2016 and 21 January 2019. The lead GP told us they did not have meetings with Health Visitors, but they had planned a future meeting. Following the inspection, the provider has informed us that they had a planned a meeting with health visitors for March 2019 and we will review this at the follow-up inspection. The lead GP told us the children's' safeguarding register is only checked on an annual basis. We reviewed evidence that the practice did not assess the safeguarding risks for patients and their families, regarding female genital mutilation, and the lead GP for safeguarding children did not appear to flag this as a concern. Although non-clinical staff had been trained to act as a chaperone for patients, the practice policy did not provide clear guidance on where they should stand when providing this role. 	

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 and if relevant to role.	N
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who required medical indemnity insurance had it in place.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had not assured themselves of the practice nurse's competency to carry out the specific duties they perform, and they did not have certificated evidence of this. The practice did not provide evidence that all staff in direct clinical contact had undertaken the requisite blood tests and vaccinations to keep patients safe, in line with current Public Health England guidance, including, MMR, Varicella, BCG, diphtheria, polio and tetanus. Following the inspection, the practice sent us evidence that only one member of non-clinical staff, out of ten staff, had completed the requirements relating to infectious diseases immunity and immunisations. The practice had not assured themselves that all members of staff had certificated immunity. The practice told us that the practice nurse had current medical indemnity insurance. However, when we asked for evidence of this, we found the practice nurses' insurance had expired in December 2018. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y 10/09/2018
There was a record of equipment calibration. Date of last calibration:	Y 10/09/2018
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y July 2018
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check:	Y 25/05/2018
There was a log of fire drills. Date of last drill:	N
There was a record of fire alarm checks. Date of last check:	Y 05/12/2018
There was a record of fire training for staff. Date of last training:	Y
There were fire marshals in place.	N
A fire risk assessment had been completed. Date of completion:	Y Inhouse 01/07/2018
Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A fire risk assessment had been undertaken, but action points from that assessment had not been completed. • Although the practice told us they had recorded fire drills in the minutes of practice meetings, we found evidence this had not been recorded consistently. • The practice did not provide evidence that Fire Marshals have been appointed and trained, and there are no documented plans in place for when members of staff are absent from the premises. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 17/08/2017
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had not undertaken an appropriate risk assessment for premises and security risk. 	

- We found evidence a legionella risk assessment had been completed in May 2018, but the practice had not recorded the dates on which temperatures had been recorded and the log provided did not allow for the documentation of any remedial action that had been taken.
- We found evidence that cords on blinds in the patient’s waiting area were long, and the practice had not risk assessed this.
- Although the reception area was accessible for wheelchair users, the main corridor through to the patients’ toilet was narrow and the practice had not considered if it was wide enough for a wheelchair to pass through safely.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Y
Staff had received effective training on infection prevention and control.	N
Date of last infection prevention and control audit:	NHSE 2017
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- The infection control plan sent by the practice did not include the action points recommended by NHS England in 2017. However, the copy the practice had sent to us differed from the audit sent to us by NHS England.
- Clinical leads for infection prevention and control had not undertaken enhanced training to perform this role.
- We found evidence that the cleaner who is employed by the practice, had not completed infection control training and it is not mentioned in the IPC policy. The provider sent us evidence after the inspection confirming the cleaner completed some on line infection control training in 2012.
- We found evidence the practice did not comply with infection protection and control (IPC) in relation to cleaning materials and storage of equipment. This had been a finding from the NHS England IPC audit in 2017.
- Privacy curtains in clinical rooms had not been changed since 2017.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Partial
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
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.	N
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice told us they did not conduct systematic risk assessments for patients, and that consultations were undertaken on an opportunistic basis. • Practice staff told us how they would screen patients for potential medical emergencies, we observed staff did screen patients who called or attended the practice to request a GP appointment for red flag signs. • We found evidence in minutes from practice meetings that the doctors did not take calls from clinicians working in hospital settings and that an action point had been identified that stated they needed to review letters received from hospitals regarding patients' medication. • We found evidence the practice nurse was involved in issuing prescriptions when they are not qualified as a nurse prescriber or an advanced nurse practitioner. 	

Information to deliver safe care and treatment

Staff did not have 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.	N
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.	N
Referral letters contained specific information to allow appropriate and timely referrals.	Partial
Referrals to specialist services were documented.	N
There was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found evidence of insufficiently detailed record keeping in relation to records of patients with serious mental illness. We did not see evidence of care plans in patients' records. However, following the inspection, the practice has told us they have improved their systems and we will review this as part of the follow-up inspection. We found evidence the practice doctors had sent 2-week wait referrals to administration staff as a task marked 'miscellaneous,' had not been documented in the patient record, but was included in the administrative task. The practice did not have a system or process to manage and safety net 2-week wait referrals. 	

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) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.73	0.65	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as	13.4%	10.6%	8.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)				

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.	N
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
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.	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.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
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.	Y
For remote or online prescribing there were effective protocols in place for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	N
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Partial

Medicines management	Y/N/Partial
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> <ul style="list-style-type: none"> The practice told us they took prescription paper out of printers overnight but did not log serial numbers of prescription pads. Staff did not know the procedures in relation to prescription security. The lead GP told us they did not have a system or policy in place to ensure changes to patients' prescriptions were completed. The practice could not provide evidence of a system in place to monitor and follow-up patients with poor mental health who fail to attend or collect their prescriptions, including those patients are subscribed to electronic prescribing. The practice could not provide evidence that a policy or protocol was in place for monitoring patients who had been prescribed high-risk medicines. The practice relied upon the CCG to review its antibiotic prescribing, but acted to support good antimicrobial stewardship in line with local and national guidance. The vaccine fridge had an internal thermometer and a data logger in situ. The practice manager told us that from June to December 2018 the data logger had not been working. They provided hand written records for twelve months, from the internal fridge thermometer, confirming temperatures from the vaccine fridge had remained within acceptable limits, between 20C and 80C, but we did not see evidence of data logger recordings. Best practice guidance recommends that a second thermometer or a temperature data logger should be used as a failsafe measure. When we asked the lead GP how the practice monitored prescription ordering and collection for anti-psychotics or other medications for treating serious mental illness, they told us by review dates. We did not see evidence of a system in place regarding patients who had passed the threshold for authorised number of repeat prescriptions. The practice was unable to show us evidence that patients were called in to see a GP for review. The practice was unable to demonstrate evidence of an audit trail regarding the management of information and changes to patient's medicines including changes made by other services. We found salbutamol nebulas that had expired in 2017 and a face mask that had expired in 2015. The emergency kit should include medicines for emergencies, and we found four of these medicines were missing. The practice did not provide evidence they had considered the risk of not having these medicines. 	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N

Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
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.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> When asked, the lead GP told us that significant events had not been shared with NHS England or the National Reporting and Learning System (NRLS) or any other practices within the locality. We found evidence that not all significant events had been recorded. significant events with potentially serious consequences had not been recorded appropriately. 	

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

Event	Specific action taken
Patient's death.	The practice implemented a 'did not attend policy,' but we found evidence they did not adhere to their own policy.
Incident concerning a vulnerable patient who became upset with reception staff.	The practice solved the issue and subsequently removed the patient from their list.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Although we saw evidence the practice had conducted a patient search for valproate, they did not provide evidence of more recent safety alerts, for example, hydrochlorothiazide. The practice did not have a system or process in place to manage safety alerts, or to record evidence of searches that had been completed. However, following the inspection, the practice has submitted evidence of recently completed searches for safety alerts. 	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The lead GP told us they did not have a co-ordinated approach to providing care following best practice evidence-based guidance, and that both GPs' followed an individual approach in providing care. The practice worked together with the End of Life multi-disciplinary team to ensure patients' needs were met safely and they received appropriate treatment. Following the inspection, the practice has submitted evidence of enhanced collaborative working arrangements with other services, and we will review this at the follow-up inspection. The practice manager told us they reviewed unplanned admissions and re-admissions, however they did not keep data to show impact on admissions in relation to this. The lead GP told us they did not conduct annual reviews for women who had suffered gestational diabetes. The practice had not provided evidence that staff who were responsible for reviews of patients with long-term conditions had received specific training in that respect. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to	1.16	0.87	0.81	No statistical variation

Prescribing	Practice performance	CCG average	England average	England comparison
30/09/2018) (NHSBSA)				

Older people

Population group rating: Inadequate

Findings

- The practice did not have systems and processes in place to effectively risk manage and monitor all patients across the population groups. This was managed by the GP and practice nurse consultations at opportunistic review.
- Older patients who were frail or may be vulnerable did not routinely receive a full assessment of their physical, mental and social needs. The lead GP told us this would be offered on an opportunistic basis. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty.
- The practice followed up on older patients discharged from hospital. However, we did not see evidence of updated care plans and prescriptions to reflect any extra or changed needs.
- The practice did not have a system in place for vaccinating patients who were aged 65 and over, according to the recommended schedule, and only 53% of this patient group had received an influenza immunisation in the 2018/2019 season.
- The practice did not have a system in place for vaccinating patients who were aged between 70 and 78, against shingles, according to the recommended schedule, and 0% of this patient group had received the appropriate immunisation in the 2018/2019 season.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions

Population group rating: Inadequate

Findings

- The practice could not provide evidence of how they identified and conducted reviews for patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The lead GP told us this was offered to patients on an opportunistic basis.
- The lead GP could not demonstrate evidence of systematic recall to enable patients with suspected hypertension to undertake Automatic Blood Pressure Monitoring (ABPM), to confirm a diagnosis of hypertension.
- The lead GP told us there were limited arrangements in place to minimise the use of psychotropic medicines for people with learning disabilities, autism or both to prevent over medication, and the practice relied on secondary care to carry this out.
- The practice told us patients with long-term conditions did not have a planned structured annual

review to check their health, and this was conducted on an opportunistic basis only.

- The lead GP told us they conducted polypharmacy reviews to ensure the patient's medicines needs were being met, however they did not have a system in place to risk manage this.
- The practice did not provide evidence that staff who were responsible for reviews of patients with long term conditions had received specific training.
- The lead GP told us patients with atrial fibrillation were assessed opportunistically for stroke risk and treated as appropriate.
- The practice told us there was no current systematic process to demonstrate how patients with commonly undiagnosed conditions are identified, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice did not have a system in place for vaccinating patients who had a medical condition, and were at risk, according to the recommended schedule, and only 35% of this patient group had received an influenza immunisation in the 2018/2019 season.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	58.1%	77.5%	78.8%	Variation (negative)
Exception rate (number of exceptions).	2.5% (7)	12.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	62.3%	72.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	3.2% (9)	11.3%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	62.9%	77.2%	80.1%	Variation (negative)
Exception rate (number of exceptions).	1.8% (5)	11.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an	76.6%	74.0%	76.0%	No statistical variation

assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0.8% (1)	6.9%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	93.8%	87.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	11.1% (2)	11.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	73.7%	78.6%	82.6%	Variation (negative)
Exception rate (number of exceptions).	1.4% (7)	5.2%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	93.5%	88.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (1)	6.0%	6.7%	N/A

Any additional evidence or comments

- The practice did not conduct a systematic risk assessment to identify patients with atrial fibrillation, with a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anti-coagulation drug therapy. This was conducted on an opportunistic basis.

Families, children and young people

Population group rating: Inadequate

Findings

- The practice did not have arrangements for following up failed attendance of children's appointments for immunisation.
- We found evidence that insufficient clinical hours are having a direct impact on patient care. We found low cervical smear achievement rates, low childhood immunisation achievement rates and

the lack of systematic risk assessments across patient population groups. In addition, we were unable to see evidence of how GP and nursing staff hours were effectively managed during annual leave and sickness and when the service was under pressure due to patient demand.

- Following the inspection, the practice submitted information regarding cervical smear achievement rates. The information provided for cervical cytology achievement relates to QOF and not Public Health England (PHE) data. PHE data is used regarding cervical smear achievement rates. In addition, the practice did not provide evidence of what years the QOF data refers to.
- The lead GP told us that he did not hold meetings with Health Visitors, which would have provided a safety net for children and communication and this was carried out by individual discussion.
- The lead GP told us they had not provided services for pregnant and postnatal women, but referred them to local services to ensure good clinical outcomes in line with best practice guidelines. Following the inspection, the practice had provided evidence of a care plan template for pregnant women who attend the practice and we will review this as part of the follow-up inspection.
- The practice did not have a system in place for vaccinating pregnant women, according to the recommended schedule, and only 0.6% of this patient group had received an influenza immunisation in the 2018/2019 season.
- The practice nurse stated that she had provided services for young people in relation to sexual health and contraception but had not undertaken the required training to ensure she was competent to do so.

Child Immunisation	Numerator	Denominator	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)(NHS England)	24	31	77.4%	Below 80% (Significant variation negative)
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) (NHS England)	20	24	83.3%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (Men C) (i.e. received Hib/Men C booster) (01/04/2017 to 31/03/2018) (NHS England)	20	24	83.3%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have	20	24	83.3%	Below 90% minimum

received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)				(variation negative)
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Working age people (including those recently retired and students) Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice did not have systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time because they did not have a significant eligible patient population. Students are at greater risk of developing meningococcal A, B, C, W and Y. Data available from NHS England shows us that the 15 to 44-year old age group was the largest patient demographic at Shepherds Bush Medical Centre. The practice did not have a systematic approach to offer patients' appropriate health assessments and checks, which were conducted opportunistically, including NHS checks for patients aged 40 to 74. The lead GP told us the practice nurse was the lead professional in relation to conducting health checks. However, we did not see evidence of appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified, because the practice nurse was unavailable for interview on the day of inspection.

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) (01/04/2016 to 31/03/2017) (Public Health England)	48.6%	57.0%	72.1%	Significant Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	59.2%	59.2%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	33.3%	42.1%	54.6%	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. (PHE)	58.8%	59.6%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	66.7%	49.8%	51.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> Cervical screening is an integral part of the practice nurse's role. Despite cervical screening rates having been significantly below the national target at our previous inspections, the practice had not developed an action to address this and increase achievement rates. Previous years

achievement rates have deteriorated from 2015/2016 57.0% to 54% up to 31 March 2017 and 53% up to 31 March in 2018.

- The practice did not have a failsafe system in place to safety net cervical smear results.
- The practice nurse told us they did not follow up patients who did not attend an appointment for a cervical smear.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- End of life care was delivered in a coordinated way which considered, the needs of those whose circumstances may make them vulnerable.
- The practice did not hold a register of patients living in vulnerable circumstances including homeless people, and people from the traveller community.
- The practice did not have a system in place for vaccinating patients who are regarded as being vulnerable condition, according to the recommended schedule, and only 35% of this patient group had received an influenza immunisation in the 2018/2019 season.
- The practice told us they did not have a system to identify people who misused substances or were homeless as other practices in the area provided care for those patient groups, and they did not provide specific services to improve health outcomes.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The lead GP told us, when patients were assessed to be at risk of suicide or self-harm, the practice did not have arrangements in place to help them to remain safe. The practice did not demonstrate an understating of the needs of patients with mental health illness and those patients who posed a suicide risk.
- We found evidence that patients who suffered mental health illness had been treated inappropriately.
- Following the inspection, the practice submitted evidence of a pathway created for patients with mental health issues who express suicidal intent. This included details regarding who to contact and what actions to take for patients requiring urgent referral to the Mental Health Crisis team, and how GPs' may access this service quickly. This will be reviewed at the follow-up inspection.
- The practice had not assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- 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.

- Following the inspection, the provider submitted evidence that five out of eight staff had completed dementia training in the last 12 months. However, three out of eight staff had completed this after the inspection.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	76.1%	87.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	0 (0)	10.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	78.3%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	9.1%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	85.8%	83.0%	Variation (positive)
Exception rate (number of exceptions).	5.9% (1)	6.5%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	477.23999999999995	-	537.5
Overall QOF exception reporting (all domains)	4.1%	7.0%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice could not demonstrate how they assured themselves of the competence of the practice nurse. The practice told us they provided staff with some ongoing support, and that there was an induction programme for new staff, supervision and revalidation. We found evidence that training records for the practice nurse were incomplete. 	

Coordinating care and treatment

Staff did not work 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 and organisations, were involved in assessing, planning and delivering care and treatment.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial

Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice provided evidence of working collaboratively to co-ordinate care for patients with the End of Life Multi-disciplinary team (MDT) and the Diabetes Nurse Specialist. • Except for the End of Life MDT and the Diabetes Nurse Specialist, we did not see evidence to show that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. • The practice did not share clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions. They did not provide evidence they shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area. • We did not see evidence that patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice did not work with patients to develop personal care plans that were shared with relevant agencies. 	

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice provided evidence of working collaboratively with the end of life multi-disciplinary team. • The practice did not have systematic risk assessment processes in place to identify patients who may need extra support and direct them to relevant services. This included patients at risk of developing a long-term condition, those people with a learning disability and carers. • We did not see evidence that staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The lead GP told us that he had good awareness of local services and pathways and could show us examples of local social signposting groups. 	

- The lead GP told us he discussed changes to care or treatment with patients and their carers as necessary.
- The practice did not provide evidence to demonstrate they supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- Following the inspection, the practice has submitted evidence they have engaged in activities to support patients in living healthier lives. This will be reviewed at the follow-up inspection.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.0%	94.8%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (2)	1.2%	0.8%	N/A

Consent to care and treatment

The practice 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.	N
The practice monitored the process for seeking consent appropriately.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We did not see evidence that clinicians supported patients to make decisions, or that they had assessed and recorded a patient's mental capacity to decide. 	

Caring

Rating: Requires improvement

Kindness, respect and compassion

Staff mostly 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.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Feedback from patients was positive about the way staff treat people. • Staff we spoke with demonstrated they understood patients' personal, cultural, social and religious needs. • We spoke with four patients during the inspection, who were positive about their experiences at the practice. 	

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	40
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comments card	Doctors are helpful and knowledgeable, and concerns are listened to.
CQC comments card	Staff are very caring and friendly.
CQC comments card	The service is good overall but could be improved upon, by having more appointments available.
CQC comments card	Generally, all services are average, but staff are very good.
CQC comments card	Staff are friendly and caring, but getting appointments can be hard.

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
3426	412	81	19.7%	2.36%

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 (01/01/2018 to 31/03/2018)	88.0%	85.3%	89.0%	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 (01/01/2018 to 31/03/2018)	85.5%	82.6%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	98.3%	94.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	87.5%	79.9%	83.8%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice nurse told us they carried out their own feedback exercise. They asked two patients, to comment on their experience.

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.	Partial

Explanation of any answers and additional evidence:

- The practice signposts patients to different services via its website.
- The practice could not provide evidence they had signposted patients and carers to services or social prescribing scheme. However, the lead GP told us they referred patients, with consent, to two social prescribing schemes.

Source	Feedback
Interviews with patients.	<ul style="list-style-type: none"> • The doctors are amazing they always make time for you. Staff apologise when appointments run late. • Getting appointments is an issue sometimes and that patients who do not have access to online services are discriminated against. Doctors will discuss the risk and benefits with care and treatment. • Doctors will listen to you; the practice has a friendly atmosphere.

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 (01/01/2018 to 31/03/2018)	87.7%	90.9%	93.5%	No statistical variation

Any additional evidence or comments

- The practice had not provided evidence that they have taken any action, for those patients who expressed a wish, to be involved in decision making regarding their care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Partial
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Partial
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:

- The practice had access to interpretation services, and staff spoke a wide range of languages,

however this information was not advertised to patients. Interpreter services, which a pre-bookable service mainly but on occasion can be obtained on the day.

- Leaflets available in the patients' waiting area were limited and contained little information regarding local support groups and advocacy services.
- The practice did not have a hearing loop.
- Practice staff told us they booked Silent Sound interpreters for patients who had a sensory impairment. This is a pre-bookable service that required a two-four days' notice period.

Carers	Narrative
Percentage and number of carers identified.	The practice has a total number of 33 patients that are carers, this represents 0.9% of the total registered population of 3426.
How the practice supported carers.	No evidence to demonstrate that carers or young carers were supported.
How the practice supported recently bereaved patients.	No evidence to demonstrate that recently bereaved patients were supported.

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.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs. • Staff recognised the importance of people's dignity and respect. • While there is some partitioning between reception and the waiting area, conversations can be overheard when patients talk to reception staff. 	

Responsive

Rating: Requires improvement

The overall rating for this practice was inadequate due to concerns in providing safe, effective and well-led services. This includes the population groups for older people, people with long

term conditions, families, children and young people, working age people and people whose circumstances make them vulnerable.

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.	N
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.	N
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.	N
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice provided evidence of multi-disciplinary work to coordinate end of life care. • The practice had not undertaken any formal analysis or needs assessment to demonstrate they understood the needs and preferences of the local population. • The practice did not make reasonable adjustments when patients found it hard to access services. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08.00am-6.30pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm
	08.00am-6.30pm
Appointments available:	
Monday	09.30am-1.00pm 4.30pm-6.20pm
Tuesday	09.30am-1.00pm 4.30pm-6.20pm
Wednesday	09.30am-1.00pm 4.30pm-6.20pm
Thursday	09.30am-1.00pm
Friday	09.30am-1.00pm 4.30pm-6.20pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
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3426	412	81	19.7%	2.36%
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Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	96.8%	93.2%	94.8%	No statistical variation

Any additional evidence or comments

The practice told us that approximately 80% of appointments were available to be booked online.

Older people

Population group rating: Requires improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived, and conducted home visits when required.

People with long-term conditions improvement

Population group rating: Requires

Findings

- The practice worked with the district nursing team and community matrons to manage the needs of patients with complex needs.

Families, children and young people improvement

Population group rating: Requires

Findings

- Staff told us they offered parents or guardians who called with concerns regarding a child, appointments outside of school hours.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Patients were able to access appointments at a local GP hub, in the evenings and at weekends.

People whose circumstances make them vulnerable Population group rating: Requires improvement

Findings

- There were eleven patients with a learning disability on the practice register. The practice did not have a nominated lead for learning disability,

People experiencing poor mental health (including people with dementia) Population group rating: Requires improvement

Findings

- We found evidence of a lack of care for some patients who suffered serious mental illness.
- Priority appointments were not allocated when necessary to those experiencing poor mental health.
- The practice had leaflets in the waiting area regarding mental health but with no specific reference to a service or support group.

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.	N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • One of our inspectors sat in the patients' waiting area and observed that patients who called for an appointment were not appropriately managed. Patients were informed by staff there were no appointments available that day.; patients were not asked if they required an urgent appointment or if the patient was experiencing any 'red flag' symptoms. Patients were not offered any appointments within the group of practices in the area or signposted to other services, for example, Urgent Care facilities, NHS 111, OOH services. Non-clinical staff told us they had not had red flag signs training to recognise those in need of urgent medical attention. • Reception staff alerted the relevant GP of home visit requests who would then contact the patient to assess the suitability and agree a time if required. 	

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 (01/01/2018 to 31/03/2018)	84.1%	74.0%	70.3%	N/A
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)	80.0%	64.6%	68.6%	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 (01/01/2018 to 31/03/2018)	83.1%	63.8%	65.9%	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 (01/01/2018 to 31/03/2018)	80.2%	68.3%	74.4%	No statistical variation

Any additional evidence or comments

- Patients from the practice had access to a GP hub for an extended hours service.

Source	Feedback
For example, NHS Choices	There were mixed reviews of the service, 6 in total, 3 which were positive and 3 which were negative. Patients commented on both the doctors and practice describing the service as caring, empathetic. Other patients described staff as being rude and unhelpful. One person stating they had not been assessed as to the urgency of their need for an appointment.
Google reviews	There were mixed reviews of the service, 22 in total, 6 which were positive and 14 which were negative. Patients commented negatively on customer service, patient care, professionalism and highlighted a problem with requesting a repeat prescription. Other patients have described it as being a fantastic service and how they feel well cared for.

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.	1
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Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw evidence of a small poster in the patients' waiting area regarding complaints, but there was no information available on the practice website in relation to this. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Poor communication re patient's test results	Practice will not use sticky notes to communicate in future.

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.	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 in place, including a succession plan.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice did not have clear systems in place to assess, monitor and improve the quality and safety of the service or to mitigate the risks associated with safe care and treatment. There was a lack of clinical leadership and oversight at the practice, and the practice leadership did not demonstrate that they had knowledge or capacity to oversee high quality safe care. We found evidence of a lack of clinical governance. There was a lack of clinical leadership, and the practice was driven by reactive approaches as opposed to proactive systematic risk 	

assessments for at risk patient population groups. Senior staff were unclear as to who held 'lead roles' in the practice and for some areas the practice had not allocated areas of responsibility to a lead person.

- Leaders lacked knowledge about issues and priorities relating to the quality and future of services. They lacked capacity and did not understand the challenges presented and therefore were unable to address them.
- The practice did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- Structures, processes and systems to support good governance and management were ineffective. They were not consistently implemented or monitored and there was a lack of day-to-day oversight by the leaders to ensure effective management of safety and risk.
- There is no system and policy in place to safely manage test results and 2 week-wait referrals.
- Following the inspection, the practice has submitted evidence of improved systems regarding 2 week-wait referrals and we will review this as part of the follow-up inspection.
- We saw evidence that the practice did not always keep patient information safe. The lead GP had left a clinical room and left the computer open, with their Smart card in situ with patient information displayed.
- We found minutes from clinical meetings were recorded but did not contain details as to whether tasks and actions discussed at meetings, were acted upon and resolved.
- The practice could not assure themselves that the practice nurse was competent to undertake the roles she had undertaken.
- We reviewed several practice policies and found evidence they were not being reviewed and updated annually. The medicines management policy in relation to cold chain does not reference where vaccines would be stored in the event of a breach, it did not state which thermometer temperature should be recorded and did not give contact details for NHS England in the event of a power supply failure. Regarding the recruitment policy, there was no reference to DBS but referenced earlier requirements. The chaperone policy did not state where the staff member should stand during the examination and did not reference DBS checks or an appropriate risk assessment in place of that.
- We saw evidence that you did not have information displayed to ensure patients' have access to information for GP services when the practice is closed.
- The practice manager told us information was displayed regarding CCTV used in the practice buildings, however we did not see evidence of that.
- We saw evidence that you have a business continuity plan in place, however, this information is not available off site for staff to access if required. The practice told us this had not been formally discussed.

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.	N
There was a realistic strategy in place to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us they had a vision to provide good quality care but there was no formal plan or strategy to support this. Although a member of staff was discussing succession planning on the day of our inspection, there are no formal plans in place. 	

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.	Y
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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	N
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We did not see evidence from training records that staff had received equality and diversity training. Although the practice had a whistleblowing policy in place, it did not reference national best practice guidance. 	

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

Source	Feedback
Non-clinical member of staff	Staff we spoke with told us they had worked at the practice for many years and felt the practice was a nice place to work.

Governance arrangements

The overall governance arrangements were ineffective.

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

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.	N
There were processes in place to manage performance.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	
When considering service developments or changes, the impact on quality and sustainability was assessed.	N

Explanation of any answers and additional evidence:

- The practice did not have systems and processes in place to effectively risk manage and monitor all patients across the population groups. This was managed by the GP and practice nurse consultations by opportunistic review.
- The practice had not undertaken an appropriate risk assessment for premises and security risk.
- The practice provided minimal evidence of quality improvement, including clinical audit, being carried out within the practice. The practice shared evidence of two two-cycle clinical audits on asthma and heart failure which demonstrated no improvement in clinical outcomes.
- The business continuity plan did not include all contact details for other practice staff members. The plan did not include the CCG and NHSE contact details.
- The practice did not provide evidence they had considered the needs of patients and whether there were sufficient clinical hours provided and assessed if there was an impact on patient safety.
- The practice could not provide evidence that a policy or protocol was in place for monitoring patients who had been prescribed high-risk medicines.

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.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	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: <ul style="list-style-type: none"> • The practice's uptake for cervical screening was 49%, which was below the CCG average cervical screening rates at 57% and the national average of 72% and below the 80% coverage target for the national screening programme. • The uptake rates for childhood immunisation rates for 2017/18 for children age one year and for two years showed a significant negative variation. 	

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.	Partial
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • As a result of patient feedback, an automatic door had been installed at the practice to help less able patients. • The practice manager told us the PPG had not functioned since 2016 and was in the process of becoming re-established. • The practice could not demonstrate that they had a culture of high quality sustainable care and acknowledged that work needed to be done to improve their systems and processes to achieve this. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • The chairperson of the group gave us positive feedback about the practice.

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:	
<ul style="list-style-type: none"> There was no innovation or service development. The clinical and non-clinical leaders could not demonstrate that improvement was a priority and there was minimal evidence of learning and reflective practice. When asked the practice could not provide evidence of how technology and/or equipment has been used to improve treatment and promote patient independence. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.

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>

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.