

Care Quality Commission

Inspection Evidence Table

Shepherds Bush Medical Centre (1-572837698)

Inspection date: 29 May 2019

Safe

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies and procedures were monitored, reviewed and updated.	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.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">The provider had improved their safeguarding systems since our last inspection of 22 January 2019, for example, they developed a register of patients who experienced mental health problems. A process had been implemented with the local pharmacy regarding patients who had not collected their prescriptions and patients had review dates logged in their records.We saw evidence that policies and procedures had been reviewed and updated.We saw evidence the provider had developed and implemented a register of children and young people for whom there were safeguarding concerns. There are 48 children currently identified on the register and we saw evidence that review dates were in place on patients records which were regularly reviewed and that the list was updated on a regular basis.The provider had developed a register of patients of young girls and women who may be at risk of female genital mutilation (FGM) and there were four patients on the register. Details are included regarding children a women may have and a review date for each patient had been added to the patients record.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> • Staff we spoke to could articulate the actions and responsibilities of being a chaperone. • The provider has initiated regular meetings with health visitors to discuss any potential safeguarding concerns. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
<ul style="list-style-type: none"> • The practice could not demonstrate that all staff had had all the relevant vaccinations appropriate to their role in line with national guidelines. 	

Safety systems and records	Y/N/Partial
There was a record of fire extinguisher checks. Date of last check: 24 May 2019	Y
There was a log of fire drills. Date of last drill: 26 March 2019	Y
There was a record of fire alarm checks. Date of last check: 24 May 2019	Y
There was a record of fire training for staff. Date of last training: multiple dates all within last 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • An issue regarding electrical wiring had been identified from the fire safety risk assessment and has not yet been actioned. • The provider had identified staff members as fire marshals and had plans in place for when they were absent from the practice premises. • The provider could demonstrate they maintained a log of fire drills. 	

Health and safety
<ul style="list-style-type: none"> • The provider had removed blinds from the patient's waiting area.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were partially met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
<ul style="list-style-type: none"> The provider had reviewed and updated their infection prevention and control (IPC) policy. The provider did not provide evidence their cleaner had completed IPC training. The provider could demonstrate they had an effective system in place regarding the management of infection control and legionella. 	

Risks to patients

There were adequate 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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<ul style="list-style-type: none"> The provider could demonstrate that care and treatment was evidence-based and up-to-date, for example, NICE guidelines in relation to the management of sepsis. Staff had received training and guidance from clinicians regarding sepsis and red flag signs. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
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.	Y
<ul style="list-style-type: none"> The provider had developed and implemented a system and policy to safely manage incoming test results and hospital letters. The provider had implemented a system to cover for annual leave and staff absences that ensured all incoming test results are reviewed on the same day by the duty doctor. The provider had developed and implemented a system and policy to safely manage two-week wait referrals. Their referrals policy contained detailed information regarding the two-week wait process. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<ul style="list-style-type: none"> The provider could demonstrate that prescription best practice standards had been met. For example, prescriptions are in stored in locked rooms and a log of serial numbers is maintained. 	
<ul style="list-style-type: none"> The provider could demonstrate they had improved their systems and process in relation to the safe management of patients who are prescribed high-risk medicines. The provider could demonstrate they had clinical oversight for auditing of all prescribers and prescribing of controlled drugs. The provider could demonstrate the safe management of emergency medicines and equipment. There was no evidence in patients records the practice nurse was involved in issuing prescriptions. However, the provider has amended their process and GPs only issue prescriptions. The provider could demonstrate they maintained appropriate records regarding the 	

Medicines management	Y/N/Partial
cold chain and that a data logger was in place as a method of cross-checking the accuracy of the in-built fridge thermometer.	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
<ul style="list-style-type: none"> The provider had improved and implemented a new policy and system regarding significant events (SEA) and this contained clear definitions of what constitutes a SEA. The provider had developed a Duty of Candour policy and this had been shared with staff. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<ul style="list-style-type: none"> The provider developed a policy and improved their system for managing patient safety alerts. A management toolkit which logs alerts had been implemented and the provider now has oversight of this process. 	

Effective

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
<ul style="list-style-type: none"> We reviewed 24 patient records and all care plans and records were satisfactory, with no clinical concerns noted. The provider could demonstrate how they managed unplanned admissions and re-admissions. For example, patients are followed-up and tasks are allocated to staff regarding this. 	<ul style="list-style-type: none">

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.	Partial
There was an induction programme for new staff.	Y
<ul style="list-style-type: none"> The provider had increased their clinical capacity by one GP session each week to meet patient demand for appointments. Whilst the practice nurse could not provide evidence of initial core specific formal training they were able to demonstrate they had the skills experience and knowledge to carry out their role. Clinical leaders were implementing a programme of audit of the practice nurses records and close clinical supervision to provide assurances regarding the quality of care and treatment provided by the nurse. 	

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 and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> The provider had improved its systems regarding recording minutes of clinical meetings, For example, we reviewed evidence that tasks and actions from meetings are documented and shared with staff. 	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had developed and implemented a register for carers' including young carers. Information signposting these patients to relevant support services was available throughout the practice.• The provider had developed and implemented a register for patients with a learning disability. Information signposting these patients to relevant support services was available throughout the practice.	

Involvement in decisions about care and treatment

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

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

Consent to care and treatment

The practice was able 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.	Y
The practice monitored the process for seeking consent appropriately.	Y

Patients with additional communication needs.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<ul style="list-style-type: none"> The provider had improved its systems for patients who have additional communication needs, For example, they had installed a hearing loop system for patients who are hard of hearing and we saw information regarding interpreter services displayed in the patients waiting area. 	

Carers

Carers	Narrative
Percentage and number of	0.9% (31)

carers identified.	
How the practice supported carers.	The provider has developed a carers identification protocol. We saw evidence of information displayed throughout the practice that encouraged carers to inform staff. Patients were coded on the clinical system and signposted to local carers organisations and other services that may benefit them.

Listening and learning from concerns and complaints

Complaints were used to improve the quality of care.

Complaints	Y/N/Partial
Information about how to complain was readily available.	Y
<ul style="list-style-type: none"> We saw evidence regarding the practice's complaints system in the patients' waiting area. 	

Well-led

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
<ul style="list-style-type: none"> The practice had implemented additional guidance for staff regarding information governance best practice and keeping patients information secure. 	
<ul style="list-style-type: none"> The provider had improved its systems regarding business continuity planning. A copy of this was held electronically and arrangements had been secured to enable staff to log into the clinical system from the pharmacy next door. 	
<ul style="list-style-type: none"> We saw information was displayed regarding access for patients to emergency and out-of-hours GP services. 	
<ul style="list-style-type: none"> We saw information was displayed regarding CCTV used in the practice premises. 	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<ul style="list-style-type: none"> The provider had reviewed and allocated a lead clinician for each area of practice and patient population group. For example, chronic disease areas, homeless people and carers. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<ul style="list-style-type: none"> The provider could demonstrate evidence of quality improvement for patients with COPD with a two-cycle audit from April 2018 to April 2019. There was improved diagnosis of this condition and patients had been prescribed more appropriate treatment. The provider could demonstrate evidence of quality improvement for children with asthma with a two-cycle audit from June 2018 to June 2019. This had resulted in improved diagnosis of dyspnoea (difficulty with breathing) and improved monitoring of these children. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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.