Care Quality Commission

Inspection Evidence Table

Park House Medical Centre (1-569455890)

Inspection date: 21 May 2019

Date of data download: 20 May 2019

Overall rating: Inadequate

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

Safe Rating: Inadequate

The practice was rated inadequate because:

- **The practice did not have clear systems and processes to keep patients safe.**
- **Monitoring was required to ensure that appropriate standards of infection control were met.**
- **There were gaps in systems to assess, monitor and manage risks to patient safety.**
- **Staff did not always have the information they needed to deliver safe care and treatment.**
- **The practice did not have appropriate systems in place for the safe management of medicines.**
- **The practice did not learn and make improvements when things went wrong.**

Safety systems and processes

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.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
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).	Partial
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	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:

- The safeguarding policy did not take into account patients accessing online services. However, we saw evidence of a patient online access to medical records policy, which had safeguards in place.
- One of the clinicians did not have up to date level three safeguarding children training. Training records showed that they had last received this training in 2014. There was evidence that safeguarding training had been booked for the clinician but this was only at level two.
- School nurses could be contacted when required.

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

Explanation of any answers and additional evidence:

- When we reviewed the recruitment records for two new staff, one clinical and non-clinical, there were gaps such as a completed application form or CV and references for the clinical member of staff. The practice told us that this documentation was not requested at the time of recruitment, despite this being a requirement in their recruitment policy. There was no signed contract for a second new member of staff, or proof of entitlement to work. There were no interview summaries for both of the new staff.
- When we reviewed staff immunisation records, there was no evidence that staff received all the required immunisations as per PHE guidelines. This included measles, despite a recent suspected measles outbreak at the practice and learning to ensure that all staff were up to date with their immunisations. There was no system in place to monitor that staff were up to date with their immunisations.
- We were not provided with evidence to show how the registration of nursing staff was regularly monitored.

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: 20 February 2019	Y
There was a record of equipment calibration. Date of last calibration: 20 May 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 13 March 2019	Y
There was a log of fire drills. Date of last drill: 22 October 2018	Y
There was a record of fire alarm checks. Date of last check: 19 May 2019	Y
There was a record of fire training for staff. Date of last training: 25 February 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 30 January 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

- The PAT test records showed the digital thermometers had failed and had been given to one of the staff members to dispose. There was no evidence to show if they had been disposed of and replaced.
- The practice told us that the most recent fire drill was carried out in February 2019; however, this was not documented as the last documented fire drill was in October 2018.
- The fire drill records were incomplete as they did not provide any details of what the fire drill consisted of and any areas identified for improvement.

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: 16 May 2019	Y

Explanation of any answers and additional evidence:

- A legionella risk assessment was carried out on 30 April 2019 but the report was not available at the time of inspection. However, when we reviewed the previous Legionella assessment carried out in 2015, we saw that the risk had been assessed as high and a re-assessment was due in 2017 but this did not take place. The high-risk recommendations with a completion target of three months, such the replacement of the cold-water storage tank and ensuring that areas of non-conformance were actioned in a timely manner to manage legionella risk, had not been actioned.
- A premises/security risk assessment had not been carried out.
- The health and safety risk assessment action plan had been completed. For example, one of the recommendations was to ensure fixed wire testing was carried out. The practice provided evidence to show that this had been arranged with an external company.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met; however, monitoring was required.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: 4 March 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- Not all clinicians had received infection control update training. One clinician had last received this training in 2016.
- The infection control audit action plan had not been completed, although we saw evidence that some actions had been completed.
- There were no sanitary bins provided in the practice toilets, including two of the patient toilets.

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Y
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.	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.	N

Explanation of any answers and additional evidence:

- The approach to managing staff absences was not effective and it was not clear how the practice assessed and monitored the impact on safety. The practice could not assure adequate staffing with the right qualifications and skills, or training to keep patients' safe, as a result of the long-term absence of key staff. This led to a shortage of qualified staff to undertake essential reviews, such as COPD reviews which were completed by junior clinicians, leading to incomplete record keeping.
- One mental health care plan we reviewed did not contain a risk assessment of the patient.
- Despite having access to an occupational health service, the practice did not utilise this service when it came to managing one staff long-term sickness absence.
- There was no rota system in place to ensure adequate staff cover. The practice told us reception staff provided cover for each other and the healthcare assistant would provide some cover for the nurse. They told us that patients were rebooked if there was no nursing cover, or locum nurses were used. However, the practice told us that not all locum nurses were able to carry out long-term condition reviews, leading to low performance in some clinical indicators.
- Sepsis posters were displayed in the reception area and staff told that us they would notify a GP immediately if they encountered a deteriorating patient.

Information to deliver safe care and treatment

Staff did not always 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.	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.	Partial
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

Explanation of any answers and additional evidence:

- The systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment was not operating effectively. For example, we found evidence of incomplete care plans. One patient on lithium (mood-stabiliser) did not have a complete mental health template record and two patients on the palliative care register did not have a care plan in place. As a result, there was a risk that staff and other agencies did not always have the information they needed to enable them to deliver safe care and treatment.
- There was no effective failsafe system to audit inadequate cervical screening results. Following the inspection, the practice carried out an inadequate smear audit; however, it was vague and difficult to establish if the inadequate smears were repeated within the recommended timeframe.
- Clinical meetings were not documented and multi-disciplinary team meeting minutes only included the patient number with no other detail recorded. We saw evidence from these patient records that entries were made discussing the outcome of the meetings, although sometimes vague.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.65	0.60	0.91	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA)	14.7%	10.5%	8.7%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA)	6.23	5.87	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	0.64	1.13	2.13	Significant Variation (positive)

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 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/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice 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.	N
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	N

Explanation of any answers and additional evidence:

- There were no arrangements in place for the monitoring and security of blank prescriptions pads and computer prescription paper, both on delivery and when they were distributed throughout the practice.
- There was no assurance that medicines reviews were taking place or that there was a system in place. We saw evidence that when patients were due medicines reviews on a given date, these were not carried out.
- The process for monitoring high risk medicines was not effective and the prescribing policy in place was not clear about how often monitoring would take place. We found three patients prescribed a high-risk medicine as advised by the secondary care consultant. The practice did not have an effective process to ensure that test results were checked each time a prescription was issued.
- One of two patients prescribed Azathioprine (immunosuppressant) had been provided with three and a half month's supply. There was no effective system to ensure patients were invited for regular blood tests as one of these patients was overdue their blood tests and there was no evidence that they had been invited for their testing.
- There were no arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. The practice told us that they had arrangements with the Clinical Commissioning Group (CCG) medicines team.
- Two patients were prescribed a medicine without being counselled about potential of serious adverse reactions in line with national guidance.

Medicines management	Y/N/Partial
• Data showed evidence of low antibiotic prescribing; however, there was higher broad-spectrum antibiotic prescribing. An audit of antimicrobial use had not been carried out and there was no evidence of clinical meetings, as they were not minuted. There was no evidence that local or national antimicrobial guidelines were used. • The recommended checks for emergency medicines were not carried out on a regular basis. Evidence showed that these checks had only been carried out in May 2019. • Emergency oxygen levels were not monitored or recorded. • The vaccines fridge was over filled and the packaging for some vaccines were soggy. • The healthcare assistant was authorised to administer medicines prior to the patient visit. The authorisation was logged electronically in the patient record.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: • We were not assured that all staff knew how to report significant events, as one non-clinical staff member told us that they were not involved in this process. • From the meeting minutes we reviewed, there was no evidence to show how learning from significant events was shared, as there was no evidence of discussion during meetings, or consideration as agenda items.	

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

Event	Specific action taken
Prescribing and transcribing error that led to patient experiencing side effects.	There was evidence of an investigation and communication between the clinicians involved. Although the practice stated the patient was satisfied with the actions and outcomes, there was no evidence of an apology given to the patient, or evidence that this event would be recorded as a near miss and sent to the National Reporting and Learning System (NRLS).
Suspected measles case and child not isolated when they attended the practice.	The practice performed measles blood tests for all staff that and patients may have come into contact with the patient. Staff were advised of the isolation process. However, the practice did not ensure all staff were up to date with their immunisations, as there were gaps in staff immunisation records on inspection.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial

Explanation of any answers and additional evidence:

- We saw evidence that the practice manager received the safety alerts and distributed them to the clinicians to action. However, when we reviewed their safety alerts, the required action had not been carried out in four alerts identified. This included the safety alerts for sodium valproate and Mirabegron. Searches were only completed on the day of inspection.

Effective Rating: Inadequate

The practice was rated inadequate for providing effective services because:

- **There was limited monitoring of the outcomes of care and treatment and clinical audits did not demonstrate quality improvement.**
- **The practice was unable to show that staff always had the skills, knowledge and experience to carry out their roles.**
- **Patient care needs were not always delivered in line with current standards. We were not assured that there was a robust process for patients with long-term conditions to receive a structured annual review to check their health and medicines needs were being met.**
- **The practice was unable to provide evidence that it always obtained consent to care and treatment.**
- **Some performance data was significantly below local and national averages and there was insufficient evidence to demonstrate how the practice had analysed and improved on this data. Key staff absence led to low performance in some clinical indicators.**

These areas affected all population groups, so we rated all population groups as inadequate.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
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

Explanation of any answers and additional evidence:

- The practice was unable to demonstrate how they kept clinicians up to date with current evidence-based practice. They told us that they held weekly clinical meetings; however, there were no documented meeting minutes.
- We were not assured that patients' ongoing needs were fully assessed or regularly reviewed and updated due to some incomplete care records. For example, we found evidence of incomplete care plans relating to one patient on lithium (mood-stabiliser) who did not have a complete mental health template record. We also found two patients on the palliative care register who did not

have a care plan in place and we observed one historic care record being completed during the inspection.

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) (01/01/2018 to 31/12/2018) (NHSBSA)	0.60	0.42	0.79	No statistical variation

Older people — Population group rating: Inadequate

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. They worked closely with Short-term Assessment, Rehabilitation and Reablement Service (STARRS) and referred patients to the local Integrated Care Team for extended out of hospital care. They were also part of the Whole Systems Integrated Care (WSIC) project, aimed at reducing avoidable hospital admissions.
- Patients with complex needs were also referred to the Complex Patient Group, which included a care navigator as part of their Kilburn network.
- Health checks were offered to patients over 75 years of age.
- 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

- We were not assured that there was a robust process for patients with long-term conditions to receive a structured annual review to check their health and medicines needs were being met. For example, the practice told us that patients were recalled by conditions; therefore, those with more than one condition had to attend a review on more than one occasion. Their medication reviews were being carried out on an ad-hoc basis. When we reviewed a chronic obstructive pulmonary disease (COPD) review record carried out by a junior clinician, we saw the template had not been completed.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- We were not provided with evidence to show how GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

- Patients with suspected hypertension were not offered ambulatory blood pressure monitoring. The practice told us that patients could check their blood pressure using the self-check machine, prior to their medication being issued; however, there was no evidence shown to demonstrate how their performance relating to normal blood pressure levels for patients with diabetes would improve.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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)	82.0%	77.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.2% (33)	11.4%	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)	58.5%	79.3%	77.7%	Variation (negative)
Exception rate (number of exceptions).	12.2% (36)	8.1%	9.8%	N/A

Any additional evidence or comments

The practice was aware of their low performance in some diabetes indicators. They told us that lack of resources in relation to staff meant that diabetes patients were not always able to get their blood pressure checks and some locums were not able to carry out these reviews, due to their lack of training. To improve in this area, the practice had applied for a junior clinician to undergo CCG-led training to enable them to carry out these reviews.

	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)	77.5%	78.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.2% (36)	8.9%	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 assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	76.2%	78.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	12.0% (39)	2.6%	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)	88.4%	93.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	17.3% (9)	9.5%	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)	78.9%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.2% (29)	3.7%	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)	85.7%	85.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.5% (4)	10.6%	6.7%	N/A

Families, children and young people Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were below the recommended targets. The practice told us that they proactively sent out invitations and parents and carers were sent text message reminders. The practice quoted data unverified public health data, which suggested that they had achieved the 90% target in all childhood immunisation indicators.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

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)	72	82	87.8%	Below 90% minimum (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)	77	87	88.5%	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 (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	78	87	89.7%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	79	87	90.8%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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) (01/04/2017 to 31/03/2018) (Public Health England)	69.6%	63.7%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	61.1%	61.8%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	48.6%	42.0%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) **(PHE)**	56.3%	79.2%	70.2%	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)	52.0%	55.2%	51.9%	No statistical variation

Any additional evidence or comments

- When we reviewed the cancer register, we saw that 71% of the 157 patients on the register had received their review within six months of the date of diagnosis and exception reporting was low where only two patients had been exception reported.
- The practice told us that clinician sickness had resulted in cancelled scheduled screening appointments. Appointments were available at the hub and during their extended hours. Unverified public health data quoted by the practice showed that they had achieved a 78% cervical screening uptake rate.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- End of life care was delivered in a coordinated way. However, not all seven patients on the palliative care register had a care plan. We reviewed three palliative care records and saw that two did not have a care plan and one had a care plan, with evidence of anticipatory medicines.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. At the time of inspection, no travellers and homeless patients were registered with the practice.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice was a dementia friendly practice and most of the staff had received dementia training in the last 12 months.

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)	90.0%	88.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	7.7% (5)	7.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption	90.5%	90.4%	90.0%	No statistical variation

has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	3.1% (2)	5.8%	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)	74.3%	84.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.8% (1)	4.1%	6.6%	N/A

Any additional evidence or comments
The practice told us that of the 60 patients on the dementia register, 97% of these patients had received their face to face review. The practice had disputed the QOF dementia performance figures of 74% and stated that this was due to a technical coding issue affecting the care planning template and outside the control of the practice. There was no evidence provided by the practice to support this, or to show how this issue had been rectified.

Monitoring care and treatment

Although the practice had a programme of quality improvement activity, there was no demonstration of improvement in care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	534.5	536.7	537.5
Overall QOF exception reporting (all domains)	5.6%	5.9%	5.8%

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

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

We reviewed three audits that did not demonstrate patient improvement and required peer review. For example, the practice carried out a heart failure audit and stated that 100% of the patients were on appropriate therapy and titrated to the maximum dose. However, when we reviewed this patient list, we saw evidence of patients not on the appropriate therapy and with no explanation provided as to how they could be titrated to the maximum dose. This was also similar to two other audits carried out whereby there was insufficient explanation of results and difficulty in demonstrating quality improvement as a result.

Any additional evidence or comments
• There was no evidence to show how the practice analysed and improved on the areas of high

exception reporting, which were higher than the CCG and national average.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Induction 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

Explanation of any answers and additional evidence:

- We saw evidence that clinicians had received training on immunisations and sample taking; however, there was no evidence to show they were up to date with their chronic disease management training. We also saw that prolonged clinical staff absence had an impact on patient care. For example, the practice told us that due to relevant staff absence, patients due to receive their chronic disease checks were often rebooked. However, we found that this was not always the case, as junior clinicians were carrying out some reviews without evidence of adequate training or supervision. When we reviewed a chronic obstructive pulmonary disease (COPD) review record carried out by a junior clinician, we saw that the template had not been completed.
- There was no clear schedule of training and development. We saw that training that included information governance, sepsis, or fire safety were omitted from the mandatory training summary. There were also gaps in mandatory staff training, with records showing that one clinician had last completed their update infection control training in 2016.
- Although the practice had an induction programme for new staff, there were no documented induction records in place.
- There were two outstanding staff appraisals since January 2019.

Coordinating care and treatment

Staff worked together and with other organisations to deliver 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)	Partial
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

- Multi-disciplinary team meetings were not minuted; however, we saw only patient Emis numbers were recorded.

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

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)	91.9%	95.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.0% (11)	0.6%	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.	N
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
The practice monitored the process for seeking consent appropriately.	N

Explanation of any answers and additional evidence:

- We were not assured that the practice understood the requirements of legislation and guidance when considering consent and decision making. When we reviewed their consent policy, it made an incorrect reference to the mental health act throughout the document, instead of the Mental Capacity Act. The policy did not provide any guidance for staff in relation to Gillick competencies, Fraser guidelines, or the power of attorney.
- Training records showed that two clinicians had not completed their update Mental Capacity Act training and some of the non-clinical staff had last carried out consent training in 2014 and 2016.
- Although we saw that clinicians supported patients to make decisions, we did not see evidence to show how they assessed and recorded a patient's mental capacity.
- The practice told us that they monitored the process of seeking consent appropriately through discussions with patients and use of the Friends and Family test survey. However, we were not provided with evidence to demonstrate this.

Caring Rating: Good

Kindness, respect and compassion

Staff generally treated patients with kindness, respect and compassion. Feedback from patients was mixed 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.	Y

CQC comments cards	
Total comments cards received.	54
Number of CQC comments received which were positive about the service.	43
Number of comments cards received which were mixed about the service.	11
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Mixed comments from patients relating to being treated with dignity and respect. Some of the positive comments related to professional staff and being listened to; however, mixed comments related to dismissive staff and not feeling listened to. Other comments highlighted issues with the building facilities.
NHS Choices	A two-star rating with mostly negative comments. Patients highlighted issues with unfriendly staff and dated facilities.

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
5261	359	107	29.7%	2.03%

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)	84.9%	85.6%	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)	81.1%	82.8%	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)	94.9%	93.1%	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)	83.9%	78.2%	83.8%	No statistical variation

Any additional evidence or comments
The practice had analysed the areas where they were slightly below the CCG and national average. For example, staff reception staff received resilience team training; however, in other areas relating to patients being treated with care and concern had not been analysed. The GPs told us that in areas where patients found it hard to see their own GP, these were difficult to improve.

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

Any additional evidence
• The practice carried out the Friends and Family test (FFT) survey and results showed that 87% of patients were likely to refer the practice to friends and family. • The practice website displayed FFT results; however, these had not been updated since 2015. They had a suggestion box at the reception area, checked weekly and a compliments folder was kept in the kitchen.

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

Source	Feedback
Feedback from patients.	Feedback sent directly to Care Quality Commission (CQC) related to concerns regarding staff attitude towards patients.

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)	92.1%	89.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	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
Explanation of any answers and additional evidence: • Patients had access to support groups such as Hestia, who visited the practice every second week to offer their assistance to patients in crisis.	

Carers	Narrative
Percentage and number of carers identified.	121 patients (2% of the practice population).
How the practice supported carers.	The practice told us that carers were offered flu immunisations. We saw evidence where the practice invited a speaker from Brent carers to discuss the services they offer. Information leaflets were distributed to registered carers.
How the practice supported recently bereaved patients.	The practice told us that bereaved patients received a call from the GP and were referred for counselling where required.

Privacy and dignity

The practice respected patients' privacy and dignity; however, action was required to ensure privacy at the reception desk.

	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.	Partial
Explanation of any answers and additional evidence: • The layout of the reception area did not allow for sufficient privacy at the reception desk; however, there was a private room offered to patients if they required one and a raised desk at reception.	

Responsive Rating:Requires Improvement

The practice was rated inadequate for providing responsive services because:

- **Services provided did not always meet the patient's needs.**
- **Patients with multiple conditions did not have their needs reviewed in one appointment. They had to attend reviews on more than one occasion.**
- **Complaints were not always used to improve the quality of care.**

These areas affected all population groups, so we rated all population groups as requires improvement.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs; however, did not always meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	N
The practice made reasonable adjustments when patients found it hard to access services.	Y
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.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Explanation of any answers and additional evidence:

- The facilities did not always cater for patients with disabilities. For example, there was no visual alarm bell in both patient toilets and there was no grab rail in both the patient toilets located on the ground and first floor. A disability access audit had not been carried out.
- There was a hearing loop available at the practice.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8:00am – 6:30pm
Tuesday	8:00am – 6:30pm
Wednesday	8:00am – 6:30pm
Thursday	8:00am – 6:30pm
Friday	8:00am – 6:30pm
Extended hours:	
Monday	6:30pm – 8:00pm
Wednesday	6:30pm – 8:00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5261	359	107	29.79%	2.03%

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)	95.1%	91.3%	94.8%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Patients were offered double appointments and open telephone triage.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions did not have their needs reviewed in one appointment. The practice told us that patients were recalled by conditions; therefore, those with more than one condition had to attend a review on more than one occasion.
- The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- Patients with long-term conditions had access to a dietitian onsite and the diabetes specialist nurse who held clinics at the practice every two months.

Families, children and young people

Population group rating: Requires Improvement

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Telephone consultations were offered.
- The practice was open until 8.00pm on a Monday and Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area.
- Patients could book appointments, order their repeat prescriptions and view their records online.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were generally 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.	Y
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

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)	81.1%	N/A	70.3%	No statistical variation
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)	65.7%	63.3%	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)	67.2%	65.0%	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)	75.9%	67.4%	74.4%	No statistical variation

Source	Feedback
For example, NHS Choices	Six negative comments on NHS Choices out of 15 highlighted issues with access to the service, including the difficulty with accessing nurse appointments. Two reviewers were satisfied with their access to care.
Comment Cards	Eleven out of 54 comment cards highlighted issues with access to appointments; however, most of the comment cards did not highlight issues with access.

Listening and learning from concerns and complaints

Complaints were listened and responded to; however, they were not always used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	3
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N

Explanation of any answers and additional evidence:

- All three complaints related to patient concerns regarding the attitude of staff towards them. From the one complaint examined, there was no evidence that the complaint was used to drive improvement in relation to staff attitude.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy with staff attitude during consultation.	Practice response to the written complaint was a statement from the staff member concerned to the patient and not a response letter to the patient. The patient was also not provided with further advice on the complaint's procedure, such as how to contact the ombudsman if they were not satisfied with the practice response. Although there was an apology issued with this statement, there was no evidence to show how the practice would rectify the attitude displayed by the staff member concerned towards the patient.

Well-led Rating: Inadequate

The practice was rated inadequate for providing well-led services because:

- **Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.**
- **While the practice had a clear vision, that vision was not supported by a credible strategy.**
- **The practice culture did not effectively support high quality sustainable care.**
- **The overall governance arrangements were ineffective.**
- **The practice did not have clear and effective processes for managing risks, issues and performance.**
- **The practice did not always act on appropriate and accurate information.**
- **We saw little evidence of systems and processes for learning, continuous improvement and innovation.**

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- We found that leaders were aware of the external and some internal challenges and priorities relating to the quality and future of services and had taken action where necessary to address these challenges. However, they had not recognised and acted on some current issues with the quality of care they provided; particularly, relating to safety and the management of staff, particularly staffing issues.
- The practice had taken action on some of the areas highlighted at the last inspection; for example, they improved on how incoming letters and pathology results were reviewed and actioned in a timely. manner. The lead GP was now responsible for dealing with incoming letters and pathology results.
- The practice was under-resourced and could not assure adequate staffing with the right qualifications and skills, or training to keep patients' safe, as a result of the long-term absence of key staff. This led to a shortage of qualified staff to undertake essential reviews, such as COPD
- The lead GP was a trained paediatrician and several of the GPs had expertise in end of life care and orthopaedics.

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.	Y
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

- The practice had a vision and staff were clear that their roles involved meeting patients' needs. They aspired to deliver high-quality care but had not established effective and sustainable systems to deliver it.
- The practice worked with external stakeholders and were part of a primary care network of four practices, with meetings held at weekends.

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.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial

Explanation of any answers and additional evidence:

- Despite access to occupational health, the practice did not utilise this service to seek advice for a clinical member of staff.
- Following a significant event, there was no evidence that the practice complied with the requirements of the duty of candour or recording a near miss.
- Although there was a whistleblowing policy in place, it did not refer to the NHS Improvement Raising Concerns policy.

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

Source	Feedback
Non-clinical staff	Staff felt that they worked well as a team and there was an effective relationship between managers and staff.
Clinical staff	Staff felt very supported

Governance arrangements

The overall governance arrangements were ineffective.

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

Explanation of any answers and additional evidence:

- Structures, processes and systems to support good governance were not well embedded in the practice. Although there were policies in place, it was not clear how often they were reviewed and some policies such as the consent policy required adequate monitoring to ensure that they complied with legislation and guidance. The consent policy referred to an incorrect legislation, not relevant to consent and decision making.
- Further ineffective governance arrangements were found in relation to recruitment checks, induction, monitoring professional registration and appraisals, consent and decision making and mandatory training.
- Mandatory training was not adequately monitored, as some of the staff had last received information governance training in 2015 and one clinician had last received infection control training in 2016. There were gaps in training such as information governance and not all clinicians had received safeguarding level three training.
- There was evidence that some staff were not always clear about their roles.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
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.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	

- There were no comprehensive assurance systems in place to identify, manage and mitigate risk. This was in relation to medicines management, patient safety alerts, staff immunisations, clinical equipment maintenance, infection control, premises and fire safety, as well as ensuring that previous high-risk recommendations from the Legionella risk assessment were actioned.
- The processes to manage performance were ineffective. This was in relation to handling long-term sickness absence.
- Although there was an audit programme, clinical audits did not always demonstrate quality improvement.

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

- Whilst we saw evidence that some data was used to adjust and improve performance, this was not applied in all areas. For example, diabetes performance indicators were not analysed to identify areas for improvement.
- Our inspection indicated that information was not always reliable and timely. This was in relation to incomplete patient care records and the lack of recorded clinical meeting minutes.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- The practice had analysed the areas where they were slightly below the CCG and national average. For example, staff reception staff received resilience team training; however, in other areas relating to patients being treated with care and concern had not been analysed. The GPs told us that in areas where patients found it hard to see their own GP, these were difficult to improve.

Feedback from Patient Participation Group.

Feedback
We saw that the PPG was active and engaged with the practice. The practice told us that 80 patients had signed up to this group and they were involved in creating newsletters for the practice. The practice acted on their suggestions; for example, they recently invited a community pharmacist and Hestia to present a presentation to a patient forum at their request.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	N

Explanation of any answers and additional evidence:

- We saw some evidence of continuous improvement and this included providing care for patients in their community. However, there was little evidence of learning and improvement in relation to the safety systems of the practice and ensuring clinical meetings, partnership meetings and multi-disciplinary team meetings were being shared effectively.
- The practice had plans to merge with another practice, extend their inhouse clinical team and introduce e-consultations.

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
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