Care Quality Commission

Inspection Evidence Table

Upton Road Surgery (1-1577808904)

Inspection date: 8 August 2019

Date of data download: 15 August 2019

Overall rating: Requires Improvement

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

At the inspection on 12 December 2018, we rated the practice inadequate overall, with a rating of inadequate for providing safe and well led services, and requires improvement for providing effective, caring and responsive services. Warning notices were issued in relation to the breaches in Regulation 12 safe care and treatment and Regulation 17 Good governance. The practice was placed into special measures for a period of six months.

During a follow up focused inspection on 9 May 2019 to check on progress against the warning notices, improvements were evident, and the practice had acted to comply with the legal requirements.

We noted further improvements when we undertook a comprehensive inspection on 8 August 2019 which was to check sufficient improvements had been made across all domains.

The practice is now rated Requires Improvement overall with safe and caring services rated good, and effective, responsive and well led services rated requires improvement.

We rated all population groups as requires improvement because of the issues identified in the effective and responsive domains.

Safe Rating: Good

At the December 2018 inspection, we rated the practice as inadequate for providing safe services because:

- The practice did not have systems and processes to keep patients safe.
- Staff were not being safely recruited.
- 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.
- The premises were not safe and suitable for staff, patients and visitors to use.

At the August 2019 inspection, we rated the practice as good for providing safe services because:

- The practice provided care in a way that kept patients safe and protected them from avoidable harm.
- Checks were in place to ensure staff were recruited safety
- There were appropriate systems for the safe management of medicines
- The practice learnt from investigations of incidents, significant events and complaints and made improvements
- Premises, health and safety risk assessments had been carried out and appropriate actions taken to keep staff, patients and visitors safe.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	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

Safeguarding	Y/N/Partial

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Although there was a safeguarding lead in place at the practice, the office manager and staff we spoke with were not aware of who this was. This lead role was not clearly defined at the practice and staff were unclear about who they would approach with any safeguarding concerns.
- We found that staff had been acting as chaperones without the required training.
- Two staff members had not been subject to the required Disclosure and Barring Service (DBS) checks and one of them had been acting as a chaperone. This staff member also worked in the service for inclusive healthcare for homeless and marginalised groups and had not completed safeguarding training.

At the inspection in August 2019 we found:

- The practice had reinforced the safeguarding leadership structure. There were separate GP leads for adult and child safeguarding. Staff we spoke with were able to identify the person they would approach with any safeguarding concerns. Records showed staff had received role specific training. Clinical staff training requirements met the revised intercollegiate guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff'.
- Staff that acted as chaperones had been trained.
- Staff had received a disclosure and barring (DBS) check where relevant.

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 if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- There were no systems in place to ensure that staff had the required recruitment checks completed on them. Staff had not had the required references submitted and staff members had commenced work without the required Disclosure and Barring Service (DBS) checks and gaps in employment history.
- There was no system in place to ensure staff vaccination was maintained in line with current Public Health England (PHE) guidance as there was no oversight of this at the practice. We asked to see the policy in place in relation to staff immunisations three times during our inspection. No policy was made available to us.

At the inspection in August 2019 we found:

- Recruitment was managed through a new policy and the five recruitment files we checked were in accordance with regulatory requirements.
- The practice had reviewed the immunisation status of applicable employees and maintained a spreadsheet.

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: 14/09/2018	Y
There was a record of equipment calibration. Date of last calibration: 08/04/2019	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: 01/2018	Y
There was a log of fire drills. Date of last drill: 06/2019	Y
There was a record of fire alarm checks. Date of last check: Weekly every Wednesday	Y
There was a record of fire training for staff. Date of last training: Various as per online training records but current	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 01/2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Not all staff who worked within the premises had completed the fire safety training offered by the practice. Staff who had recently transferred to the practice for the new enhanced service for inclusive healthcare for homeless and marginalised groups had not received updated training according to the staff records we looked at during our inspection.
- A risk assessment was implemented for the storage of hazardous substances following our inspection and we saw evidence of this. However, this was not in place at the time of our inspection.

At the inspection in August 2019 we found:

- There was records of current fire safety training for all staff.
- There was evidence of actions taken because of fire safety risk assessments for example portable heaters had been removed to improve fire safety.
- Appropriate risk assessments and controls for the storage of hazardous substances were evident.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 26/09/2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/04/2019 (Site Safety risk assessment)	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- There was no adequate oversight in relation to the premises. We asked to see evidence of how this was risk assessed on an on-going basis and were told that no such risk assessments took place. The premises were not suitable for the new inclusive healthcare service for the homeless and marginalised groups. Staff we spoke with told us they did not feel safe and the required modifications to the premises had not been made to ensure the safety of staff and patients. Staff could not see patients in the waiting area from the reception desk and staff reported to us that they did not have a safe system to alert people if they needed to. The premises did not provide adequate safety measures for this type of service and posed a risk to staff and patients.

At the inspection in August 2019 we found:

- Risk assessments had been completed with adequate safety measures installed including to ensure the safety and confidentiality of staff and patients using the service for the homeless and marginalised groups.
- Staff that worked at this service told us the new improved measures facilitated a better environment for patient care and interaction.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 31 January 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- There was no infection control lead across the service and no systems to ensure that regular infection control audits were completed. There was no record of an infection control. Not all staff had received infection control training as part of their induction and staff were unclear as to who to refer any infection control concerns to. We found staff to be unclear as to how they reported any infection control incidents. One incident involving a blood spillage had been recorded in February 2017, however, no follow action or lessons learnt were recorded.

At the inspection in August 2019 we found:

- Infection control was implemented and managed through a practice policy. There was an infection control lead. Staff had received infection control training through an online training resource. Following a recent infection control audit several improvements were evident. These included replacement of waiting room chairs and an enhanced spillage kit to clean accidental body fluid spillage. Other related audits were evident. For example, a hand hygiene audit was completed in April 2019 with actions progressed to ensure appropriate handwashing techniques.

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
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Due to a lack of effective practice management being in place, there was no evidence of any planning in terms of the practice workforce and there was little in place in terms of an effective and tailored induction programme for staff. One member of staff we spoke with had not had any induction prior to starting their role and had no training completed at the time of our inspection. They had been working at the practice since June 2018. The practice used locum GPs, but we did not see evidence of locum induction packs.
- Staff we spoke with knew the action they would take in the case of an acutely unwell patient. However, staff had not received any training in relation to Sepsis (a life-threatening reaction to an infection).

At the inspection in August 2019 we found:

- Practice management was strengthened with a practice manager in post (seconded from a consultancy company). There were strengthened governance arrangements. There was evidence of systematic evaluation of staffing needs, for example a service lead had been recruited to the service for inclusive healthcare for homeless and marginalised groups, and the practice had further plans for staff recruitment through joint working with the Primary Care Network (PCN). There was evidence of an induction process for new staff and we saw evidence of this in the recruitment files

we reviewed. A locum induction pack was available for temporary staff.
- Staff had received Sepsis training in April 2019 and the practice had plans for regular updates.

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 and there was a system to monitor delays in referrals.	P
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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

Appropriate and safe use of medicines

The practice had 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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.81	0.84	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	8.7%	9.5%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.00	5.89	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.30	1.58	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols 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
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

Explanation of any answers and additional evidence:
At the inspection in December 2018 we found:

- Blank prescriptions were not being stored securely including overnight. We found blank prescriptions in the Doctors bag and found that prescription numbers were not logged and monitored to ensure they were managed safely.
- The safety of storing medicines that needed refrigeration, within the enhanced service for inclusive healthcare for homeless and marginalised groups were not in accordance with the protocol for ordering, storing and handling vaccines issued by Public Health England (PHE).

At the inspection in August 2019 we found:

- The practice operated a system to log blank computer-generated prescription sheets. Rooms with printers that contained blank prescriptions were locked when not in use. Prescription sheets left within printers were removed and stored securely at the end of the day or at the end of a session as applicable. Pads for handwritten prescriptions (usually carried in the doctor's bag) were logged by each GP.
- The vaccine refrigerator within the enhanced service for inclusive healthcare for homeless and marginalised groups had been replaced.
- Medicines that needed refrigeration were stored in accordance with a cold chain policy and staff had been trained in vaccine management. Temperature monitoring was evident as per guidance by PHE. In addition, we saw monthly audits were used to check temperature fluctuations.

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
Number of events recorded in last 12 months: (since January 2019)	35
Number of events that required action:	22

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Inadequate system in place for recording and acting on incidents and significant events which took place at the practice. Staff we spoke with were not always clear on where these should be recorded. There was no evidence that incidents of significant events were monitored to look for any trends or patterns. There was no evidence of any learning from these. There was no analysis or oversight of complaints at the practice. Although complaints were looked at and responded to, they were not collated to look for trends and patterns and no learning outcomes were identified as a result of complaints to drive continuous improvement. Systems were introduced to improve this following our inspection, however, these systems were not in place at the time we inspected the practice.

At the inspection in August 2019 we found:

- There was a system to report log and act on incidents and significant events and complaints which was managed by the deputy practice manager. Events were recorded individually and were accessible to all staff including locum staff on the practice shared computer drive. Discussion of Incidents and significant events and any learning points were evident during staff meetings. Any event that needed immediate action were discussed during the daily lunchtime 'Huddle' which was a quick get together of staff available on the premises each day. An annual review of significant events in July 2019 had identified three trends related to administration errors, unacceptable behaviours from patients and medicines. An annual review of complaints had identified a specific trend with the practice telephone system. The practice intended to use the next monthly protected training afternoon to discuss trends identified and provide any additional training as needed.
- We found a larger than expected number of significant events recorded since January 2019. Our review of a sample suggested that this might be due to the interpretation of the definition of a significant event.

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

Event	Specific action taken
Regular patient monitoring because of the type of medicine they were prescribed	The clinical team had introduced revised processes, so the monitoring was done in a timely manner to maintain patient safety

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

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- The system for recording and acting on safety alerts did not ensure that all safety alerts were seen and recorded.

At the inspection in August 2019 we found:

- A revised protocol for managing safety alerts was evident. There was a responsible lead GP. A spreadsheet gave the status of all alerts received since July 2018 which also contained details of actions taken. Safety alerts were discussed during practice meetings. We checked actions taken in response to three alerts and we found the practice had acted upon these appropriately. For example, the practice had reviewed patients that carried automatic anti-allergy injector pens to treat severe, life-threatening allergic reactions in an emergency (because of faulty allergy injectors) and had acted appropriately as per the guidance given in the safety alert.

Effective Rating: Requires Improvement

At the December 2018 inspection, we rated the practice as requires improvement for providing effective services because:

- Consent was not always being sought as required by law and that staff were not being adequately trained and supported in their roles.

At the August 2019 inspection, we rated the practice as Requires Improvement for providing effective services because:

- A review of unverified monitoring data for 2018/19 for long term conditions showed that the practice had improved in some indicators while others showed a decline in performance.
- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.
- The operation of the 'failsafe system' to check on outstanding cytology results so these were operated as intended needed improvement.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways 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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: Care provision for people with long term conditions, families children and young people and Working age people (including those recently retired and students) needed improvement. Details are given in the population groups section. Digital services were governed by 'good practice guidelines for general practice electronic patient records'.	

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) (01/04/2018 to 31/03/2019) (NHSBSA)	0.82	0.60	0.77	No statistical variation

Older people

Population group rating: Good

Findings

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice supported approximately 49 patients living in two care homes. The practice operated weekly ward rounds at these homes to assess and treat patients as needed.
- The practice carried out structured annual medication reviews for older patients.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. A frailty coordinator offered support older to patients over the age of 75 who were living with moderate or severe frailty.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, a review of unverified monitoring data for 2018/19 for long term conditions showed that the practice had improved in some indicators while others showed a decline in performance.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- The percentage of patients with diabetes, on the register, in whom the last blood test showed good control in the preceding 12 months was lower than the CCG and England average.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- 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)	64.8%	78.2%	78.8%	Variation (negative)
Exception rate (number of exceptions).	3.3% (19)	15.0%	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	79.2%	76.6%	77.7%	No statistical variation

to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	3.1% (18)	10.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	76.5%	79.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	4.7% (27)	13.2%	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)	86.8%	75.6%	76.0%	Variation (positive)
Exception rate (number of exceptions).	1.4% (5)	5.7%	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)	95.4%	90.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	3.6% (4)	9.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.2%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.8% (23)	3.5%	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%	91.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.5% (3)	5.9%	6.7%	N/A

Any additional evidence or comments

The practice was aware of the lower than the CCG and England average of patients with diabetes, on the register, in whom the last blood test showed good control in the preceding 12 months. The lead GP told us that the practice population had high proportion of patients of Asian origin and compliance with attendance for monitoring was an issue. The practice had developed a plan that included increased access to a nurse led clinic to increase compliance.

A review of unverified monitoring data for 2018/19 for long term conditions showed that the practice had improved in some indicators while others showed a decline in performance as follows:

Diabetes

- 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: 69% (64.8% in 2017/18)
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading140/80 mmHg or less: 70% (79.2% in 2017/18)
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol is 5 mmol/l or less: 77% (76.5% in 2017/18)

Other long-term conditions

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control:78% (86.8% in 2017/18)
- 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: 81% (95.4% in 2017/18)
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less: 76% (84.2% in 2017/18)
- 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 90% (85.7% in 2017/18)

Families, children and young people*

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.
- 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.
- 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.
- Young people could access services for sexual health and contraception.
- The practice policy did not match clinical practice described by clinicians on assessing the capacity of children to consent to medical treatment (Gillick competent).
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	106	121	87.6%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	118	135	87.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	119	135	88.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	116	135	85.9%	Below 90% minimum

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

Any additional evidence or comments
The practice was aware of the slightly lower uptake of childhood immunisation compared to WHO targets and were reviewing their recording systems and patient recall systems to ensure better compliance.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings
• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. • 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. • The practice's 'failsafe system' to check on outstanding cytology results had been paused for several months.

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)	69.0%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	62.6%	69.9%	69.9%	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)**	43.6%	55.3%	54.4%	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)**	77.8%	75.6%	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)	53.8%	51.6%	51.9%	No statistical variation

Any additional evidence or comments

- The practice was reviewing the below 70% uptake for cervical cancer screening. They told us a contributing factor was the processing laboratory services operating with a backlog of 10 weeks.
- A review of unverified monitoring data for 2018/19 for cancer indicators showed that the practice had improved performance as follows:
    - 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): 85% (69% in 2017/18)
    - 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: 100% (77.8% in 2017/18)
- At our inspection we found 65 cervical cytology results outstanding from specimens sent in May 2019. The practice advised that the laboratory services were operating with a backlog of 10 weeks and at the laboratory's request the practice operated a checking system only for patients that expressed a concern at this delay. The practice gave us an example of a GP checking with the laboratory. However, we found the practice's 'failsafe system' to check on outstanding cytology results had been paused for several months. After our inspection the practice wrote to us and confirmed 'failsafe system' had been reinstated and that 24 results were still outstanding.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• The practice provided inclusive healthcare for homeless and marginalised groups. • Same day appointments and longer appointments were offered when required. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice provided a service for inclusive healthcare for homeless and marginalised groups.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

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. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

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)	96.6%	90.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	2.2% (2)	7.8%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.1%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (2)	6.8%	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)	97.8%	84.9%	83.0%	Variation (positive)
Exception rate (number of exceptions).	4.2% (2)	4.6%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	535.6	539.9	537.5
Overall QOF score (as a percentage of maximum)	95.8%	96.6%	96.2%
Overall QOF exception reporting (all domains)	4.0%	5.2%	5.8%

	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
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- An audit of patients that received a medicine to treat pain caused by damage or disease affecting nervous system had resulted in ensuring only patients with clear indication of need received this medicine.
- An audit of patients that received certain medicines that required regular monitoring had resulted in the rationalisation of these prescriptions based on patient need, monitoring and a reminder system for patient compliance with the monitoring requirements.

Any additional evidence or comments

At the inspection in December 2018 we found:

- There was a lack of effective management oversight and we saw no evidence of effective clinical audits during our inspection, despite asking for these. We found no evidence of improvement initiatives as a result of any quality improvement activity. The lack of effective practice management meant that there was little quality monitoring or audit activity at the practice.

At the inspection in August 2019 we found:

- The practice had established a quality improvement plan which included clinical audits. We reviewed three. Two of these (completed in April and May 2019) were two cycle audits. Clinical audits were led by a clinician and we saw evidence of discussions with appropriate clinicians of the results and any improvements that may be needed. We also saw evidence of participation in CCG led audits for example antibacterial prescriptions.

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.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	P
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Although some staff had received an appraisal in the last 12 months, there was no on-going monitoring of staff performance and staff we spoke with told us that they did not attend regular one to one meeting with their line manager. Staff did say that management were approachable, however, when we asked to see an overview of staff training, this was not made available to us as no such overview existed. We found gaps in staff training and one staff member had not received any training since commencing their employment at the practice in June 2018. The records we looked at were chaotic and the office manager was unable to locate staff training files easily.

At the inspection in August 2019 we found:

- A training matrix that detailed training needs and compliance, based on job roles was evident. This matrix showed that mandatory training specified by the practice was current. Staff had received appraisals in the previous 12 months. Staff communication had been improved. The GPs and practice management operated an open-door policy for staff communication and daily ‘Huddles’ around midday to discuss immediate issues. In addition, the practice participated in a half day learning and development day together with an adjoining practice usually during the first Tuesday of each month.
- The advanced nurse practitioner (ANP) and clinical pharmacist undertook independent consultation in the minor illness clinics. The nurses participated in group supervision provided by the CCG. The clinical pharmacist had a designated clinical mentor with a buddy mentor who were always on site during minor illness consultations and had a two weekly meeting to discuss competency and training needs. However, there was no formal documentation of this process. For daily and periodic clinical oversight both the ANP and clinical pharmacist took part in a daily huddle

	(a lunchtime meeting that involved all staff to communicate and agree issues related to clinical and other issues encountered. Short bullet point records of the Huddle were kept. Both ANP and clinical pharmacist had access to a GP during their minor illness sessions where they could discuss specific clinical issues including advise on prescribing. The practice monitored prescribing patterns through the CCG dashboards, but this was collective and not individual prescribing patterns. The practice did not currently audit the clinical effectiveness of the decisions made about treatments of both the ANP and clinical pharmacist.

Coordinating care and treatment

Staff did not always work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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.	P
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: • Cancer two-week referrals: The GP usually booked this appointment electronically via the hospital's referral system while the patient was in consultation with them. If an appointment was not available electronically the GP deferred the request to the hospital who then contacted the patient by telephone with an appointment. The patient was given written instructions on the process of securing this appointment. However, we found that the practice did not have a system to check if the patient with deferred referrals had received a confirmed appointment.	

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
Patients had access to appropriate health assessments and checks.	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: • Health checks were provided by the Health Care Assistant • The practice offered referrals to external wellbeing programmes such as 'shape up exercises, and other social prescribing initiatives.	

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)	96.6%	94.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (6)	0.6%	0.8%	N/A

Consent to care and treatment

The practice 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 make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- The practice had registered 16 patients from St Anthony's Care Home in Watford, Hertfordshire. None of these patients had given consent to register with the practice and all the registration forms we looked at had not been signed to provide patient consent. We were told that this alignment of the care home to the practice was done as directed by the CCG. This did not remove the requirement for patient consent. Some of these patients may have lacked the mental capacity to agree to a change in their GP. This had not been considered by the practice. We found a lack of evidence in terms of how mental capacity was considered at the practice by clinicians and staff. There was a lack of understanding of this across the practice and improvement was needed in understanding and requiring the legal requirements in relation to consent and mental capacity.

At the inspection in August 2019 we found:

- The practice had taken steps to ensure affected patients or their legal representatives had

consented to the transfer of care from their previous provider. We saw evidence that practice staff had completed an in-house training on the legal reasons why consent should be sought prior to having any patient join the practice or have a procedure done.

- Consent and application of Gillick Competencies:
  The practice policy on treating children stated that any child up to the age of 16 would only be seen if accompanied by a parent or legal guardian. We raised this issue with the GPs they told us that in practice they would see mature children of this age independently without a parent or legal guardian and were unaware that the practice policy contradicted clinical practice. The GPs talked us through examples where they had indeed seen such patients independently and had applied the principles of Gillick competencies during such consultation on whether it was appropriate to proceed. Immediately after the inspection the practice sent us an amended policy that reflected current clinical practice.

Caring Rating: Good

At the December 2018 inspection, we rated the practice as requires improvement for providing caring services because:

- Patients had not always been treated appropriately and there was limited evidence of how the practice considered feedback from patients.

At the August 2019 inspection, we rated the practice as good for providing caring services because:

- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients we spoke with and comment cards we received during the inspection indicated that staff were helpful and caring.

We found one area where the provider should improve:
Look at methods to improve patient satisfaction (based on 2019 national GP survey results) in relation to interaction with a healthcare professional during consultations.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	22
Number of CQC comments received which were positive about the service.	19
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment card	Staff always courteous. They work above and beyond to reassure and explain care and treatment.
Comment cars	An exceptionally good service. The clinical staff and receptionists are very friendly and

	helpful.
Patient	Can be difficult to obtain on the day appointment. Must telephone several times starting at 8am before the call is successfully answered. But the clinical service is very good, and the GPs are listening and caring.

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
9482	469	115	24.5%	1.21%

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 (01/01/2019 to 31/03/2019)	83.5%	90.0%	88.9%	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 (01/01/2019 to 31/03/2019)	78.2%	88.5%	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 (01/01/2019 to 31/03/2019)	92.9%	96.3%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	81.5%	86.2%	82.9%	No statistical variation

Any additional evidence or comments
• Patient feedback from the latest GP patient survey rates the practice positively although marginal positive and negative variations were evident against the previous year's results. Comment cards and patient feedback received on the day of inspections also rated caring services positively.

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

Any additional evidence or comments

At the inspection in December 2018 we found:

- There was no patient feedback survey completed over the last 12 months. It was not clear how the practice assessed patient experience or how they took on feedback from patients to drive improvements

At the inspection in August 2019 we found:

- In response to the 2018 National GP Survey results the practice had in March 2019 carried out its own patient survey. It had also reviewed complaints and comments received and identified a trend in patient dissatisfaction with the telephone system. Work was underway to review and make improvements to the telephone system. Work was also being progressed to reorganise the appointment system that included encouraging patients to use the online system, and to make more time available for telephone consultations. This was being supervised through the practice governance structure.

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
Interviews with patients.	We spoke with six patients. They all told us that the GPs nurses and other clinical staff always listened to them and explained any care and treatment proposed.

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 (01/01/2019 to 31/03/2019)	94.3%	94.4%	93.4%	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: • The practice told us that information in other languages and in other accessible formats could be made available if needed.	

Carers	Narrative
Percentage and number of carers identified.	1.2%, 113 carers
How the practice supported carers (including young carers).	There was a process for identifying carers that included a recent text messaging campaign. There was a notice board which provided information for carers including external organisations that provided help and support. There were two carers champions. Carers could be referred to Carers in Hertfordshire as appropriate.
How the practice supported recently bereaved patients.	The practice usually contacted the bereaved family and offered signposting to appropriate organisations for support and counselling.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Explanation of any answers and additional evidence:

To subscribe to the online services offered by the practice such as for example to book or cancel appointments, order repeat prescriptions or view parts of GP record, appropriate information was provided to the patient during the patient registration process to access these services.

Responsive

Rating: Requires Improvement

At the December 2018 inspection, we rated the practice as requires improvement for providing responsive services because:

- The practice had not always responded to patient needs.

At the August 2019 inspection, we rated the practice as Requires Improvement for providing responsive services because:

- Patients satisfaction in relation to access to care and treatment in a timely way in the 2019 National GP Survey had significantly decreased in comparison to the 2018 National GP Survey results.
- The issues related to access to care and treatment affected all population groups, so we rated all population groups as requires improvement.

We found one area where the provider should improve:
Look at methods to improve patient satisfaction (based on 2019 national GP survey results) in relation to access to the services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	08:30 – 18:30
Tuesday	08:30 – 18:30
Wednesday	08:30 – 18:30
Thursday	08:30 – 18:30
Friday	08:30 – 18:30
	08:30 – 18:30

There is extended opening one day each week on varying days until 8.45pm for GP, healthcare assistant and pharmacist appointments.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9482	469	115	24.5%	1.21%

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 (01/01/2019 to 31/03/2019)	93.2%	95.2%	94.5%	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.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Requires Improvement

Findings

- As part of the Watford extended access, families, children and young people could access weekday and weekend GP appointments.
- 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. Records we looked at confirmed this.
- 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.
- The practice offered flexible appointments to maintain continuity of care. Face to face consultations were available on the day as well as pre- bookable appointments up to 14 days in advance.
- Telephone consultations with a GP and the nurse were available which supported patients who were unable to attend the practice during normal working hours.
- Extended opening one day each week was available on varying days until 8.45pm for GP and healthcare assistant appointments.
- The practice offered temporary medical services to returning university students for example during university vacation periods.
- Through the Electronic Prescribing System (EPS) patients could order repeat medicines online and collect the medicines from a pharmacy near their workplace or any other convenient location.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice provided a healthcare service for the homeless and marginalised groups
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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.
- Patients had access to the wellbeing service hosted by the local mental health trust for care and support.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were, at times, not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	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

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- We found instances of patients being treated without being seen by a GP when this would have been appropriate. One patient had waited for seven weeks for a blood test without any clear explanation from the practice as to why this had happened. The practice had failed to provide adequate care and treatment to this patient.
- We found that visits to a local care home had not always been made as planned. The practice had stated that this was due to staff shortages.

At the inspection in August 2019 we found:

- Guidance was available for reception staff to direct patients to a GP, nurse or clinical pharmacist appointment.
- The practice supported approximately 49 patients living in two care homes. The practice operated structured weekly ward rounds to assess and treat patients as needed that lived at these homes.

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 (01/01/2019 to 31/03/2019)	60.7%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	62.2%	71.6%	67.4%	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 (01/01/2019 to 31/03/2019)	65.7%	66.7%	64.7%	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 (01/01/2019 to 31/03/2019)	65.1%	76.5%	73.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison

Explanation of any answers and additional evidence:

In comparison with the 2018 GP patient survey results, we noted patient satisfaction in 2019, in relation to timely access had significantly decreased.

The 2018 results with the 2019 comparisons are given below:

- 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: 82% (60.7% in 2019)
- The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment: 80% (62.2% in 2019)
- The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times: 71% (65.7% in 2019)
- The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered 72% (65.1% in 2019)

In response to the 2018 National GP Survey results the practice had in March 2019 carried out its own patient survey. It had also reviewed complaints and comments received and identified a trend in patient dissatisfaction with the telephone system. Work was underway to review and make improvements to the telephone system. Work was also being progressed to reorganise the appointment system that included encouraging patients to use the online system, and to make more time available for telephone consultations. This was being supervised through the practice governance structure.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	28
Number of complaints we examined.	28
Number of complaints we examined that were satisfactorily handled in a timely way.	28
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.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient not kept in the loop about a clinical decision to refer to acute services	Apology given to patient. Patient communication procedure was updated reinforcing clinician responsibility for keeping patient in the loop. Staff reminded of their responsibly and discussed during practice meeting.
Concern about involvement in medicine clinical trial	Even though written patient consent was on file the practice wrote to the complainant explaining the shared information protocol in clinical trials.

Well-led Rating: Requires Improvement

At the December 2018 inspection, we rated the practice as inadequate for providing well-led services because:

- There was no clear governance structure in place at the practice. Roles and responsibilities were not clearly defined. Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- The practice lacked a clear vision and there was no credible strategy in place.
- 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.

At the August 2019 inspection, we rated the practice as requires improvement for providing well led services because:

- The practice had implemented systems that provided leadership and governance which had promoted a positive culture to support inclusive patient centred care. However, systems and process to review clinical and quality monitoring data were not fully established.

We found the following areas where the provider must improve:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care:
  This was because:
- Systems and process to review clinical and quality monitoring data were not fully established. The quality of data in some areas needed refinement so it accurately reflected performance Examples included the clarification of the definition of a significant event, so such events are classified appropriately; the monitoring of long term conditions, the operation of the 'failsafe system' to check on outstanding cytology results so these are operated as intended; the follow up of patients referred under the cancer two-week referrals process; the arrangements to audit the clinical effectiveness of the decisions made by the ANP and the clinical pharmacist; a policy we reviewed which related to treating children stated that any child up to the age of 16 did not reflect clinical practice.

- **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
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- Recent changes to service provision. However, the associated risks had not been fully evaluated to safely and effectively implement the required changes. A supporting management structure was not evident.

At the inspection in August 2019 we found:

- The integration of the enhanced service for inclusive healthcare for homeless and marginalised groups into the practice service was complete. There was a dedicated lead for this service.
- Risks to service provision across the practice including for the service for inclusive healthcare for homeless and marginalised groups had been evaluated and the practice maintained a risk register with specific actions highlighted and implemented.
- A new leadership team was evident comprising a seconded practice manager, deputy practice manager and governance management team. The lead GP told us that the leadership arrangement will be further refined as they intended to merge with an adjoining practice soon.
- Regular staff meetings, training days and away days were part of the development for leaders.

Vision and strategy

The practice had a vision and 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.	Y
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.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- There was lack of clarity on the vision and values of the practice. Changes were not well communicated to staff. Meeting minutes focussed on finances. Staff told us that they felt under pressure due to the changes being implemented and noted that they did not have the time to consolidate their work and plan effectively. An overarching strategy was not in place with the supporting management structure.

At the inspection in August 2019 we found:

- The practice had developed a vision which included 11 points directed at providing a patient centred care that was evidence based and delivered by trained staff using modern technology wherever possible to gain the best health outcomes for the practice population.
- There were structured staff meetings, training and away days which facilitated effective communication.
- The staff members we spoke with told us that their working environment was more supportive and facilitative and that leaders were very approachable.
- There was a practice plan for improvements which was being facilitated by consultancy company. These included priority work in complying with the legal requirements in health care provision and the merger with the adjoining practice.
- A new leadership team was evident which staff told us was supportive.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

At the inspection in December 2018 we found:

- There was no direction in terms of how staff were expected to behave due to the lack of stated vision and values. There was little in place to ensure staff well-being due to the demands on the role of the office manager and the number of changes which had been implemented very quickly and with little support. Staff in the service for inclusive healthcare for homeless and marginalised groups did not always feel supported.

At the inspection in August 2019 we found:

- The practice had developed a vision. There were structured staff meetings, training and away days which facilitated effective communication.
- The GPs and practice management operated an open-door policy for staff communication and daily 'Huddles' to discuss immediate issues.
- The staff members we spoke with told us that their working environment was more supportive and facilitative and that leaders were very approachable.
- A new leadership team was evident which staff told us was supportive. This included a dedicated lead for the homeless and marginalised groups, the appointment of a seconded practice manager and deputy practice manager.

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

Source	Feedback
Non-clinical staff	The relationship between managers and staff were approachable and friendly
Clinical staff	In the past months the working environment has improved considerably. GPs and senior leaders are very approachable listen to us and together make improvements.

Governance arrangements

There were responsibilities, roles and systems of accountability to support governance and management however, further improvements were required.

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

Explanation of any answers and additional evidence:
At the inspection in December 2018 we found:

- There was no governance structure in place. There were no systems and structures in place to ensure that the quality of care and treatment was being assessed on an on-going basis. Roles and responsibilities were not clearly defined which meant that information was recorded but that no analysis or learning happened as a result. There was no evidence of the practice understanding their risks and no evidence of continuous improvement.

At the inspection in August 2019 we found:

- The practice had taken steps to improve governance structures. Lead roles had been defined. Meetings were formalised. The policies and procedures we reviewed had been updated except for the policy on determining the capacity of children to consent to medical treatment (Gillick competent) which was updated immediately after our inspection.
- A seconded practice manger was in post supported by a consultancy company.
- The practice was working with the CCG to explore the possibility of merging with the nearby practice based on the upper floor of the practice building.
- Systems for understanding risks and learning from significant events incidents and complaints had been refocused and these were now regularly reviewed that included annual reviews trend analysis and actions to ensure continuous improvements. However, these systems were not fully established as the quality of data in some areas needed overview refinement and purpose so it accurately reflected performance and reported variance in a timely way. For example, those to cervical cytology, monitoring of nurse prescribing levels.

Managing risks, issues and performance

There were 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

Explanation of any answers and additional evidence:
At the inspection in December 2018 we found:

- Due to ineffective management and governance at the practice there was no oversight of risk. No risk register was in place. There was no clarity on staff training needs or an audit of staff performance, training and recruitment needs. Changes had been implemented at the practice without adequate planning and risk assessment and this had impacted on the quality of care and treatment.

At the inspection in August 2019 we found:

- The practice had undertaken premises/security and health and safety and other risk assessments.
- Identified risks were recorded in the practice risk register with specific actions highlighted.
- Training needs of staff had been reviewed and records of staff mandatory training (as specified by the practice) were now maintained.
- The practice told us that lessons had been learnt with the transfer of the enhanced service for inclusive healthcare for homeless and marginalised groups and the care homes realignment project and appropriate actions had been taken to mitigate the risks that had arisen and to avoid a reoccurrence.

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

Explanation of any answers and additional evidence:
At the inspection in December 2018 we found:

- There was an absence of clinical and quality monitoring data which meant that this could not be used to drive improvement and to act on information appropriately. Information we were shown during our inspection was difficult to locate and there was no oversight and effective management of information held at the practice. Risks were not being mitigated on an on-going basis due to a lack of oversight. The practice had not submitted any recent notifications to CQC despite these being required by law.

At the inspection in August 2019 we found:

- While the practice had a process to review clinical and quality monitoring data, we found this was not fully established as the quality of data in some areas needed refinement so it accurately reflected performance. For example, the definition of a significant event needed clarifying; the 'failsafe system' to check on outstanding cytology results needed management overview to ensure this was operated as intended; the follow up of patients referred under the cancer two-week referrals process; the arrangements to audit the clinical effectiveness of the decisions made by the ANP and the clinical pharmacist; a policy we reviewed which related to treating children stated that any child up to the age of 16 did not reflect clinical practice.
- The lead GP told us that with the establishment of the new leadership team which included the recent appointment of a seconded manager and deputy, and the governance management team would help focus management and provide the oversight needed.
- The registered manager was aware of their responsibilities in making notifications to the CQC.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:
At the inspection in December 2018 we found:

- There was little evidence of consultation with patients. Staff recent changes had not been managed effectively and remained unclear about the future of their roles.

At the inspection in August 2019 we found:

- There were two active patient participation groups. One for the entire practice and another dedicated to people that used the service for inclusive healthcare for homeless and marginalised groups. The practice operated a 'you said' 'what we have done/doing' format to report on issues highlighted for improvements. For example, in response to patients being unaware of services available, the practice had incorporated the service for inclusive healthcare for homeless and marginalised groups in the practice leaflet and updated a poster board with access times for the service.
- The practice had reviewed significant events and complaints and through a recent annual review had identified trends and action point for making improvements.
- There was daily lunchtime 'Huddles' which was a quick get together of staff available on the premises each day to discuss immediate issues and provide updates.
- Job roles had been clarified and staff we spoke with felt supported and listened to.

Feedback from Patient Participation Group.

Feedback
• We did not speak to members of the Patient Participation Group. However, we reviewed recent minutes of meetings. These related to meetings held in July and August 2019. The two PPGs met independently, approximately 6 to eight weeks intervals. • The PPG that supported people that used the service for inclusive healthcare for homeless and marginalised groups had recently moved their meeting location to a charity restaurant and had reported better attendance. A variety of service and community related issued were discussed with agreements for improvements made. • The whole practice PPG met at the practice and usually chaired by the practice manager with attendance by a GP. A review of the most recent minutes showed a variety of topics were discussed. For example, health promotion issues such as bowel screening and general issues such as car parking.

Continuous improvement and innovation

There was 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.	Y

Explanation of any answers and additional evidence:

- The practice overall was committed to continuous improvements demonstrated by improved and focused staff training, infection control processes, systems for the management of cold chain. This had been complemented by defined leadership and governance structures.
- Through recently established governance and structured meetings the practice ensured lessons were learnt and appropriate improvements made.

Examples of continuous learning and improvement
• The service for inclusive healthcare for homeless and marginalised groups offered evidence based and non-judgemental primary health care. The service was delivered in conjunction with partner agencies to ensure the best possible outcome for this population group. Arrangements included the provision of outreach one morning a week to register patients booking appointments and fostering relationships, onsite chaplaincy and counselling service, supporting people with complex needs including through community navigators to signpost appropriate local services alongside social prescribing where appropriate.

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.