

Care Quality Commission

Inspection Evidence Table

The Mitcham Medical Centre (1-558070433)

Inspection date: 17 December 2019

Date of data download: 13 December 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Requires Improvement

The practice was rated as requires improvement for providing safe services because:

- The systems and processes in place to keep patients safe required improvement; for example, we found gaps in safety systems and records, infection prevention and control, safe management of medicines and significant events.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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.	Partial
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	Y

Safeguarding	Y/N/Partial
workers to support and protect adults and children at risk of significant harm.	
During the inspection we found that one out of eight clinical staff and 18 out of 20 non-clinical staff had not completed the required level of child safeguarding training. After we raised this issue with the provider informed us that all staff had completed the required level of training and sent us their updated staff training log with training completion dates the day following the inspection.	

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
The practice had a record of Hepatitis B vaccinations in staff files we looked at had a disclaimer in place for staff who refused to be vaccinated.	

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 (Main site): May 2019 Date of last inspection/test (Branch site): May 2019	Y
There was a record of equipment calibration. Date of last calibration (Main site): 01 February 2019 Date of last calibration (Branch site): 01 February 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 (Main site): August 2019 Date of last check (Branch site): Not carried out	Partial
There was a log of fire drills. Date of last drill (Main site): 13 December 2019 Date of last drill (Branch site): December 2019	Partial
There was a record of fire alarm checks. Date of last check (Main site): Weekly Checks Date of last check (Branch site): April 2019	Partial
There was a record of fire training for staff. Date of last training: December 2019	Y

There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion (Main site): 14 November 2019 Date of completion (Branch site): 19 November 2019	Y
Actions from fire risk assessment were identified and completed.	Partial
1. There was no record of fire extinguisher checks in the branch site. 2. There was no log of fire drills before December 2019 in the branch site. 3. No record of fire alarm checks in the branch site since April 2019. 4. Actions following the fire risk assessment had not been completed.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment (Main site): 14 November 2019 Date of last assessment (Branch site): November 2019	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment (Main site): 14 November 2019 Date of last assessment (Branch site): November 2019	Partial
<ul style="list-style-type: none"> • Actions following the health and safety risk assessment had not been completed. • The provider had a remedial and compliance works proposal with the actions required following fire, legionella, health and safety risk assessments and disability access audit; however, these actions had not been completed. • In the branch practice blinds had loop cords and the practice had not risk assessed these to ensure safety of patients. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were partially met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: 28 October 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
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
The practice had identified a number of actions following the infection prevention and control which had not been addressed. For example, the practice had sinks were not in line with current infection prevention and control standards. The provider informed us that they had applied for an improvement	

grant which is still being processed; they said they would address the identified issues once the grant was approved.

During the inspection it was not clear who was the infection prevention and control lead for the practice. After we raised this issue with the provider they informed us that they had reviewed the clinical and non-clinical leads for the service and sent us a list to support this the day following the inspection.

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.	Partial
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
During the inspection we found that some of the staff had not completed basic life support training. After we raised this issue with the provider they informed us that they had booked this training to be undertaken by staff on 28 January 2020 and sent us evidence to support this.	

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.	Y
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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.94	0.72	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	12.2%	10.5%	8.5%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.48	5.85	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.85	1.17	2.08	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.	Partial

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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 changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<ol style="list-style-type: none"> 1. During the inspection we found some uncollected prescriptions dated back to August 2019 which was not in line with their local policy for monitoring uncollected prescriptions. After we raised this issue with the provider the provider informed us that they had implemented a monitoring system to ensure monthly checks were carried out according to their prescribing policy. The provider had sent us a copy of their new monthly check protocol and their monthly check log which indicated that the provider had started monitoring of uncollected prescriptions the day following the inspection. The provider also informed us that they had considered this as a significant event and had discussed it on 19 December 2019 to ensure this does not happen again and sent us evidence to support this. 2. During the inspection we found that the practice did not use Patient Specific Directions (PSD) appropriately to administer B12, pneumonia and influenza vaccinations; hence, the healthcare assistants were not legally authorised to administer these medicines. After we raised this issue with the provider informed us that they undertook a review of all the injectable medicines 	

Medicines management	Y/N/Partial
<p>(Influenza and B12) administered by the healthcare assistant from 1 January 2019 to 18 December 2019 and found that they were appropriately administered and sent us a copy of the review; following the review the practice informed us that they had entered a PSD in each patient's notes, read coded it and noted that it was retrospectively performed following a review of the patient's medical records. The provider informed us that they had put a new PSD protocol in place which was shared with relevant staff and sent us a copy of the protocol the day following the inspection. They also informed us that the protocol was operational the day following the inspection and sent us evidence to support this.</p> <p>3. During the inspection we reviewed the records of five patients taking warfarin (a medicine used to thin blood) of which two patients had their repeat prescription without the signing doctor having sight of the most recent blood test. After we raised this issue with the provider they informed us that they had carried out medicines review for these two patients and taken the required actions.</p> <ul style="list-style-type: none"> - During the inspection we reviewed the records of five patients taking methotrexate (a medicine used to suppress the immune system) of which two patients had their repeat prescription without the signing doctor having sight of the most recent blood test. After we raised this issue with the provider they informed us that they had carried out medicines review for these two patients and taken the required actions. - We reviewed the records of patients taking lithium (a medicine used to treat mental health disorders) and azathioprine (a medicine used to treat Crohn's disease) and found that these patients' blood tests were appropriately monitored before the issue of repeat prescriptions. - After the inspection the provider informed us that they had considered the gaps in monitoring of patients on high-risk medicines as a significant event and discussed with staff on 18 December 2019 and sent us evidence to support this. <p>4. According to the practice policy the defibrillator and medical oxygen should be checked weekly; however, in the branch site we saw two checks for December 2019 and only one check for November 2019 and no record of checks before November 2019.</p> <p>5. During the inspection in the main practice we found that on one occasion in July 2019 the temperature recorded for one of the refrigerators that stored medicines was out of the recommended range and the reason for this was not recorded. After we raised this issue with the provider, they informed us that this incident would be discussed in a staff meeting on 28 January 2020 to ensure this did not happen again and that staff would be provided further training if needed. We found a gap in recording of fridge temperature at the branch practice on one occasion in December 2019 for one of the two refrigerators that stored medicines.</p>	

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.	Partial
Number of events recorded in last 12 months:	18
Number of events that required action:	18
During the inspection the non-clinical staff we spoke to indicated that they did not have regular meetings and that significant events and complaints were not discussed with them; they were not able to give us an example of a significant event.	

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

Event	Specific action taken
The provider had four instances of delay in processing referrals in the last year.	<ul style="list-style-type: none"> The practice had put a system in place to ensure referrals were dealt with on a timely manner when the medical secretary was on leave. The practice had devised a referral protocol for staff and performed weekly referral audits.

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
The practice had a system in place to receive and act on medicines and safety alerts; however, during the inspection the provider was not able to show us their system to monitor the implementation of medicines and safety alerts on a continuous basis. After we raised this issue with the provider, they informed us that their prescribing pharmacist kept a record of audits performed for medicines and safety alerts and monitored these on a continuous basis and sent us evidence to support this the day following the inspection.	

Effective

Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services because:

- Outcomes for patients with diabetes and atrial fibrillation was below average and clinical exception reporting for patients with long-term conditions were above average.
- The childhood immunisations and cervical screening uptake were below average.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients 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.	Partial
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
<p>We found that medicine reviews were undertaken; however, these were not appropriately coded in the practice's electronic patient management system. After the inspection the provider informed us that they had trained all the GPs on how to code medicines reviews on a clinical meeting held at 26 November 2019 and sent us evidence to support this.</p> <p>During the inspection we found the following:</p> <ul style="list-style-type: none"> • 93% of patients on four or more medicines had their medicines reviewed in the last year. • 82% of patients on repeat medicines had their medicines reviewed in the last year. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.94	0.51	0.74	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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 carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.6%	74.8%	79.3%	No statistical variation
Exception rate (number of exceptions).	11.4% (74)	10.1%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	62.7%	71.4%	78.1%	Variation (negative)

Exception rate (number of exceptions).	16.0% (104)	8.6%	9.4%	N/A
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	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.8%	75.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	15.4% (100)	10.8%	12.7%	N/A

Any additional evidence or comments

The provider was aware of their below average performance in 2018-19 QOF diabetes indicators and have taken the following steps to improve uptake:

- They have signed up and in the process of implementing for a primary care network diabetes local incentive scheme. This involves identifying patients with poor blood sugar control and ensure they receive dietetic and lifestyle advice and support. It also involves case discussions with other practices in the local network to improve management of diabetic patients.
- The practice's diabetes lead had one to one meeting with the GPs working at the practice and discussed care of patients with diabetes.
- The provider had scheduled quarterly educational sessions for their clinicians over the next year and held a session with a diabetes consultant from a local hospital.
- The practice would be inviting patients with poor blood sugar control to attend extended consultations with the practice's diabetic lead in addition to their regular reviews.
- Planning to recruit a practice nurse with diabetic experience.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.1%	73.7%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.8% (7)	2.6%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.9%	88.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	12.9% (18)	6.1%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.9%	78.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.6% (92)	3.4%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.6%	88.2%	91.1%	Variation (negative)
Exception rate (number of exceptions).	2.7% (2)	6.2%	5.9%	N/A

Any additional evidence or comments

The provider was aware of the high exception reporting for patients with long-term conditions and had performed a review of 2018-19 Quality and Outcomes Framework (QOF) exception reporting to ascertain the reasons for the high exception reporting. They looked at exception reporting for dementia, chronic obstructive pulmonary disease, atrial fibrillation, hypertension, diabetes, influenza and cervical screening.

Dementia: The practice had high exception reporting for new diagnosis of dementia was due to a coding error; the practice informed us that the administrative staff had been informed to appropriately code these patients.

Chronic Obstructive Pulmonary Disease: The practice had high exception reporting for patients requiring spirometry; the practice informed us that the majority of patients' exception reported were elderly, frail, housebound or on nursing homes and spirometry was unsuitable for them, hence were exception reported.

Diabetes: The practice had a higher rate of patients who did not attend their review appointments and found that the practice had followed the correct protocol for exception reporting. The practice informed us that in future patients would be called and sent a text reminder prior to their appointment to improve uptake for diabetic reviews.

Hypertension: The provider informed us that the practice had a large Asian and Afro-Caribbean population who were difficult to achieve adequate blood pressure control. On review the majority of these patients were on 3 or more blood pressure medications and many had been referred to the hypertension clinic and found that exceptions were appropriately reported.

Influenza: The practice had a high exception reporting rate for influenza vaccinations across a number of patient groups. This was because the practice actively called these patients to attend for appointments for flu jabs during the flu season. Lists were distributed to all admin staff who then make three attempts to call the patients. Those who were unable to be contacted were left voice mails, sent text messages and letters. We saw patients who declined were appropriately coded in their records.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice has not met the minimum 90% target for any of the four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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)	61	79	77.2%	Below 80% uptake
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)	55	66	83.3%	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)	55	66	83.3%	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)	50	66	75.8%	Below 80% uptake

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 provider informed us that they had implemented the following changes over the last year to improve uptake for childhood immunisations:

- Having a dedicated member of staff to contact patients' parents to encourage them to attend for their child's immunisation.
- Using text messages reminders for patients to attend appointments.
- Ensure patients bring their red books for new patient checks so that data could be verified and entered correctly on to the child's medical records.
- Working in collaboration with their Health Visitor to ensure that all children under the age of 5 were vaccinated. If the practice is struggling to get hold of the patient, the Health Visitor would try and chase the parents as well.
- The practice receives weekly reports from Child Health Information Service (An NHS commissioned service that is responsible for collecting data from various organisations for all children aged 0-19 that are either residents or registered with a GP Practice in a specified area, into a single Child Health Record) with children due their vaccinations which forms the basis for their recall system. The recalls were performed on the weekends as they find it is easier to get in touch with the parents.

The provider informed us that these changes had led to an improvement in the uptake for childhood immunisations. The practice informed us that they had developed the following plans to be implemented in the next year:

- To utilise the newly formed GP Hub nursing clinics for childhood immunisations increasing the availability of appointments to parents and carers.
- To work with other practice within the primary care network to increase the uptake by sharing best practice.
- Having a childhood immunisation campaign week to increase awareness of the benefits of immunisations.
- Increasing nursing appointments out of normal hours with our existing nurse.
- To recruit another practice nurse to further increase availability (they informed us that an advert was posted in November 2019).

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.

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). (31/03/2019 to 30/06/2019) (Public Health England)	62.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	70.5%	67.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	40.6%	51.3%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	79.4%	73.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	41.5%	49.2%	53.8%	No statistical variation

Any additional evidence or comments

The practice had taken steps to improve uptake for cervical screening by participating in the targeted Clinical Commissioning Group (CCG) cervical screening drive campaign during July 2019. This involved contacting a list of patients via text messaging and followed up by telephone calls to encourage women to attend. The idea with text message was to send it at a time of the day that the patient would be able to call the surgery and book once they get the message, i.e. between 11am or 5pm and the principal with the phone calls was to vary it and not always call the same time, i.e. before 8am when people haven't left the house yet for work or after 6pm once they have returned home and on the weekend as most people were able to take calls. The practice informed us that they managed to recall and carry out screening on 50% of previous non-responders which was above the expected levels. The practice had agreed to participate in the next campaign and were due to start shortly which would be for three months. The practice informed us the following:

- The clinicians had been reminded to act upon pop up reminders on the clinical system to opportunistically remind patients to attend for cervical screening.
- Patients were able to have screening carried out in the local GP hubs if the practice was fully

booked or when the practice was closed.

- They had increased practice nurse extended hours commitment and offered more evening appointments for working women to attend for screening.

The practice had developed further plans to improve cervical screening uptake by:

- Having a cervical screening campaign week
- Providing patient leaflets in a range of languages to support any hard to reach groups.
- Discussing ideas and best practice on screening uptake in their Primary Care Network (PCN) group.

Unverified Data provided by the practice indicated the following:

The practice had achieved 61.9% in 2018-19 for females 25-64yrs attending for cervical screening.

Their current performance at beginning of December 2019:

Females 25-49yrs attending for cervical screening: 59%.

Females 50-64yrs attending for cervical screening: 84%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. During the last year all 32 patients with learning disability had received a 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 demonstrated that they had a system to identify people who misused substances.

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.
- All patients in the practice's mental health register were offered a physical assessment in addition to their regular mental health assessment.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Following a significant event, the provider had developed and implemented a protocol to ensure patients with mental illness who were taking antipsychotic medicines were adequately monitored. The protocol included monitoring compliance of patients taking anti-psychotic medicines. For example, the provider informed us that they recently found that a patient had stopped taking their antipsychotic medicines and that their psychotic symptoms had returned and they urgently followed up this patient.
- The provider informed us that they would be hosting the community psychiatric nurse clinic one session a week in the new year and they would be able to book patients directly to this service.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	97.9%	86.0%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.8% (8)	8.2%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.8%	85.4%	90.2%	No statistical variation
Exception rate (number of exceptions).	7.8% (8)	6.5%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.5%	79.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	4.3% (5)	3.8%	6.7%	N/A

Monitoring care and treatment

The practice had a comprehensive 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)	543.3	No Data	539.2
Overall QOF score (as a percentage of maximum)	97.2%	No Data	96.4%
Overall QOF exception reporting (all domains)	8.3%	No Data	No Data
QOF clinical exception reporting for 2018-19 was 13.5% which is higher than the Clinical Commissioning Group (CCG) average of 8.4% and England average of 9.7%.			

	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:

The practice had undertaken nine audits in the last three years, of which five were completed cycle clinical audits where changes were implemented and monitored.

For example, the practice had undertaken an audit to ascertain if warfarin (a medicine used to thin blood) was prescribed and monitored according to evidence-based guidelines. In the first cycle of the audit the practice identified 30 patients who had been prescribed this medicine of which recent blood test results were only documented for 23% (seven patients) of patients. The provider implemented the following changes after the first cycle of audit:

1. Patients on warfarin medications must bring their warfarin monitoring booklets at the time of prescription request. If they do not bring in any results an appointment would be made for them to see the doctor who will educate them on their need to bring in the blood test results.
2. Administrative staff were trained to enter the relevant information and READ code in to the patient medical records and that they have seen the appropriate monitoring parameters. This would include using the code 'International Normalised Ratio (INR)' and input the recent test, plus date taken. Also document code 'target INR' and indication.
3. All patients with warfarin to have an alert in their electronic patient management warning the clinician that the patient was on warfarin.
4. Prescribing team would enter the latest INR in the prescribing electronic prescription to remind doctors to check for the latest INR.
5. For each warfarin prescription the doctor would check the medical records to see if the information has been properly READ coded and that it is safe to issue a prescription.
6. All patients on warfarin should have a clear diagnosis documented on their records.

In the second cycle of the audit after the above changes had been implemented the practice identified 28 patients who had been prescribed this medicine of which recent blood test results were documented for 100% (28 patients) of patients, which is a significant improvement compared to the first cycle of the

audit. Following the audit, the provider had also devised a spreadsheet to monitor prescribing of this medicine which was regularly monitored. However, during the inspection we found that the improvements made had not been sustained.

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.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
During the inspection we looked at recruitment and training records for six members of staff and found that the practice had an induction checklist signed by a member of clinical staff on 16 December 2019; however, they had been in post for nearly five years. One of the non-clinical staff we spoke to indicated that they did not have an induction when they started working at the practice. We also found that the appraisal for one non-clinical staff was not signed. After we raised this issue with the provider they sent us a copy of the signed appraisal for this staff. One of the non-clinical staff we spoke to informed they were not happy with the appraisal process; they said that the management was aware of this and the management informed her that this would be improved.	

Coordinating care and treatment

Staff worked 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 (01/04/2018 to	Y

31/03/2019) (QOF)	
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

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.	Partial
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
<ul style="list-style-type: none"> • Four of the six patients we spoke to indicated they were not been provided with information on healthy lifestyles or managing their long-term condition. • Three of the six patients we spoke to indicated they were not offered regular health checks. 	

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 (01/04/2018 to 31/03/2019) (QOF)	95.0%	93.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (8)	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

Caring

Rating: Requires Improvement

The practice was rated as requires improvement for providing caring services because patient satisfaction to care was below average.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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.	9
Number of CQC comments received which were positive about the service.	8
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comments cards	<p>Patients indicated the following:</p> <ul style="list-style-type: none"> The practice is caring, proficient, well-run and the medical team are excellent and staff deal with all issues exceptionally well. Reception staff are polite, nurses are brilliant and doctors are really good. Staff are helpful, caring, supportive, accommodative, professional and hard working. Staff treat patients with respect and provide good care and personal treatment. Patients felt listened to and that their needs were met. The environment was safe and hygienic. Patients said there had been a significant improvement in the management of the practice.
NHS Choices	The practice had received six reviews and ratings (One patient had given 3/5 stars; One patient had given 2/5 stars and four patients had given 1/5 stars). The practice had responded to 5/6 reviews.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8843.0	469.0	113.0	24.1%	1.28%

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)	75.6%	84.7%	88.9%	Variation (negative)
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)	74.5%	83.2%	87.4%	Variation (negative)
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)	88.4%	93.4%	95.5%	Tending towards variation (negative)
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)	76.1%	81.0%	82.9%	No statistical variation

Any additional evidence or comments

We did not find any evidence of specific actions taken by the provider to address the above low performing national GP patient survey indicators.

All the six patients we spoke to during the inspection indicated that they felt involved in their care and treatment, the healthcare professional listened and understood their wishes, were given treatment options and the healthcare professional explained their treatment and medication.

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

Any additional evidence

The provider obtained regular feedback from the patients through the friends and family test.

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
The provider informed us that large print materials were available on request.	

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)	83.5%	90.2%	93.4%	Variation (negative)

Any additional evidence or comments

We did not find any evidence of specific actions taken by the provider to address the above low performing national GP patient survey indicator.

All the six patients we spoke to during the inspection indicated that they felt involved in their care and treatment, the healthcare professional listened and understood their wishes, were given treatment options and the healthcare professional explained their treatment and medication.

	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

Carers	Narrative
Percentage and number of carers identified.	98 carers (1.1% of the practice population)
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The main practice had a carers corner in the waiting area with information to support and signpost carers. The provider informed us that they sent a carers booklet to patients.

	<ul style="list-style-type: none"> The provider offered annual health checks to carers.
How the practice supported recently bereaved patients.	<p>Staff told us that if families experienced bereavement, their usual GP contacted them or sent them bereavement support information. This call was either followed by patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.</p> <p>The provider undertook an after-death audit to ascertain indicators which they could improve. Following the audit, they had developed a bereavement protocol and trained staff on what to do when a patient died.</p>

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

Responsive

Rating: Requires Improvement

The practice was rated as requires improvement for providing responsive services because patient satisfaction in relation to access to care was below average.

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 (Main Practice in Mitcham)	
Day	Time
Opening times:	
Monday	8:30am to 6:30pm
Tuesday	8:30am to 6:30pm
Wednesday	8:30am to 8:30pm
Thursday	8:30am to 6:30pm
Friday	8:30am to 6:30pm
Appointments available:	
Monday	9am to 12pm and 2:30pm to 6pm
Tuesday	9am to 12pm and 2:30pm to 6pm
Wednesday	9am to 12pm and 2:30pm to 6pm
Thursday	9am to 12pm and 2:30pm to 6pm
Friday	9am to 12pm and 2:30pm to 6pm
Extended hours:	Wednesdays from 6:30pm to 8:30pm

Practice Opening Times (Branch Practice in Tooting)	
Day	Time
Opening times:	
Monday	8:30am to 8:30pm
Tuesday	8:30am to 8:30pm
Wednesday	8:30am to 6:30pm

Thursday	8:30am to 6:30pm
Friday	8:30am to 6:30pm
Appointments available:	
Monday	9am to 12pm and 2:30pm to 6pm
Tuesday	9am to 12pm and 2:30pm to 6pm
Wednesday	9am to 12pm and 2:30pm to 6pm
Thursday	9am to 12pm and 2:30pm to 6pm
Friday	9am to 12pm and 2:30pm to 6pm
Extended hours: Mondays and Tuesdays from 6:30pm to 8:30pm	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8843.0	469.0	113.0	24.1%	1.28%

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)	95.4%	93.2%	94.5%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> 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. The practice GPs supported 117 patients in two local care homes; they mostly supported residents with dementia.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> 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. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Additional nurse appointments were available until 8:30pm on a Mondays, Tuesdays and Wednesdays for school age children so that they did not need to miss school.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

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 was open until 8:30pm on a Monday, Tuesday and Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available on weekdays from 5pm to 8pm and on Saturdays and Sundays from 8am until 8pm.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- 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 such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- Practice patients had access to a social prescriber who worked one day a week in the main practice in Mitcham. The social prescriber offered support to socially isolated patients, frequent attenders for non-medical issues and those with social needs including housing, employment and benefits.

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

Population group rating: Requires Improvement

Findings

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

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	40.1%	N/A	68.3%	Significant Variation (negative)
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)	54.6%	68.7%	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)	59.0%	67.3%	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)	67.4%	74.0%	73.6%	No statistical variation

Any additional evidence or comments

The provider informed us that they had taken the following steps to improve telephone access of the service; however, they had not reviewed the changes made to ascertain if patient access had improved:

- Increased the number of reception staff available to answer calls during peak times in the morning and evening.
- Encouraging patients to book on line and use patient apps as they had dedicated slots for online bookings which were often not utilised.
- Looking into the option of changing their telephone provider as the practice informed that the current telephone provider was not able to address their telephone problems.
- Actively recruiting for a part-time senior practice nurse and a salaried GP to improve access.

During the inspection the provider informed that they have received and agreed a quote from a new telephone provider and new telephone system would be in place in the next two to three months.

Main practice in Mitcham: During the inspection we found that a GP appointment was available the next day and a nurse appointment was available in four working days.

Branch practice in Tooting: During the inspection we found that a GP appointment was available the next day and a nurse appointment was available in three working days.

Source	Feedback
Interviews with patients	<p>During the inspection we spoke to six patients using the service and they indicated the following:</p> <ul style="list-style-type: none"> • Four out of six patients indicated difficulty in getting appointments. • Patients generally indicated that their appointments system needs to improve. • Two patients indicated that they wait around 30 minutes to an hour when they attended for an appointment. • Two patients indicated they felt rushed in appointments by some of the GPs. • Three patients indicated they were not offered regular health checks.
NHS Choices	The practice had received six reviews and ratings (One patient had given 3/5 stars; One patient had given 2/5 stars and four patients had given 1/5 stars). The practice had responded to 5/6 reviews.

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.	8
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Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
During the inspection we found that the response letters for complaints sent by the practice did not have escalation information for patients in case they were dissatisfied with the outcome. After we raised this issue with the provider they indicated that they had updated their response letter template and complaints leaflet to include this information and sent us evidence to support this.	

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
The provider informed us that they also record verbal complaints and formally discuss the verbal complaints in meetings.	

Example(s) of learning from complaints.

Complaint	Specific action taken
The provider received two complaints regarding the attitude of the reception staff.	<ul style="list-style-type: none"> Spoke to reception staff about how to deal with patients. Training for reception staff on how to deal with patients. Training needs of staff was obtained through a staff survey in December 2019.

Well-led

Rating: Requires Improvement

The practice was rated as requires improvement for providing well-led services because the governance arrangements in place required improvement.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
The provider informed us that they currently do not require succession planning.	

Vision and strategy

The practice had a clear 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Y
<ul style="list-style-type: none">Some of the staff we spoke to were not aware of the practice's vision or mission statement.	

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

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

Source	Feedback
Interviews with staff	<ul style="list-style-type: none"> Non-clinical staff we spoke to indicated that reception and administrative staffing levels were not sufficient. The provider was aware of this and had restructured the reception team and appointed three reception supervisors (two for main practice and one for branch practice; who were due to start in January 2020) to ensure three reception staff were available at any time. One of the clinical staff we spoke to indicated they were not able to voice their opinion since the new management was in place and said the practice needs more nursing staff. The practice was aware of staffing levels and informed us that they were actively recruiting for a part-time senior practice nurse and a salaried GP Non-clinical staff we spoke to indicated that they did not have regular meetings and that significant events and complaints were not discussed with them. The provider informed us that the appointment of reception supervisors would improve non-clinical staff communication with the management team.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>However, governance arrangements in place required improvement in the following areas:</p> <ul style="list-style-type: none"> The management safety systems and processes. The management of risks to patients and staff. Learning from complaints and significant events. 	

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.	Partial
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
Risks in relation to the following areas were not effectively identified and managed. <ul style="list-style-type: none"> • Staff training. • Premises/security and health and safety risk assessment. • Medicines management. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
The provider had a remedial and compliance works proposal with the actions required following fire, legionella, health and safety risk assessments and disability access audit; however, these actions had not been completed.	

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
The provider informed us that following suggestions from the Patient Participation Group they were planning to provide newsletters for patients.	
The provider informed us that they obtained feedback from staff through staff surveys and staff training needs and had their first round in November 2019; the provider informed us that feedback from staff indicated that newer staff would like to upskill and develop in their role.	

Feedback from Patient Participation Group.

Feedback
<p>During the inspection we spoke to the chair of the Patient Participation Group (PPG) and they indicated the following:</p> <ul style="list-style-type: none"> • They have a joint PPG with members from the main and branch practice and have about two meetings a year. The meetings were attended by four to seven members, the practice manager and GPs. • The practice invites people who complain to attend the meeting to have their say. • The practice is managed very well and try to improve things; they get regular positive feedback from patients about the service. • Following feedback from the PPG the practice had increased extended hours appointments to accommodate people. They had also put posters and information in the waiting area following feedback from patients. • The PPG informed that the practice was open and honest and keep them informed.

Continuous improvement and innovation

There were 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.	Partial
Learning from complaints and significant events were not effectively shared with staff.	

Examples of continuous learning and improvement

Following a significant event, the provider had developed and implemented a protocol to ensure patients with mental illness who were taking antipsychotic medicines were adequately monitored.

The practice had developed a comprehensive mental health monitoring policy to ensure patients with mental health illness were obtaining their repeat prescriptions and that administrative staff and GPs were aware of what to do and who to contact should they fail to collect their prescriptions.

The provider informed us that this protocol was presented in the local Clinical Commissioning Group (CCG) locality meeting in December 2019 and that they had implemented some changes across the CCG. This included a dedicated email and phone number of which practices could use to inform relevant services if patients with mental health had stopped taking their medicines.

For example, the provider informed us that they recently found that a patient had stopped taking their antipsychotic medicines and that their psychotic symptoms had returned and they urgently followed up this patient.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases, at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.