Care Quality Commission

Inspection Evidence Table

Dr Anjum Zaidi and Partners (1-556904802)

Inspection date: 21 November 2019

Date of data download: 19 November 2019

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

At the previous inspection in September 2018, the practice was rated requires improvement for providing safe services because:

- **The child safeguarding policy was not signed or reviewed on a regular basis and the alert codes recorded in the child safeguarding policy were inconsistent with those recorded on their computer system.**
- **Appropriate recruitment checks had not been carried out.**
- **We were not provided with vaccination records for nursing staff.**
- **There was no Control of Substances Hazardous to Health (COSHH) risk assessment carried out.**
- **Fire drills were not carried out regularly and the fire risk assessment actions were not clearly implemented.**
- **There were gaps in mandatory training including fire safety and yellow fever update training for nursing staff.**
- **Actions were not always taken to address the risk assessments recommended areas for improvement.**
- **Recommended actions from the infection control audit had not been carried out. Clinical waste bags were not labelled.**
- **They had failed to monitor that two-week referrals had been followed up and documented on the two-week referral log since May 2018.**
- **The practice did not maintain a log of blank prescription serial numbers on receipt or when they were distributed through the practice and we found prescription pads were not stored securely.**

- **The practice did not hold all recommended emergency medicines such as morphine, and a risk assessment was not in place to determine the range of medicines held.**

- **Three out of four of the vaccines fridges only had one thermometer.**

- **There was no information provided to demonstrate to staff what the practice considered to be a significant event. The significant event log did not always identify action and outcome of event, and it was not always clear what learning took place from their investigations.**

- **The provider did not have processes in place to ensure that all staff read safety alerts relevant to their roles.**

At this inspection we found improvements had been made; however, some areas still required further attention and improvement. The practice remains rated Requires Improvement for providing safe services because:

- **The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.**
- **Appropriate standards of cleanliness and hygiene were not all met.**
- **The practice did not always have systems for the appropriate and safe use of medicines.**
- **The practice did not have an effective system to learn and make improvements when things went wrong.**

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N
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

Safeguarding	Y/N/Partial
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.	Partial

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, we found the child safeguarding policy was not signed or reviewed on a regular basis and the alert codes recorded in the child safeguarding policy were inconsistent with those recorded on their computer system. At this inspection, we found the safeguarding policy was now being reviewed by the GP partners and the alert codes had been amended to ensure they were consistent with those on their computer system. However, further clarity on the correct process was required. For example, the practice provided two different safeguarding policies as part of their action plan and as part of the inspection evidence gathering; therefore, it was not clear which policy was distributed and communicated to staff. One of the safeguarding policies provided did not record the names of the safeguarding leads.
- Policies did not take account of patients accessing online services.
- Safeguarding was an agenda item at business and nurses' meetings. The practice also held a whole practice safeguarding meeting every three months which was recorded. However, three of the four safeguarding meeting minutes we reviewed did not indicate who was in attendance and how minutes were shared for those not in attendance.
- There was joint working with community midwives at the practice. The practice told us health visitors were no longer based at the surgery; however, they were contacted when required. There was no contact with school nurses.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
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 previous inspection in September 2018, we found appropriate recruitment checks had not been carried out. At this inspection, we found the practice had implemented a comprehensive recruitment policy and application form. We saw evidence of completed interview summaries for two new staff; however, we saw only one reference on file for two new clinicians, instead of two references as per their recruitment policy.
- At the previous inspection in September 2018, we were not provided with immunisation records for nursing staff. At this inspection, while we saw evidence of some immunisation records, they were not all complete. For example, we saw evidence of Hepatitis B and measles, mumps and rubella vaccination but we did not see evidence of diphtheria, varicella, tetanus and polio vaccination for all staff as per Public Health England (PHE) guidelines.

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: January and February 2019	Y
There was a record of equipment calibration. Date of last calibration: January and February 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 17 September 2019	Y
There was a log of fire drills. Date of last drill: October 2019	Y
There was a record of fire alarm checks. Date of last check: twice a week	Y
There was a record of fire training for staff. Date of last training: adhoc	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: September 2019	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, there was no Control of Substances Hazardous to Health (COSHH) risk assessment. At this inspection, we found one had been carried out; however, this did not account for all chemicals stored in the practice. For example, the risk assessment did not include bleach stored at the practice.
- At the previous inspection in September 2018, we found fire drills were not carried out regularly and had last been carried out in July 2017. At this inspection, we found this had improved. The practice had carried out two fire drills in the last year and we saw completed records for this.
- At the previous inspection in September 2018, we found fire risk assessment actions were not clearly implemented. At this inspection, we found further improvement was required. For example, some actions taken were recorded as ticks, with no information provided of the action taken and date. Some actions such as weekly fire alarm testing and servicing of the fire panel were completed; however, the recommended fixed electrical installation testing had not been carried out.
- At the previous inspection in September 2018, we found there were gaps in fire safety mandatory training. At this inspection, we saw there were no fire safety training records for three members of staff. After the inspection, the practice sent evidence to show this outstanding training had been completed.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 21 November 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2019	Partial

Explanation of any answers and additional evidence:

At the previous inspection we found actions were not always taken to address the risk assessments recommended areas for improvement. At this inspection, we found this had improved although clearer record keeping was required.

- We saw the health and safety action plan had been completed; however, some actions were not always clear. For example, the practice indicated on the action plan that an appointment had been booked for an emergency lighting service as per the risk assessment recommendations; however, there was no information recorded on the action plan as to when this would take place.
- A disability access audit was carried out in September 2019 and the identified risk ranged between very low and high risk. The action plan had not been completed and the recommended actions such as visible alarm systems and allocating a dedicated disabled parking had not been carried out. The practice told us that they had not implemented the action plan due to the current refurbishment work taking place at the practice to improve and extend the premises due to be completed in 2020. We also observed reduced available parking spaces onsite due to building equipment. However, this had not been recorded on the action plan.
- It was also unclear what action had been taken to service the portable air conditioning units in the practice as per recommendations of the Legionella risk assessment carried out in September 2019. The practice told us that these units would be disposed of upon completion of ongoing building works; however, this had not been recorded on the action plan.
- The Legionella risk assessment showed on area of high risk recommended an annual service of the water tank but this action had not been completed prior to the inspection. On the day of inspection, the practice provided evidence to show this service had been booked for December 2019.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not all met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
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:

- Not all staff had received infection control training relevant to their role. Training records showed two non-clinical and three clinical staff had not undertaken this training.
- At the previous inspection in September 2018, we found there were gaps in update yellow fever training for nursing staff. At this inspection we found nurses carrying out yellow fever vaccinations had received training.
- At the previous inspection in September 2018, we found recommended actions from the infection control audit such as maintaining cleaning schedules had not been carried out. At this inspection, we found there was a cleaning schedule in place. However, other recommended actions such as changing the type of hand towels, handwashing liquid and needles had not been taken. We saw evidence that these recommended actions had been discussed at a practice meeting and a decision had been made to purchase the recommended items after finishing the existing stock first.
- The practice also provided an inhouse infection control checklist updated in November 2019; however, it was not complete as some answers were not explained. For example, the checklist stated some of the furniture was not of a type and material that was easy to clean but no further information was provided to show what action would be taken.
- At the previous inspection in September 2018 we found clinical waste bags were not labelled. At this inspection, we found they were labelled waste bags.

Risks to patients

There were 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.	Partial

Explanation of any answers and additional evidence:

- The monitoring of safety systems and processes was not effective.

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

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, we found that the practice had failed to monitor that two-week referrals had been followed up and documented on the two-week referral log since May 2018. At this inspection, we found this had improved. The practice has trained a second member of staff to undertake this task. Every referral sent was checked every two weeks to ensure an appointment had been received and checked every three weeks to ensure the patient had attended the appointment. The administration team manager maintained oversight of this process. When we reviewed the two-week wait referral log, we found evidence that two-week waits were appropriately logged with evidence of follow up of appointment received and appointment attended.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.69	0.70	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). (01/07/2018 to 30/06/2019) (NHSBSA)	10.8%	11.7%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	6.60	6.26	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.23	0.93	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.	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 changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	N
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	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 previous inspection in September 2018, we found the practice did not maintain a log of blank prescription serial numbers on receipt or when they were distributed throughout the practice and prescription pads were not stored securely. At this inspection, we found further improvement was required. We saw blank prescriptions were stored securely in a clinical room which was locked when not in use and there was a process to log serial numbers.
- The practice told us they referred any controlled drugs prescribing issues to the Clinical Commissioning Group (CCG) prescribing lead; however, there was no reference to the nominated Controlled Drugs Accountable Officer (CDAO). The requirement of the misuse of drugs (supervision of management and use) regulations is for all organisations involved in the handling or use of controlled drugs (including prescribing) to have a standard operating procedure which states the persons to report all controlled drug related concerns to. This must include the nominated CDAO.
- At the previous inspection in September 2018, we found the practice did not have morphine, emergency medicine for pain and a risk assessment had not been carried out. At this inspection we found the practice had carried out a risk assessment to determine why they did not stock morphine as an emergency medicine.
- When we reviewed the emergency medicines, we found the available diazepam (for seizures) was out of date. The practice told us that this was due to a supply issue and we saw evidence of a risk assessment that explained why the out of date stock could still be used and the action to take in the event of an emergency.
- At the previous inspection in September 2018, we found three of the four vaccines fridges did not have a second thermometer and there was no evidence of calibration. At this inspection we found this had improved. There was a second thermometer for all vaccines fridges and there

Medicines management	Y/N/Partial
was appropriate cold chain monitoring.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	3
Number of events that required action:	3

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, we found there was no information provided to staff to demonstrate what was considered a significant event. At this inspection, we found the practice had implemented a new significant event policy; however, the information relating to what was classed as a significant event was still vague and required further clarification. For example, they identified a near miss as a significant event but there were no examples provided of what would entail a near miss event.
- The practice significant events log had recorded only three significant events. On the day of inspection, staff told us about three other significant events that had occurred in the last 12 months that had not been recorded on the significant events log. We saw evidence the practice had carried out an audit of missed or delayed referrals between April and July 2019 that had not been recorded as significant events.
- We saw evidence that significant events were a standing agenda item at business and practice meetings. We saw evidence of when a significant event involving a delayed referral was discussed at a practice meeting.

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

Event	Specific action taken
There were 13 missed or delayed routine referrals between April and July 2019. One delayed referral was due to the clinician not notifying the designated staff member that there was a referral to action.	Discussed at practice meeting and admin staff kept record of missed or delayed referrals. Clinicians were reminded to be vigilant. All referrals were now recorded by the clinicians on a referrals sheet prior to a referral being made and patients were provided with contact slips to chase their appointment if they had not received one after a month. When the practice reviewed this new system in October, there was improvement with only one missed referral which was recorded as a significant event.
Loss of internet system	Staff followed their business continuity plan and avoided disruption of services.

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 previous inspection in September 2018, we found the process to ensure staff had read safety alerts was not in place. At this inspection, we found this had improved. We saw evidence that the relevant staff had received and acted on the alerts. We also saw evidence that alerts were discussed at business meetings with evidence of clear actions taken.
- We saw examples of actions taken on recent alerts for example, regarding sodium valproate.

Effective Rating: Good

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.

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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	n/a

Explanation of any answers and additional evidence:

- There was an area of notable practice. Following identification of a patient with an infectious disease, the practice acted to ensure all patients living at the residence received the disease specific vaccine. This resulted in 29 patients receiving the vaccination and a referral to the infectious diseases team.

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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.63	0.55	0.75	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 had an enhanced practice nurse who carried out home visits to patients identified as most at risk. The practice told us patients at risk were also identified from the hospital dashboard data.
- The practice carried out structured annual medication reviews for older patients including those in the care homes.
- 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 vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Patients with asthma were offered an asthma management plan.
- The practice held a nurse-led diabetes clinic and offered insulin initiation. They also held asthma and chronic obstructive pulmonary disease COPD clinics.
- 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, 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.

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) (QOF)	75.7%	79.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	9.4% (62)	9.0%	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) (QOF)	75.4%	78.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	10.6% (70)	6.6%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	79.3%	82.1%	81.3%	No statistical variation
Exception rate (number of exceptions).	7.7% (51)	8.1%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	76.9%	77.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.6% (9)	2.2%	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) (QOF)	91.4%	93.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	6.3% (7)	6.7%	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) (QOF)	82.4%	83.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.2% (38)	2.8%	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) (QOF)	84.2%	86.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.4% (4)	8.2%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice has not met the minimum 90% target for four 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 visitor when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. They held a midwife led antenatal clinic. 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)	114	129	88.4%	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)	133	155	85.8%	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)	134	155	86.5%	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)	136	155	87.7%	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 told us they had a transient population and some of their population groups declined immunisations, despite some disease outbreaks such as measles in the area. The practice had dedicated immunisation clinics on Wednesday lunchtimes and also offered opportunistic appointments. Letters were also sent to non-attenders and there was a system in place to contact them by telephone.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice is rated requires improvement for providing effective care to working age people because performance for cervical screening is significantly lower than national average.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	60.1%	N/A	80% Target	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)	68.3%	69.4%	72.1%	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)	47.2%	48.5%	57.3%	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)	73.2%	75.4%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	47.2%	57.9%	51.9%	No statistical variation

Any additional evidence or comments

- The practice told us patients were sent text message and letter reminders to attend their cervical screening appointment, as well as being contacted by telephone if they missed their appointment. The practice also offered these patients Saturday appointments. Patients who declined the screening signed disclaimers.
- The bowel and breast cancer screening uptake was reviewed by the practice and their Primary Care Network (PCN) and they were about to commence a pilot project to increase screening.

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.
- 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. They held an inhouse substance misuse clinic.

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.
- 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.
- Most of the staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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) (QOF)	94.9%	91.2%	89.4%	No statistical variation
Exception rate (number of exceptions).	3.7% (6)	7.8%	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) (QOF)	93.6%	93.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	3.1% (5)	6.2%	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) (QOF)	85.7%	85.9%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.8% (3)	5.6%	6.7%	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)	550.4	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.5%	No Data	96.4%
Overall QOF exception reporting (all domains)	7.3%	No Data	No Data

	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 carried out various audits which included prescribing, palliative care and oral anticoagulation audits.
- They also carried out a three-cycle oral nutritional supplement audit.

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.	Partial
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.	Y
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:

- The programme of learning and development required monitoring to ensure all mandatory training was completed by all staff. This included fire safety and infection control training.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

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 31/03/2019) (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.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a

Explanation of any answers and additional evidence:

- The practice achieved a 'gold-star' in maintaining the Co-ordinate my care register.
- The lead GP held a weekly community ophthalmology clinic at the practice for their registered patients as well as patients referred from other practices in Harrow. This service was provided in conjunction with Moorfields eye hospital.

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: • The practice held smoking cessation clinics carried out by the healthcare assistant.	

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)	97.7%	96.1%	95.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.2% (5)	0.7%	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: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mostly 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.	36
Number of CQC comments received which were positive about the service.	30
Number of comments cards received which were mixed about the service.	6
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Most of the comment cards expressed satisfaction with the service and stated practice staff were respectful, kind and caring. Patients also felt listened to and felt their needs were met. Four of the mixed comments related to access to appointments and two other mixed comments related to improvements in the waiting area and improving the music played in the waiting rooms.
NHS Choices	The practice had a four-star rating out of three reviews. Two of the reviews provided positive feedback and one comment related to unsatisfactory care received.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10163.0	350.0	112.0	32.0%	1.10%

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)	85.4%	88.2%	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)	86.5%	86.1%	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)	94.6%	94.9%	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)	84.8%	81.2%	82.9%	No statistical variation

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

Any additional evidence
• The practice carried out their own inhouse patient surveys which also included the NHS Friends and Family tests. • A survey carried out by the practice between October and November 2019 asked patient views ranging from their experience of collecting a prescription, confidence in the nurse to their satisfaction of using the online service. For example, out of 65 patients, 56 agreed they were confident in the last nurse they saw.

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 one patient who was a member of the Patient Participation Group (PPG). They felt involved in their care and treatment and felt staff were very friendly.

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)	90.6%	92.5%	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

Carers	Narrative
Percentage and number of carers identified.	60 carers registered with the practice
How the practice supported carers (including young carers).	• Carers were offered annual health checks. • Carers were offered priority appointments and could email the on-call GP when required. • All carers were registered with Harrow carers and were offered annual flu immunisations.
How the practice supported recently bereaved patients.	• Staff received email alerts when a bereavement occurred. • The GP would contact the next of kin and offer support, including referral for bereavement counselling. • We saw bereavement leaflets displayed in the reception area.

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

Explanation of any answers and additional evidence:

- There were arrangements to ensure confidentiality at reception desk due to the layout. The waiting room was small and open to the reception counter. Conversations taking place in the waiting room could be overheard. However, the practice took steps to ensure confidentiality by playing low level music in the waiting areas to prevent conversations being overhead. The practice was also undergoing redevelopment of the premises that would provide a larger reception area and private reception.

Responsive Rating: Good

At the previous inspection in September 2018, the practice was rated requires improvement for providing responsive services because:

- **The practice had not carried out a disability access audit to ensure patients with mobility problems could access the service without restrictions.**
- **We identified patient concerns related to access to the service and opening hours.**
- **Learning from complaints was not demonstrated**

At this inspection, we found improvements had been made; therefore, the practice is now rated as Good for providing responsive 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

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, the practice had not carried out a disability access audit to ensure patients with mobility problems could access the service without restrictions. At this inspection, we found the practice had carried out this audit in September 2019, although recommended actions had not been completed.
- We observed building works taking place at the practice; however, there was a ramp access into the practice and patients with mobility restrictions were seen in downstairs consulting rooms.
- At the time of inspection, the practice was undergoing building redevelopment works for a new purpose build premises that would provide extra capacity and access, including a lift facility.
- The practice created a new website which was easy to navigate and had a translate facility.
- A hearing loop was available at the practice.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.00am – 6.30pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm
Extended hours:	
Saturday	9.00am – 11.30am
Appointments available:	
Monday	8.30am – 11.30am and 3.30pm – 6.00pm
Tuesday	8.30am – 11.30am and 3.30pm – 6.00pm
Wednesday	8.30am – 11.30am and 3.30pm – 6.00pm
Thursday	8.30am – 11.30am and 3.30pm – 6.00pm
Friday	8.30am – 11.30am and 3.30pm – 6.00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10163.0	350.0	112.0	32.0%	1.10%

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)	94.7%	93.9%	94.5%	No statistical variation

Older people Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived. The practice provided care to 10 local care homes.
- 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.
- Housebound patients were offered the annual flu vaccinations.

People with long-term conditions — Population group rating: Good

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 held nurse-led diabetes clinics and carried out insulin initiation. They also held anticoagulation clinics twice a week and dietitian clinics once a week at the practice.
- The practice liaised regularly with the local district nursing team, diabetes specialist nurse and the tissue viability team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- Additional nurse appointments were available on Saturday for those that could not attend during the week.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a weekly well-baby clinic at the practice.
- The practice held midwife-led antenatal clinics and patients were offered double appointments.

Working age people (including those recently retired and students) — Population group rating: Good

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.
- Pre-bookable appointments were available on a Saturday morning and cervical screening was also offered during this period.
- The practice offered online prescription requests, telephone appointments and travel clinics.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• The practice held a register of patients living in vulnerable circumstances including homeless people 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. Patients were offered double appointments. • The practice cared for a 24 bedded nursing home whose residents were all registered with the practice. These patients had a named GP who carried out weekly visits.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

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. • The practice offered inhouse psychologist sessions at the practice and delivered care to a local mental health unit.

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

Explanation of any answers and additional evidence:

At the previous inspection in September 2018, we identified patient concerns with access to the service and opening hours. At this inspection, this had improved. Patients could now access the service from 8am until 6.30pm. The practice also made the following changes:

- Patients could contact the practice by email using the generic email address, which was checked regularly throughout the day. These emails would be forwarded to the duty doctor as an alert and to ensure it was acted upon in a timely manner.
- Appointments could be booked online and through their automated telephone booking system.
- Appointment reminders were sent via text messages. In addition, if a patient had been identified as being at risk of forgetting their appointment, the receptionist would place a reminder message on the appointment screen to call the patient on the day.

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)	57.9%	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)	70.3%	65.5%	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)	65.5%	64.3%	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)	73.5%	69.6%	73.6%	No statistical variation

Any additional evidence or comments
There was evidence of improved patient satisfaction regarding access to the service. For example: • Data for 01/01/19 to 31/03/19 showed 70% of patients responded positively to the overall experience of making an appointment and this was higher than the data for 01/01/18 to 31/03/18 of 54%. • Data for 01/01/19 to 31/03/19 showed 66% of patients were satisfied with their appointment times and this was higher than the data for 01/01/18 to 31/03/18 of 52%. • Data for 01/01/19 to 31/03/19 showed 74% of patients were satisfied with the type of appointment they were offered and this was higher than the data for 01/01/18 to 31/03/18 of 63%.

Source	Feedback
For example, comment cards	Patients were mostly satisfied and only four of the 36 comments highlighted issues with access

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.	13
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: • Although there was information on the complaints procedure including practice contact details and NHS England contact details, the practice did not provide information about how to escalate complaints to the ombudsman.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Written complaint regarding staff attitude.	Training was provided to staff where required.

Well-led Rating: Requires Improvement

At the previous inspection in September 2018, the practice was rated requires improvement for providing responsive services because:

- **There were gaps in governance structure.**
- **Risk management was not consistently implemented or monitored. Mitigating actions had not been effectively implemented to address all identified risks.**

At this inspection we found:

- **Effective monitoring was required to demonstrate leaders understood the challenges to quality at all levels.**
- **The overall governance arrangements were ineffective.**
- **The practice did not have clear and effective processes for managing risks, issues and performance.**

Leadership capacity and capability

There was compassionate and leadership; however, effective monitoring was required to ensure this was taking place at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
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:

- The partners in the practice had the capacity and skills to deliver high quality care and took several lead roles at the practice. The lead GP carried out minor surgery as held the community ophthalmology clinic in conjunction with the eye hospital.
- There had been insufficient oversight of the practice management to ensure all areas highlighted for improvement at the previous inspection in September 2018 had been actioned and improved. While there was evidence of action taken in some areas, there were areas where effective action had not been taken.
- The practice was in the process of recruiting a new practice manager.

Vision and strategy

The practice had a clear vision to provide high quality 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:

- The practice had a vision that encouraged openness and honesty at all levels of the organisation including people who use the service.
- The practice were now part of a Primary Care Network of six practices called 'The Sphere' consisting of 63,000 patients. The benefits of this network included, improved quality and patient outcome and enabling GPs to support each other.

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.	Partial
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.	N
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial

Explanation of any answers and additional evidence:

- Although there was a whistleblowing policy in place, it did not refer to the NHS Improvement Raising Concerns (Whistleblowing) Policy.
- Not all staff had undertaken equality and diversity training.

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

Source	Feedback
Clinical staff	Staff felt supported and told us concerns were always listened to.
Non-clinical staff	Staff felt they had a good relationship with the leadership and found them approachable.

Governance arrangements

The overall governance arrangements were ineffective.

	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

Explanation of any answers and additional evidence:

- At the previous inspection in September 2018, we found there were ineffective systems to support good governance. At this inspection, we found although some governance systems had improved, there were still gaps. For example, we saw improvements relating to carrying out regular fire drills and servicing of the fire panel, two-week wait referrals, emergency medicines risk assessments, cold chain monitoring, patient safety alerts and dealing with complaints. However, there continued to be gaps in governance systems in some areas such as safeguarding and information sharing, recruitment and mandatory staff training.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Partial
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

Explanation of any answers and additional evidence:

- The assurance systems in place to identify, manage and mitigate risk were not regularly reviewed to ensure they remained effective. This was in relation to staff immunisations and significant events.
- The practice had not taken sufficient action to ensure health and safety risk assessment action plans were clearly recorded. This included the COSHH risk assessment, legionella, health and fire safety risk assessments and infection control audits.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	N
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:

- Whilst data was used to adjust and improve performance; for example, in Quality and Outcomes Framework (QOF) performance, we found improvement was still required in areas such as cervical screening.
- Information was not always accurate and timely. This related to the reporting of significant events whereby not all reported significant events had been recorded.

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:

- There was a lead GP for the Patient Participation Group (PPG) who met every four months. The PPG were involved in the discussions with the architect about the ongoing redevelopment works. The practice had an away day prior to the inspection which was attended by a PPG member.

Feedback from Patient Participation Group.

Feedback

The PPG worked collaboratively with the practice and formed a patient walking group. They found the practice was open and honest. They told us they were currently looking at reducing the amount of Did Not Attend (DNA) appointments at the practice.

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.	Partial

Explanation of any answers and additional evidence:

- Although there was some improvements made since the last inspection, they were not consistently applied in all areas; for example, significant events. We also found the safeguarding policies provided as part of the inspection evidence were different to the ones provided with the action plan.

Examples of continuous learning and improvement
• The practice developed a new website which offered online access to appointments, prescription and sick note requests. The practice told us that there were future plans to carry out online consultations. • The practice redevelopment works to the premises would result in improved access and capacity. The building would consist of a lift access and 90% of the consulting rooms would be located on the ground floor, as well as rooms for the physiotherapist and a paramedic. • The practice told us that the extra consulting rooms would be used to accommodate various health professionals as per the five-year forward view in general practice.

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.