

Care Quality Commission

Inspection Evidence Table

Chelsea Medical Services (1-6654175832)

Inspection date: 11 November 2019

Date of data download: 06 November 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

Safety systems and processes

The practice did not 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 1
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/A
Policies and procedures were monitored, reviewed and updated.	N 2
Partners and staff were trained to appropriate levels for their role.	Partial 3
There was active and appropriate engagement in local safeguarding processes.	Partial 4
The Out of Hours service was informed of relevant safeguarding information.	N 5
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial 6
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial 7
1. We were not assured that safeguarding systems and practices were fully developed and implemented in a way that kept people safe. 2. The provider could not demonstrate that practice policies were regularly reviewed and updated as required. The safeguarding policy referenced out of date information regarding safeguarding training and the appropriate levels of training for staff according to their position. The provider was not aware of the recent intercollegiate guidance update regarding training requirements for some clinical and	

Safeguarding	Y/N/Partial
<p>non-clinical staff.</p> <p>3. We saw evidence that training for safeguarding vulnerable adults for the practice's safeguarding lead had expired. Following the inspection, the provider submitted evidence this training had subsequently been undertaken.</p> <p>4. Staff told us they engaged with local safeguarding processes. However, the provider could not demonstrate this. For example, with minutes of meetings they had attended.</p> <p>5. The provider could not demonstrate they shared relevant information with out-of-hours primary care services in the borough. For example, documentation or records from the practice systems.</p> <p>6. We reviewed five staff records regarding DBS checks. We saw evidence that the last DBS check undertaken for one member of staff was in 2015 and from a previous employer. The provider had not undertaken a written risk assessment as to whether a new DBS check should be undertaken.</p> <p>7. Staff told us they invited Health Visitors to meetings to support and protect adults and children at risk of significant harm. However, they could not demonstrate evidence of this.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial 1
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial 2
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N 3
<p>1. The provider could not demonstrate they had a safe recruitment system in place. We reviewed five staff records and found gaps in these records. For example, three records did not contain photo ID. There were no induction records for four out of four staff. One staff member had been working at the practice for 10+ years so their record was excluded from this part of our review.</p> <p>2. We reviewed eight out of eight staff records regarding staff immunisations and certified immunity. The provider could not demonstrate that any member of staff in direct clinical contact had a complete record of the requisite blood tests and vaccinations to keep patients safe, or who had certified immunity, in line with current Public Health England (PHE) guidance.</p> <p>3. The provider could not demonstrate they had a system in place to monitor registrations for professional staff on a regular basis.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: September 2013</p>	N 1
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 2019</p>	Y
There were risk assessments for any storage of hazardous substances for example, liquid	Partial 2

nitrogen, storage of chemicals.	
There was a fire procedure.	N 3
There was a record of fire extinguisher checks. Date of last check: May 2018	Partial 4
There was a log of fire drills. Date of last drill: unknown	N 5
There was a record of fire alarm checks. Date of last check: May 2019	Y
There was a record of fire training for staff. Date of last training: Unknown	N 6
There were fire marshals.	Partial 7
A fire risk assessment had been completed. Date of completion: Not available	N 8
Actions from fire risk assessment were identified and completed.	N 8
<ol style="list-style-type: none"> 1. The provider could not demonstrate they had undertaken portable appliance testing (PAT). When we asked a senior member of staff for evidence this had been carried out, they asked us what PAT testing was. We reviewed some appliances in the practice premises and saw stickers on those items dated September 2013. 2. The provider submitted evidence of a control of substances hazardous to health (COSHH) risk assessment. However, it did not contain data sheets and did not include all substances held on the practice premises in the COSHH risk assessment. For example, liquid-based cytology. 3. The provider could not demonstrate they had a fire safety policy in place. We saw in minutes of a practice meeting they had discussed this but have not submitted evidence regarding it. 4. The provider submitted a record of fire extinguisher checks. However, this expired in May 2019. 5. We saw in minutes of a practice meeting they had discussed a fire drill. However, the provider could not demonstrate any other evidence regarding this. 6. We saw in minutes of a practice meeting they had discussed fire safety training for staff. However, the provider could not demonstrate any other evidence regarding this. 7. The provider could not demonstrate they had fire marshals in place who were adequately trained for this role. In addition, there were no contingency plans in place for when this member of staff was away from the practice. 8. The provider could not demonstrate they had a fire safety risk assessment in place. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: unknown	N 1
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: unknown	N 2 3
<ol style="list-style-type: none"> 1. The provider could not demonstrate they had undertaken a premises and security risk assessment. Records of associated checks in this regard were unavailable. 2. The provider could not demonstrate they had undertaken a health and safety risk assessment. Records of associated checks in this regard were unavailable. 	

3. The provider could not demonstrate they had an appropriate legionella risk assessment in place. The provider submitted self-written information reading Legionella. However, this did not meet the standards required in line with national guidance. For example, a Legionella risk assessment must be undertaken by a “competent person” and water temperatures must be monitored and recorded on a regular basis. Remedial actions must be noted and actioned.
4. The provider could not demonstrate they had an appropriate asbestos risk assessment in place. However, this did not meet the standards required in line with national guidance. For example, an inspection of any affected sites must be re-inspected every.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	N ¹
Staff had received effective training on infection prevention and control.	Partial ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: NHSE IPC Unit Audit: August 2019	Partial ³
The practice had acted on any issues identified in infection prevention and control audits.	N ⁴
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
<ol style="list-style-type: none"> 1. The provider could not provide evidence of an appropriate infection prevention and control (IPC) risk assessment and policy. IPC practices were found to be not in keeping with IPC guidance and did not mitigate the risks of healthcare acquired infection. We found concerns in relation to IPC and gaps in its management. 2. The provider could not assure us that their infection prevention and control (IPC) lead had clear oversight of IPC within the practice. They had not undertaken training for the lead role that included specific knowledge IPC acquisition to mitigate the risk of healthcare acquired infection. For example, we saw there were gaps in staff IPC training as three out of five staff had not undertaken appropriate training. 3. The NHSE IPC unit had undertaken an external audit on 28 August 2019. However, the provider could not demonstrate they undertook internal IPC audits. 4. Action points had been identified during the NHSE IPC audit and this had mandatory requirements and timescales attached to it. We found some mandatory action points had not been completed within the specified timescale. For example, a Legionella risk assessment. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	N ¹

Comprehensive risk assessments were carried out for patients.	N 2
Risk management plans for patients were developed in line with national guidance.	N 3
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial 4
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.	N 5
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.	N 6
<p>1. We reviewed staff employment and recruitment records and found gaps in the practice system. For example, the provider could not demonstrate they had carried out an induction for four out of four staff.</p> <p>2. The provider could not demonstrate they had safety netting systems in place regarding two-week urgent referrals and high risk medicines. Risk assessments for the practice premises were absent</p> <p>3. We found that some risk assessments undertaken to ensure the safety of the premises for patients and staff had not been undertaken, for example fire safety, Legionella, asbestos and COSHH risk assessments.</p> <p>4. and 5. Non-clinical staff we interviewed told us what actions they would take if a very unwell patient attended the practice. However, the provider could not demonstrate that all staff had undertaken sepsis or red flag signs training in line with national guidance.</p> <p>6. We were not assured that the practice had assessed and monitored the impact on patient safety when planning the skill-mix and availability of clinical staff at the practice. The clinical pharmacist, who the practice told us was going to undertake some of the work undertaken by a previous practice nurse, was available one day per week. The healthcare assistant had not undertaken the Care Certificate training course or any role specific training including health checks for adults and children. The practice could not demonstrate that they had considered the impact on patient safety for all patient population groups.</p>	

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial 1
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.	N 2
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.	Partial 3 4 5
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
<ol style="list-style-type: none"> 1. We saw the practice managed electronic clinical records in line with national guidance and legislation. However, we saw that paper medical records are stored in their reception area and in a "server room" which is easily accessible to others. In both storage areas, records could easily be removed without a member of staff seeing. 2. The provider could not assure us they had a consistent approach to sharing all relevant information with all staff and with external agencies. For example, minutes of multi-disciplinary meetings, and significant events. 3. We reviewed the system and process the provider had in place regarding two-week wait urgent referrals. The provider could not demonstrate they operated a fail-safe system. For example, we found ten patients had not been followed up by the practice to check they had attended an appointment with secondary care. Checks regarding these patients were made on the same day to assure us that patients had been seen appropriately. Following the inspection, the provider submitted evidence regarding a new system they planned to implement regarding this. 4. We saw that Public Health England (PHE) data available for 1 April 2017 to 31 March 2018 for the number of new cancer cases treated (detection rate % of which resulted from a two-week wait referral) was 16.7% (CCG average 53.2 .8%; England average 51.9%). The practice was not aware of this data. We were not assured regarding patient safety. 5. The provider could not demonstrate they had a failsafe system in place to manage and monitor cervical smear screening. We were not assured regarding patient safety. 	

Appropriate and safe use of medicines

The practice had limited 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)	0.52	0.50	0.87	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total	15.4%	9.3%	8.6%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>				
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) <small>(NHSBSA)</small>	7.12	5.53	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) <small>(NHSBSA)</small>	0.89	0.77	2.08	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N ₁
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 ₂
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N ₃
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	4
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient	Y

Medicines management	Y/N/Partial
outcomes and reduce the risk of adverse events and antimicrobial resistance.	
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.	Partial 4
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.	N 5
<ol style="list-style-type: none"> 1. The practice did not employ a practice nurse, and the healthcare assistant did not undertake the administration of influenza vaccines. We found that only GPs' were administering influenza vaccinations. 2. The provider could not demonstrate they had oversight of the clinical pharmacist role and work undertaken with patients in the practice. We made arrangements on three occasions to interview the clinical pharmacist and were unable to do so. The practice did not hold any records regarding the pharmacist's training, education, peer review or clinical supervision. Therefore, we were not assured regarding patient safety. 3. We reviewed the system and process the provider had in place to monitor and manage high-risk medicines. The provider could not demonstrate they operated a safe effective system regarding this. For example, we found evidence that six patients had not undertaken appropriate blood monitoring. We were not assured regarding patient safety. 4. The provider did not maintain stock of a medicine used for the treatment of croup in children. The provider had not conducted a risk assessment as to why they did not stock this medicine. They did not have signage to alert staff/visitors as to where to find the emergency kit. 5. We found the vaccine fridges were overstocked. The vaccines were stored to the sides of the fridge which did not facilitate the air circulation system to maintain vaccines at a safe optimum temperature. We found that temperatures had fallen below recommended on several occasions on the vaccine fridge in a consultation room and no remedial actions had been undertaken regarding this. They did not have a system in place to monitor new stock and manage stock rotation. Therefore, we could not be assured that the cold chain was being maintained in accordance the Public Health England guidance. 	

Track record on safety and lessons learned and improvements made

The practice had limited systems 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.	Partial 1
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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial 2
There was evidence of learning and dissemination of information.	Partial 3 4

Number of events recorded in last 12 months:	5
Number of events that required action:	5
<ol style="list-style-type: none"> 1. We were not assured that the practice monitored and reviewed information from a variety of sources to demonstrate a comprehensive approach to learning and quality improvement. They did not undertake an annual thematic analysis to identify any trends that may require further investigation. The practice's approach to learning from significant events was reactive rather than proactive. For example, they had not provided staff training regarding repeat prescription requests for reception staff. 2. We reviewed evidence that demonstrated staff knew how to raise concerns regarding significant events. For example, the practice had submitted one significant event to the National Reporting and Learning System (NRLS). However, we saw several examples of significant events the practice could have submitted to share relevant learning across primary care services and had not done so. The significant event policy did not make any reference to the National Reporting and Learning System (NRLS). The practice policy for significant events did not contain information regarding significant events processes in primary care and the analysis of an incident. Instead, the policy signposted staff to different folders and a media storage device to access this information. The practice did not use a proforma to collect relevant information when an incident had occurred and could not demonstrate that learning was shared with staff. 3. Staff told us they did not undertake clinical meetings and therefore could not demonstrate that significant events concerning clinical concerns were thoroughly reviewed and learning was disseminated. 4. We reviewed minutes from practice meetings. Significant events were not a standing agenda item. Therefore, we could not determine if learning was adequately shared with all staff to ensure any learning was disseminated. 	

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

Event	Specific action taken
Blood test undertaken on wrong patient	Ensure patients' ID is appropriately checked prior to tests being undertaken.
Prescribing error	Practice repeat prescribing policy discussed with reception staff. GPs to always review patients' notes.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N 1
Staff understood how to deal with alerts.	N 2
<ol style="list-style-type: none"> 1. The practice could not demonstrate a consistent and failsafe system for receiving, recording and acting on patient safety alerts. could not demonstrate they had captured all alerts; what actions had been taken and by whom; when actions had been completed and that this information was shared with all staff. We were not assured regarding patient safety. 2. Staff told us the practice did not undertake clinical meetings. Therefore, there was limited potential for relevant patient safety alerts to be discussed by clinical staff. 	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

We could not be assured that patients' needs were always assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance. Clinical practice was supported by clear pathways and tools. However, there were limited systems and processes in place to assure patient care was delivered safely and no formal supervision or oversight of clinical practice.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial 1
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.	Partial 2
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N ₃
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.	N/A
<ol style="list-style-type: none"> Clinicians were aware of national guidance, for example, NICE guidance. However, they did not undertake clinical meetings so could not demonstrate this had been discussed. Staff told us that patients with potentially serious illness were followed up in a timely way. However, they could not demonstrate they had a system and policy in place to manage and monitor this. For example, two-week urgent referrals. We found evidence that patients' treatment was not always reviewed regularly. For example, six patients on high-risk medicines did not have appropriate regular monitoring in line with national guidance. 	

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) <small>(NHSBSA)</small>	0.85	0.80	0.75	No statistical variation

Older people

Population group rating: Inadequate

Findings

- Staff told us each patient has a named GP.
- The provider prioritised home visits and telephone consultations for older people and pro-actively visited housebound patients as part of its care planning and annual immunisation programme.
- The provider told us they participated in regular multidisciplinary meetings with other healthcare professionals to discuss patients at-risk and nearing end-of-life. However, we did not see any evidence regarding this.
- The provider performs a monthly clinic at a local “hub” practice which offers longer appointments with input available from social services, a community pharmacist and a geriatrician.

People with long-term conditions

Population group rating: Inadequate

Findings

Quality and outcomes framework (QOF) data relates to the time period (01/04/2018 to 31/03/2019).

- Staff told us chronic disease management was undertaken by a clinical pharmacist at a weekly clinic at the practice. The provider could not demonstrate this member of staff had been appropriately trained to undertake this work as they did not keep records for the clinical pharmacist in this regard.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The achievement rate for patients with for 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 is 100%. This is a positive variation. However, the exception reporting rate is 29%. This is compared to 9.4% locally and 11.2% nationally. When we asked the provider to explain this they were unable to do so.
- The achievement rate for 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 is 100%. This is a significant positive variation. However, the exception reporting rate is 18.6%. This is compared to 3.6% locally and 7.4% nationally. When we asked the provider to explain this they were unable to do so.
- The achievement rate for patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less is 95.2%. However, the exception reporting rate is 17.5%. This is compared to 5.2% locally and 4.0% nationally. When we asked the provider to explain this they were unable to do so.
- The achievement rate for patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anti-coagulation drug therapy is 94.4%. However, the exception reporting rate is 14.3%. This is compared to 5.1% locally and 5.9% nationally. When we asked the provider to explain this they were unable to do so.

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>	71.4%	76.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.4% (4)	9.4%	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>	75.4%	77.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	6.8% (5)	8.4%	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) <small>(QOF)</small>	74.3%	79.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.4% (4)	9.7%	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) <small>(QOF)</small>	100.0%	78.3%	75.9%	Significant Variation (positive)
Exception rate (number of exceptions).	18.6% (13)	3.6%	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>	100.0%	90.7%	89.6%	Variation (positive)
Exception rate (number of exceptions).	29.0% (9)	9.4%	11.2%	N/A

Indicator	Practice	CCG	England	England
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		average	average	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>	95.2%	80.1%	83.0%	Significant Variation (positive)
Exception rate (number of exceptions).	17.5% (44)	5.2%	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>	94.4%	88.7%	91.1%	No statistical variation
Exception rate (number of exceptions).	14.3% (3)	5.1%	5.9%	N/A

Families, children and young people

Population group rating: Inadequate

Findings

- The practice has not met the minimum 90% target for four of four childhood immunisation uptake indicators (the recommended standard for achieving herd immunity is 95%).
- The provider told us they utilised the skills of the clinical pharmacist in place of a practice nurse. However, the clinical pharmacist did not undertake childhood immunisations and achievement rates were low for this indicator.
- We asked clinical leaders regarding the deterioration in childhood immunisations rates. They told us that parents took their children to have their immunisations with private providers. However, they did not share data with us to evidence this.

Overview of childhood immunisations achievement rates for the previous five years:

	Year ending 31/03/2015	Year ending 31/03/2016	Year ending 31/03/2017	Year ending 31/03/2018	Year ending 31/03/2019
Immunisations					
Children aged 1 year: DTaP/IPV/Hib/Hep B	79.3%	50.0%	64.0%	79.3%	55.6%
Children aged 2 years: PCV	72%	73.5%	57.1%	46.9%	48.4%
Hib & Men C	76%	76.5%	60.7%	59.4%	54.8
MMR	72%	70.6%	64.3%	53.1%	51.6%

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)	10	18	55.6%	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)	15	31	48.4%	Below 80% uptake
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)	17	31	54.8%	Below 80% uptake
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)	16	31	51.6%	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>

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> Patients could access a GP hub out-of-hours service in the evenings and weekends. Staff told us female patients could access cervical smear testing at the hub. Public Health England (PHE) data demonstrated that the achievement rate for eligible women for cervical cancer screening in 2017/2018 was 38.8%. This compared to an achievement rate in 2018/2019 (PHE data) for the same indicator of 41.5%. The national achievement target is 80%. The provider told us they utilised the skills of the clinical pharmacist in place of a practice nurse. However, the clinical pharmacist did not undertake cervical smears and the achievement rate for this indicator was low. We asked clinical leaders for data regarding the uptake rate for cervical screening at the hub service and details of how the practice monitored this. Senior managers told us this information was not available to them. Patients had access to NHS checks for those who are aged 40 to 74. However, the healthcare assistant tasked with undertaking these roles had not completed appropriate training for health care assistants. For example, Care Certificate training.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery; telephone consultations were available each day.

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)	38.8%	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)	50.7%	56.2%	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)	30.3%	37.9%	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)	75.0%	62.6%	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)	16.7%	53.2%	51.9%	No statistical variation

Any additional evidence or comments

- We saw that Public Health England (PHE) data available for 1 April 2017 to 31 March 2018 for the number of new cancer cases treated (detection rate % of which resulted from a two-week wait referral) was 16.7% (CCG average 53.2 .8%; England average 51.9%). The practice was not aware of this data.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The provider has a register for patients who have a learning disability. There are three patients currently on the register. Staff told us the lead GP offers annual health checks for this patient population group.
- Patients had access to NHS checks for those who are aged 40 to 74. However, the healthcare assistant tasked with undertaking these roles had not completed appropriate training for health care assistants or role specific training. For example, Care Certificate training.

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

Population group rating: Inadequate

Findings

- Patients had access to NHS checks for those who are aged 40 to 74. However, the healthcare assistant tasked with undertaking these roles had not completed appropriate training for health care assistants. For example, Care Certificate training.
- The achievement rate for 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) indicator is 100.0%. This is a positive variation. However, the exception reporting rate is 34.5%. This is compared to 6.1% local and 12.3% national rates. When we asked the provider to explain this they were unable to do so.
- The achievement rate for 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) is 100.0%. However, the exception reporting rate is 24.1%. This is compared to 4.5% local and 10.1% national rates. When we asked the provider to explain this they were unable to do so.

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>	100.0%	91.2%	89.4%	Variation (positive)
Exception rate (number of exceptions).	34.5% (10)	6.1%	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>	100.0%	93.6%	90.2%	Variation (positive)
Exception rate (number of exceptions).	24.1% (7)	4.5%	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>	90.9%	87.4%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.7%	6.7%	N/A

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	494.7	No Data	539.2
Overall QOF score (as a percentage of maximum)	88.5%	No Data	96.4%
Overall QOF exception reporting (all domains)	6.8%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial ¹
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N ^{2 3}
Quality improvement activity was targeted at the areas where there were concerns.	N ⁴
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N ⁵

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

<ol style="list-style-type: none"> 1. The provider could not demonstrate evidence they engaged in local and national quality improvement initiatives. 2. There was a limited programme of clinical and internal audit. Information submitted by the practice related to monitoring and not quality improvement. We reviewed two monitoring audits related to dermatology referrals and high-risk medicines. The first monitoring audit related to dermatology referrals undertaken in the period April-June in 2018 and 2019, using three indicators to assess appropriate referrals using local guidelines. This demonstrated an improvement across all three indicators. 3. The clinical pharmacist, who belonged to the West London GP Federation, undertook an audit to identify if the practice monitoring of five commonly used high-risk medicines, was in alignment with national and local guidance. For one medicine no patients were identified on the clinical system in the first and second cycles. The first cycle was undertaken in November 2018. The second cycle was undertaken six months later. Improvement in monitoring was noted as nine percent and twenty percent respectively in relation to two medicines. The practice submitted a list of audits undertaken in the past two years. However, they did not provide any further evidence regarding this. 4. The provider could demonstrate limited evidence of quality improvement activity. For example, quality audits were not yet driving consistent improvements across all areas of concern. 5. The practice could not demonstrate they regularly reviewed unplanned admissions and readmissions and took appropriate action.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
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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.	N 1
The learning and development needs of staff were assessed.	N 2
The practice had a programme of learning and development.	N 3
Staff had protected time for learning and development.	N 4
There was an induction programme for new staff.	N 5
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N 2
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.	N 7
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 8
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<ol style="list-style-type: none"> 1. The practice could not demonstrate that all staff who were responsible for reviews of patients with long-term conditions had received appropriate and up-to-date training. For example, asthma, diabetes and chronic obstructive pulmonary disease (COPD). 2. The practice could not demonstrate they assessed the learning and development needs for staff. For example, the practice had not identified that the healthcare assistant was required to undertake Care Certificate training. 3. The provider could not demonstrate they had an appropriate embedded system of learning and training for staff. For example, they did not have a programme of regular training in place. They could not evidence that any staff had undertaken appropriate training regarding fire safety training and sepsis/red flag signs. 4. It was not possible to determine whether staff had protected time for learning and development as there was insufficient evidence regarding any appropriate training haven taken place. 5. We reviewed four staff records and saw that none of them had undertaken an induction programme. 6. We reviewed five staff records and saw that three out of five did not contain evidence of an annual appraisal. The provider could not demonstrate they undertook clinical supervision with the healthcare assistant. They could not demonstrate they had oversight of the clinical pharmacist role and work undertaken with patients in the practice. We made arrangements on three occasions to interview the clinical pharmacist and were unable to do so. The practice did not hold any records regarding the pharmacist's training, education, peer review or clinical supervision. Therefore, we were not assured regarding patient safety. 7. The provider could not demonstrate the clinical pharmacist or the healthcare assistant had undertaken role specific training to carry out long term conditions reviews or other patient centred tasks. For example, asthma, chronic obstructive pulmonary disease and NHS health checks with adults and children. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 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 ₁
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
1. The provider undertook regular multi-disciplinary meetings with the wider healthcare team regarding palliative care and older people. We reviewed minutes of meetings to evidence this.	

Helping patients to live healthier lives

Staff were not always 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.	N ₁
Patients had access to appropriate health assessments and checks.	Partial ₂
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.	N ₃
<ol style="list-style-type: none"> 1. Information was available for patient on the practice website regarding signposting to other services, including social prescribing, for example, mental health well-being. 2. Patients had access to appropriate health assessments and checks. However, neither the clinical pharmacist or the healthcare assistant had not undertaken appropriate training and been competency checked to carry out these checks. 3. The provider could not demonstrate they engaged with patients regarding health improvement activities. They did not have systems in place to support the national screening programme, for example breast and bowel screening, and were not aware that patient outcomes were lower than local and national averages 	

Smoking Indicator	Practice	CCG	England	England
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		average	average	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) <small>(QOF)</small>	100.0%	94.9%	95.0%	Significant Variation (positive)
Exception rate (number of exceptions).	6.2% (24)	1.1%	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.	N 1
Policies for any online services offered were in line with national guidance.	N/A
<ul style="list-style-type: none"> The provider could not demonstrate they had oversight regarding monitoring consent in patients records. 	

Caring

Rating: Good

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

Source	Feedback
Comments cards	Patients reported a consistent theme regarding the provision of consistent compassionate care from GPs'.
Comments cards	Several patients commented on the professionalism and kindness of practice staff.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3091.0	457.0	82.0	17.9%	2.65%

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)	92.2%	88.3%	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)	91.6%	86.3%	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)	99.3%	94.1%	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)	96.7%	84.7%	82.9%	Tending towards variation (positive)

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

Any additional evidence
<ul style="list-style-type: none"> The practice undertook feedback from patients via the Friends and Family Test. Staff told us they had not implemented any changes as feedback from patients was overwhelmingly positive.

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.	Patients provided consistent positive commentary regarding the practice and its staff. They described the practice team as being extremely kind, understanding and empathetic.

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)	99.3%	91.6%	93.4%	Tending towards variation (positive)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y ₁
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Partial ₂

Information leaflets were available in other languages and in easy read format.	N ₃
Information about support groups was available on the practice website.	Y
<ol style="list-style-type: none"> Staff told us that interpreter services were available for those patients who required them. There was limited information available to patients in the waiting room. However, the practice website contained information on a variety of topics, for example, carers support, those patients who wish to access support for domestic violence and healthy living information including in different languages. Information was available to view in different languages on the provider's website. However, information leaflets in different languages and in easy to read format were not available in the practice premises. 	

Carers	Narrative
Percentage and number of carers identified.	1.55% (48)
How the practice supported carers (including young carers).	The provider told us they are not aware of any young carers within their patient population group. Carers are proactively identified by the practice.
How the practice supported recently bereaved patients.	Bereaved patients are referred to the bereavement organisation "Cruise" or to the "My Care My Way".

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

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.	N ₁
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.	Partial ₂
The practice made reasonable adjustments when patients found it hard to access services.	Partial ₃
There were arrangements in place for people who need translation services.	Partial ₁
The practice complied with the Accessible Information Standard.	Y
<ol style="list-style-type: none"> 1. The provider had extended their use of registers to widen the scope of vulnerabilities it takes account of. For example, patients who are partially sighted and hard of hearing. Silent Sound interpreters were available on a pre-bookable basis. However, they it could not demonstrate what specific arrangements were in place for patients with a visual impairment or other disability. 2. The premises are located in the basement of a building and there was no lift within the practice premises . Therefore, access for older people, those with a disability and mobility issues, and parents/carers with babies and young children would have difficulty in accessing the practice. Patients told us GPs' would conduct home visits for those people who had mobility issues. 3. Appointments were available at a local GP hub service, which provided step-free access for patients, in the evenings and at weekends. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08.00am-08.00pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm
Appointments available:	
Monday	08.00am-6.30pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00a,m-6.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
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3091.0	457.0	82.0	17.9%	2.65%
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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)	99.0%	93.7%	94.5%	No statistical variation

Any additional evidence or comments

- We found evidence that access to GP appointments at the practice was excellent. Patients told us they could access a GP appointment frequently and at most there was a two-day wait.

Older people

Population group rating: Requires improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Transport is organised for older patients when attending appointments with the older person care team at a local GP hub practice.

People with long-term conditions

Population group rating: : Requires improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- Patients who required monitoring services, for example, ECG and phlebotomy.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: : Requires improvement

Findings

- Same day appointments are prioritised for this patient population group. There is no nursing provision provided at this practice currently.
- Access to the practice is difficult for parents with babies and young children as the premises is located in the basement of a building.
- Staff told us childhood immunisations are offered at eight-week baby checks and they booked appointments for immunisations at the GP federation hub during extended hours and weekends. The GP hub premises is step-free.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice offered extended hours appointments each day to accommodate the needs of this patient population group.
- 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. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm). The provider does not employ a practice nurse and women are signposted to the local GP hub for cervical screening.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice held a register of patients living in vulnerable circumstances, for example those with a learning disability.
- Extended appointments were offered to facilitate patients who had more complex needs. Longer appointments could be pre-booked if required.

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.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Staff told us that patients with poor mental health have annual medical checks. This included a physical health check, health promotion and a check that they are up to date with blood tests and ECG monitoring as required is made. However, we reviewed evidence that regular blood monitoring and annual ECG's were not undertaken for patients with serious mental illness who had been prescribed on anti-psychotic medicines.
- Health checks were undertaken by the healthcare assistant who had not undertaken appropriate training, for example, Care Certificate training, to enable them to do so safely. Staff told us that patients were referred to other GP practices for ECG's.

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 1

The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y ₂
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<ol style="list-style-type: none"> 1. We reviewed evidence that patients were able to access GP appointments quickly and the practice was flexible and accommodating with the appointments system. 2. Staff told us they would prioritise at-risk groups for same-day or immediate appointments. For example, older people and babies and young children. 	

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)	97.1%	N/A	68.3%	Significant Variation (positive)
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)	94.4%	73.5%	67.4%	Variation (positive)
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)	83.0%	71.2%	64.7%	Tending towards variation (positive)
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)	85.4%	72.2%	73.6%	No statistical variation

Source	Feedback
For example, NHS Choices	5* overall rating (from two patient reviews available) Both patients reflected the practice offered excellent care, were caring and flexible with appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	1

Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
<ul style="list-style-type: none"> Staff told us that most complaints were dealt with informally by the practice manager or the duty doctor. 	

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<ul style="list-style-type: none"> It was not possible to determine whether complaints were used to drive continuous improvement as they had received no complaints during the previous 12 months. The practice do not record verbal complaints. We reviewed evidence of patient feedback the practice had received via the portal on its website. An apology had been given to this patient. However, there was no reference made to referring the complaint to the Parliamentary and Health Service Ombudsman, if they were not satisfied with how the practice had responded. 	

Well-led

Rating: Inadequate

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N ¹
They had identified the actions necessary to address these challenges.	N ^{2 3}
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial ⁴
<ol style="list-style-type: none"> The management team could not demonstrate they were aware of the challenges to delivering care within a primary care setting or that they had an action plan to address those challenges. Leaders could not demonstrate the capacity to prioritise safety and quality improvement. Several systems and processes had been found to be unsafe. We found the practice was reactive rather than proactive and some actions had been undertaken immediately following the inspection. For example, a process regarding a failsafe system for two-week wait urgent referrals. <ul style="list-style-type: none"> The provider had a protocol in place to monitor and safely manage patients who had been prescribed high-risk medicines, but they had not adhered to the terms of their own protocol. For example, we found nine examples of patients who had been prescribed high-risk medicines and who had not undertaken regular blood monitoring. The provider could not demonstrate they operated a system regarding patient safety alerts. For example, they could not identify all relevant alerts, did not record searches had been 	

<p>completed for patients and document completed actions.</p> <ul style="list-style-type: none"> ➤ The provider could not demonstrate they had a failsafe system in place to manage and monitor cervical smear screening and achievement levels were poor. ➤ The provider had a schedule of mandatory training, including for safeguarding children and adults. They told us training and development was identified at induction and appraisal. However, we reviewed limited evidence of training certificates for staff. For example, fire safety training and infection prevention and control. <p>4. We saw there was a leadership development programme, including a succession plan. For example, the previous Registered Manager and Lead GP had stepped back from their position and taken semi-retirement, although they still undertook some clinical sessions. A former salaried GP had successfully taken on these leadership roles at the practice. However, the only other GP is a long term locum and we found there are no firm plans in place to further strengthen the clinical team.</p>

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N 1
There was a realistic strategy to achieve their priorities.	N 2
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N 3
Staff knew and understood the vision, values and strategy and their role in achieving them.	N 4
Progress against delivery of the strategy was monitored.	N 5
<ol style="list-style-type: none"> 1. The practice had a mission statement in place that reflected “ We aim to provide excellent healthcare within our resources, which is responsive, accessible and within a learning environment that stimulates personal and professional growth and encourages collaboration with other healthcare teams”. Patient data was poor in some clinical areas and practice did not contain fail-safe systems. We were not assured regarding patient safety. 2. The provider could not demonstrate they had a credible strategy in place to address challenges they had identified and concerns we found on inspection. They had a reactive rather than proactive approach regarding this. We found that there was a lack of oversight in key areas relating to the safety systems in place, staff provision, and governance structures all of which had the ability to compromise the quality of care provided by the practice and impact on its vision, aims and objectives. The practice had an active patient participation group and could not demonstrate that the strategy had been developed in consultation with patients. 3. We were not assured that staff knew and understood the vision, values and strategy and their role in achieving them. Not all staff we spoke with were aware of the practice vision and told us they had not been involved in the creation of the strategy. 4. The provider could not assure us they monitored progress of the practice strategy. 	

Culture

The practice culture did not always support 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.	N 1
The practice had access to a Freedom to Speak Up Guardian.	N 2
Staff had undertaken equality and diversity training.	N 3
<ol style="list-style-type: none"> 1. The provider could not demonstrate they had a speaking up policies in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. 2. The practice could not demonstrate that staff had access to a Freedom to Speak Up Guardian. 3. A member of the management team told us that all staff had completed equality and diversity training. However, they could not provide certificated evidence of this. 	

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

Source	Feedback
No-clinical member of staff	Staff told us they felt supported by the management team and they were approachable.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N 1 2
Staff were clear about their roles and responsibilities.	Partial 3
There were appropriate governance arrangements with third parties.	N 4
<ol style="list-style-type: none"> 1. We found that structures, processes and systems to support good governance were not effective. In particular, we found concerns around the management and monitoring of safeguarding, recruitment, premises risk assessments, urgent two-week wait referrals, cervical smear screening, significant events and patient safety alerts. 2. The provider could not demonstrate that all practice policies were regularly reviewed and updated as required. For example, the safeguarding policy did not contain recent intercollegiate guidance and changes to levels of safeguarding training policy regarding different staff groups. 	

3. Although all staff had specific roles and responsibilities the practice could not demonstrate who had oversight of all systems and processes to ensure effective care and to drive quality improvement. For example, effective staffing in relation to core and role-specific training, supervision and appraisal, clinical audit and an overall lack of oversight to ensure safe and effective care.
4. The provider could not demonstrate what governance arrangements they had in place regarding safety and the practice premises. For example, with the leaseholders of the building and premises risk assessments.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N 1
There were processes to manage performance.	N 2
There was a systematic programme of clinical and internal audit.	N 3
There were effective arrangements for identifying, managing and mitigating risks.	N 4
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.	N 5

1. We were not assured that comprehensive and effective systems and process were in place and regularly reviewed to manage risk and some performance data. For example, following the inspection the provider submitted evidence regarding a fails-safe system for urgent two-week wait referrals. However, the provider could not demonstrate that it proactively identified and responded to all risks and assessed the impact on safety and quality.
2. The provider could not demonstrate what systems they had in place to manage performance that was poor or variable. For example, the lack of improvement in the achievement rate for cervical screening since our last inspection.
3. There was a limited programme of clinical and internal audit. We reviewed two monitoring audits related to dermatology referrals and high-risk medicines. In addition, the practice submitted a list of audits undertaken in the past two years. However, they did not provide any further evidence regarding this.
4. The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective. For example, the two-week wait urgent referral follow-up system.
5. The provider could not demonstrate they had considered the impact on quality and sustainability when service developments or changes had occurred. For example, the impact on childhood immunisations and cervical screening when the previous practice nurse left the practice and they were not replaced.

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.	Y
Performance information was used to hold staff and management to account.	N ¹
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N ²
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<ol style="list-style-type: none"> 1. The provider could not demonstrate that when performance was below national targets, this information was used to hold staff and management to account. 2. The provider could not demonstrate there were effective arrangements for identifying, managing and mitigating risks. For example, the management of two-week wait urgent referrals and the infection control risk assessment. 	

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	Partial
<ul style="list-style-type: none"> • The practice could not demonstrate they had worked with all stakeholders to build a shared view of challenges and of the needs of the population. For example, young people who were living in the hostel located close to the surgery. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • The Patient Participation Group (PPG) told us the group was active, worked closely with the practice and met on a regular basis. They described the practice as being open and responsive to patients' views.

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous

improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<ul style="list-style-type: none"> We were not assured that systems and process for learning and continuous improvement were fully developed and implemented. The practice could not demonstrate a comprehensive approach to quality improvement and did not always review the effectiveness and appropriateness of care provided. 	

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 practice's 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.