

Care Quality Commission

Inspection Evidence Table

Dr Ravindrasena Muthiah (1-489153917)

Inspection date: 11 February 2020

Date of data download: 10 February 2020

Overall rating: Inadequate

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

Safe

Rating: Inadequate

Safety systems and processes

At our inspection on 11 February 2020 we found concerns regarding:

- We were not assured that safeguarding systems and practices were fully developed and implemented in a way that kept people safe.
- The provider could not demonstrate they operated safe recruitment practices.
- The provider could not demonstrate they operated safe premises practices, including fire safety and COSHH.
- The management of patients who have been prescribed anti-psychotics and hypnotics medicines.
- The management of infection prevention and control within the practice, including the management of clinical waste.
- There were gaps in systems to assess, monitor and manage risks to patient safety, including the safety netting of urgent referrals and cervical screening.
- The provider could not assure us they had a consistent approach to sharing all relevant information with external agencies. For example, with the National reporting and Learning System (NRLS) and the local Clinical Commissioning Group (CCG).
- Patient safety alerts.
- The management of emergency medicines and equipment.

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	Partial 1

Safeguarding	Y/N/Partial
communicated to staff.	
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial 2
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial 3
There was active and appropriate engagement in local safeguarding processes.	N 4
Systems were in place to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	N 5
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	N 6
<ol style="list-style-type: none"> 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. For example, the safeguarding policies did not reference female genital mutilation, of the legal requirement to report this and of the necessity to undertake safeguarding risk assessments for children whose mother may have been affected by FGM. Or they suspected that a female child may be at risk of FGM. The provider had referenced the recent intercollegiate guidance update regarding training requirements for some clinical and non-clinical staff. However, policies did not contain this information. 3. The provider, who was the safeguarding lead for vulnerable adults and children, could not demonstrate they had met the learning and training requirements for this role in line with national guidance. 4. The provider could not demonstrate they were actively and appropriately engaged in local safeguarding processes. For example, minutes of local safeguarding meetings. 5. We could not be assured regarding the safeguarding of children and vulnerable adults as the provider did not hold a register of these patient groups or have appropriate oversight of this for patients at the practice. On the day of the inspection, they undertook a search of patients and created a register of seven patients. The search results we reviewed did not include siblings of children on the safeguarding register. We looked at two patients records and saw that alerts had been placed on them. 6. The practice did not hold multi-disciplinary meetings with health visitors. They told us if they had any concerns regarding safeguarding, they would refer to social services. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N 1
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who required medical indemnity insurance had it in place.	Y
1. We reviewed five staff recruitment records and found gaps in these records. For example, two out of five records did not contain photo ID or references and two did not contain a signed contract. No staff records contained two references, and information regarding interview summaries and inductions.	

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: April 2019	Y
There was a record of equipment calibration. Date of last calibration: April 2019	Y
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial 1
There was a fire procedure in place.	Y
There was a record of fire extinguisher checks. Date of last check:	Y
There was a log of fire drills. Date of last drill: December 2019	Partial 2
There was a record of fire alarm checks. Date of last check:	Y
There was a record of fire training for staff. Date of last training: various	Y
There were fire marshals in place.	Partial 3
A fire risk assessment had been completed. Date of completion: February 2020	Partial 4
Actions from fire risk assessment were identified and completed.	N 5
1. The provider submitted evidence of two substances they had identified as potentially harmful to health. For example, a preparation used in cervical screening. However, they had not undertaken an overall control of substances of hazardous to health (COSHH) risk assessment with relevant data sheets of chemicals/substances. We identified additional substances on the	

- practice premises that had not been included in the COSHH risk assessment.
2. We saw evidence of a fire drill undertaken in 2019. However, the provider could not provide records to demonstrate they had undertaken this on a six-monthly basis in accordance with national guidance and their own policy.
 3. We saw that the Lead GP had undertaken training as a fire marshal. The provider submitted training information regarding two other people. However, the provider could not demonstrate any other member of staff, who worked regularly at the premises, had been appropriately trained in the instance they were absent from the practice. Following the inspection, the provider submitted evidence that a part-time receptionist/administrator had undertaken fire warden training, which mitigated some but not all risk regarding this.
 4. The fire safety risk assessment had been completed by the temporary deputy practice manager. We saw this risk assessment was not in line with national guidance or legislation. For example, they had not identified all sources of ignition and identified people who may be at risk in the event of a fire.
 5. We saw the provider had not identified all fire safety concerns in their risk assessment. Therefore, it was not possible to accurately assess whether they had undertaken appropriate actions.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y ¹
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 6 January 2020	Partial ^{1 2}
<ol style="list-style-type: none"> 1. The provider could demonstrate they had undertaken a combined premises/security risk and health and safety assessment. However, they had not assessed all risks we found in the practice. For example, the potential hazard caused by a stair lift installed onto a narrow stair case leading to consultation rooms in the basement. 2. The provider could not demonstrate they had undertaken risk assessments regarding legionella and asbestos. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Y
Staff had received effective training on infection prevention and control.	Partial ^{1 2 3}
Date of last infection prevention and control audit: 06 November 2019	Partial ⁴

The practice had acted on any issues identified in infection prevention and control audits.	Partial 5
The arrangements for managing waste and clinical specimens kept people safe.	N 6
<ol style="list-style-type: none"> 1. Infection prevention and control (IPC) practices were found to be not in keeping with IPC national guidance and did not mitigate the risks of healthcare acquired infection. The provider had undertaken an infection prevention and control risk assessment and documented they were compliant with national guidance. However, 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 which included specific knowledge IPC acquisition to mitigate the risk of healthcare acquired infection. 3. We saw evidence that the healthcare assistant and all non-clinical staff had undertaken infection prevention and control training. 4. The provider could not demonstrate they had undertaken regular IPC audits. We reviewed an IPC audit undertaken by the lead GP and healthcare assistant (HCA). We identified IPC concerns that had not been highlighted in the practice IPC risk assessment. For example, the practice premises were dirty and dusty, and the provider did not keep a log regarding the cleaning and maintenance of clinical equipment. We saw evidence that clinical waste was kept in a cupboard under the stairs. The provider has not submitted evidence of clinical waste receipts to demonstrate this was safely managed. 5. We saw the provider had not identified all IPC concerns in their risk assessment. For example, in clinical rooms, sinks had overflows and posters were not laminated. Therefore, it was not possible to accurately assess whether they had acted on any issues identified in infection prevention and control audits. 6. The provider could not demonstrate evidence of appropriate arrangements for the collection of waste. For example, we saw clinical waste bags thrown in a cupboard under the stairs with other equipment and items. We requested to see evidence of transfer notices regarding waste collection. However, these have not been submitted by the provider. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N 1
There was an effective induction system for temporary staff tailored to their role.	N 2
Comprehensive risk assessments were carried out for patients.	Partial 3
Risk management plans for patients were developed in line with national guidance.	Partial 4
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	N 5

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
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Partial 6
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Partial 6
When there were changes to services or staff the practice assessed and monitored the impact on safety.	N 7
<ol style="list-style-type: none"> 1. The provider could not demonstrate they had an effective approach to managing staff absences and busy periods. For example, there was only one GP, no practice nurse and the healthcare assistant worked one session per week. In addition, the temporary deputy practice manager worked only one-two sessions per week. 2. The provider could not demonstrate that temporary locum staff were provided with an induction into the practice. 3. We found that the outcomes of some risk assessments undertaken to ensure the safety of the premises for patients and staff had not been actioned. For example, the fire safety and IPC risk assessments. We saw the provider had not identified all concerns in relation to their risk assessments. Therefore, it was not possible to accurately assess whether they had acted on any issues identified. 4. We found the emergency medicines and equipment kit was not maintained in line with national guidance. For example, that two of the medicines on the recommended list were not available. The provider had not conducted a risk assessment as to why they did not stock these medicines. 5. The provider told us they did not utilise the sepsis toolkit on their clinical IT system. They did not have a paediatric pulse oximeter to enable assessment of babies and children with presumed sepsis or other clinical emergency. Staff told us they had ordered this piece of equipment and had been sent an adult pulse oximeter. They had not raised this with their supplier and obtained the appropriate replacement for this. 6. The provider could not assure us they assessed and monitored the impact on safety when there were changes to services and when staff were unexpectedly absent. For example, the long-term locum employed at the practice had left and they had not been replaced. The only clinical sessions at the practice were undertaken by the lead GP, between 8.00am-10.00am and 4.00pm-6.00pm, Monday to Friday. 	

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.	Partial 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
There was a documented approach to the management of test results and this was managed in a timely manner.	N 4
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.	N 5

1. The provider could not assure us they had a consistent approach to sharing all relevant information with external agencies. For example, they could not demonstrate they shared significant events with the national reporting and learning system (NRLS) and the local GP Federation and Clinical Commissioning Group (CCG).
2. The provider could not demonstrate there was a safe effective system to monitor delays in referrals. The lead GP told us the practice did not follow-up patients who had been referred via the urgent two-week wait referral pathway. They could not demonstrate they had undertaken regular audits to assure themselves that all patients who had been referred via this pathway had been followed up. We reviewed five patient records and all patients we reviewed had been followed up.
3. We saw evidence that blood test results were reviewed promptly. However, this process is not supported by a documented policy. We reviewed evidence there was no failsafe system in place to manage and monitor cervical smear screening. They could not demonstrate they had undertaken regular audits to assure themselves that results had been obtained for all patients who had undertaken cervical screening and where necessary patients had been followed up. We reviewed five patient records and all patients we reviewed had been followed up.
4. The provider could not share examples of instances where patients use multiple services to support their ongoing care needs. We were unable to establish the extent to which the provider works collaboratively to improve patient outcomes.

Appropriate and safe use of medicines

The practice had limited systems in place for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.65	0.56	0.87	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	9.5%	9.4%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	5.00	5.49	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.15	0.82	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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial 1 2

Medicines management	Y/N/Partial
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 outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial 3
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial 3
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial 5
<ol style="list-style-type: none"> 1. We reviewed the system and process the provider had in place to monitor and manage medicines, including high-risk medicines. The provider could not demonstrate they operated a safe effective system regarding the management of medicines which required additional monitoring. For example, we found evidence that the provider had not undertaken appropriate blood and cardiovascular monitoring for patients who were prescribed antipsychotic medicines. We were not assured regarding patient safety. 2. We saw evidence that the provider did not prescribe these hypnotics medicines in line with national guidance. For example, we reviewed records for four patients. Patients had been prescribed hypnotic medicines for long periods of time without medicines reviews being undertaken. We were not assured regarding patient safety. 3. The provider had an emergency medicines kit in place. We found they did not have a paediatric pulse oximeter for use in the safe management of babies and children. One of the medicines was stored in the fridge-there was no evidence of alerting staff to this in the emergency kit. They did not keep a stock of two medicines in line with national guidance and had not completed a written risk assessment regarding this. The provider did not keep a log of when emergency medicines, the defibrillator and oxygen were checked. We found the oxygen cylinder to be full and adult and child masks were available. 4. We saw evidence of a potential cold chain breach which the practice had not acted on. The thermometer showed that a maximum temperature of 21.6C had been reached The maximum temperature recorded for the vaccine fridge was 21.6C. The actual temperature at the time of recording data was 5.1C. There was no evidence this temperature had been documented in the cold chain recording system. This had not been flagged as a potential breach of the cold chain. Staff told us they would download and print a copy of the datalogger on the day of our inspection visit and submit this evidence to us. We requested this information following the inspection and this has not been submitted to us. The information from the data logger would have verified what actual temperatures had been reached in the vaccine fridge. There was no signage in place to alert staff not to remove the vaccine fridge plug. We have not received an assurance that the practice had sought advice from the appropriate authorities. 	

Medicines management	Y/N/Partial

Track record on safety and lessons learned and improvements made

The practice had limited systems in place 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.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial 1
There was evidence of learning and dissemination of information.	Partial 2
Number of events recorded in last 12 months:	1
Number of events that required action:	1
<p>1. The provider had a system in place regarding significant events. However, we reviewed evidence of only one event that had been reported to the practice manager. Staff told us they strived to encourage staff to report any significant events, and we reviewed evidence in minutes of practice meetings where this had been discussed. We will review the effectiveness of the practice system at the next comprehensive inspection.</p> <p>2. We were not assured the provider had an effective system in place regarding significant events. They had recorded one event within the past 12 months. Following the inspection, the provider submitted evidence of a second significant event.</p>	

Example of a significant event recorded and actions by the practice.

Event
We have not recorded information regarding this significant event as it may potentially identify the patient concerned.

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 1
<p>1. The provider had a system in place regarding the safe effective management of patient safety alerts. We saw that patient safety alerts had been disseminated to staff, searches had been completed and any patients identified had been followed up. However, when we spoke with the lead GP, they could not articulate the correct process for providers regarding the management the corona virus alert.</p>	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

At our inspection on 11 February 2020 we found concerns regarding:

- Care and treatment was not consistently delivered in line with national guidance.
- The provider could not demonstrate they had a comprehensive programme of quality improvement in place and used information about care and treatment to drive improvements in patient care.
- Childhood immunisations achievement rates were low.
- Cervical screening achievement rates were low.
- The provider could not demonstrate the healthcare assistant had undertaken appropriate core specific training.
- The provider could not demonstrate they had undertaken appropriate clinical supervision with the healthcare assistant.
- The provider could not demonstrate they had undertaken annual appraisals with the healthcare assistant.
- The provider could not demonstrate how they supported national priorities and initiatives to improve the population's health.

The concerns we found during our inspection affected all population groups; so we rated all population groups in the effective domain as inadequate.

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial 1
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial 2
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial 3
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N 4
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.	Partial 5

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"> 1. When we spoke with the provider, they told us they were aware of national guidance regarding patient care and treatment. However, we reviewed three patient records and saw that national guidance was not consistently followed. For example, we reviewed evidence that several medicines were prescribed for an older patient who had several co-morbidities. These medicines required additional regular blood monitoring for the patient. We saw that blood tests had not been carried out since 2015. 2. We reviewed five patients' records. The provider could not demonstrate they had fully assessed patients' immediate and ongoing needs. This included their clinical needs and their mental and physical wellbeing. For example, we saw that blood and cardiovascular monitoring for anti-psychotic medicines had not been carried out appropriately. This is not in line with national guidance. We are not assured regarding patient safety. 3. We reviewed evidence that patients presenting with potentially serious illness were not assessed or followed up appropriately. For example, sepsis in babies and children. The provider did not have emergency equipment in line with national resuscitation guidance to adequately assess the risk of sepsis for this patient population group. In addition, the lead GP told us they did not use the sepsis toolkit on the clinical system. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	1.52	0.71	0.74	Tending towards variation (negative)

Older people

Population group rating: Inadequate

Findings

- The provider told us they undertook home visits and telephone consultations for older people when required.
- The provider told us they participated in regular multidisciplinary meetings with other healthcare professionals to discuss patients at-risk and nearing end-of-life. Following the inspection, the provider submitted evidence of minutes of meetings with the End of Life team.

People with long-term conditions

Population group rating: Inadequate

Findings

- A Diabetes Clinical Nurse Specialist from the GP Federation attended the practice on a regular basis to undertake reviews for patients with Type Two Diabetes.
- We reviewed evidence of a deterioration in achievement rates, as evidenced in the third table below, for one Type Two diabetes indicator and for patients with hypertension. We found a decline of 5.0% in the percentage of patients with diabetes, on the register, in whom the last the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. In addition, we saw the provider has not driven any improvement in the percentage of patients with

hypertension, as evidenced in the sixth table below, in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less.

- The provider could not demonstrate how they had assessed the needs of their patient population. There was no practice nurse provision at the practice. They could not demonstrate the healthcare assistant, who worked one session per week at the practice, had been appropriately trained and competency checked.

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)	72.7%	77.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.7% (4)	12.0%	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)	60.6%	74.9%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.7% (4)	11.3%	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)	80.3%	78.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.7% (4)	10.9%	12.7%	N/A

Long-term conditions additional evidence		
Indicator	Achievement rate for period 01/04/2017-31/03/2018	Achievement rate for period 01/04/2018-31/03/2019
The percentage of patients with diabetes, on the register, in whom the last the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	65.6%(NHS Digital)	60.6% (QOF)

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)	80.0%	72.9%	75.9%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.8%	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)	90.9%	86.5%	89.6%	No statistical variation
Exception rate (number of exceptions).	15.4% (2)	11.0%	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)	69.7%	80.5%	83.0%	Variation (negative)
Exception rate (number of exceptions).	3.1% (6)	7.4%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	75.0%	89.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	11.1% (1)	4.9%	5.9%	N/A

Long term conditions additional evidence		
Indicator	Achievement rate for period 01/04/2017-31/03/2018	Achievement rate for period 01/04/2018-31/03/2019
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less	71.0%(NHS Digital)	69.7% (QOF)

Long term conditions additional comments
<ul style="list-style-type: none"> The exception reporting rate 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 is 11.1%. This is more than twice the local average (4.9) and almost twice as high as the national average (5.9%) and the achievement rate was low.

Families, children and young people

Population group rating: Inadequate

Findings

- The practice has not met the minimum 90% for four of four childhood immunisation uptake indicators. Therefore, the recommended standard for achieving herd immunity for childhood immunisation uptake indicators has not been reached.
- There has been a deterioration in the achievement rates for each childhood immunisation uptake indicator, since the last dataset was produced. We have re-checked this data on three occasions.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
(to) (NHS England)				No Data!
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)	0	8	0.0%	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)	2	8	25.0%	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)	3	8	37.5%	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>

Child Immunisation additional evidence

Indicator	Achievement rate for period 01/04/2017 to 31/03/2018	Achievement rate for period 01/04/2018 to 31/03/2019	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)((i.e. three doses of DTaP/IPV/Hib)	33.3%	No data available.	2017-2018: below 80% uptake 2018-2019: below 80% uptake
The percentage of children aged 2 who have received their booster	33.3%	0.0%	2017-2018: below 80% uptake

immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)			2018-2019: below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC)	67.7%	25.0%	2017-2018: below 80% uptake 2018-2019: below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	77.8%	37.5%	2017-2018: below 80% uptake 2018-2019: below 80% uptake

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- Patients had access one one afternoon per week to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat prescriptions without the need to attend the surgery.
- The lead GP was the only clinician available to undertake cervical screening for female patients at the practice. However, appointments were limited to between Monday to Friday 8.00am-10.00am and 4.00pm-6.00pm. Patients were otherwise signposted to pre-bookable appointments 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). This included practice nurse appointments.
- The provider could not demonstrate they had identified and assessed the needs of all working age patients within their patient population.

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). (01/07/2019 to 30/09/2019) (Public Health England)	45.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	76.0%	60.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	40.9%	41.7%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months,	41.7%	50.6%	68.1%	N/A

who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) ^(PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) ^(PHE)	42.9%	52.7%	53.8%	No statistical variation

Cancer indicator (cervical screening) additional evidence

Indicator	Achievement rate for period 01/04/2016 to 31/03/2017	Achievement rate for period 01/07/2019 to 30/09/2019
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).	43.1%	45.9%

Cancer indicator (cervical screening) additional comments

- The provider had a low achievement rate regarding cervical screening, and this was a finding at our last inspection in 2018. The achievement rate for cervical screening has increased by 2.8% between 2017-2018 and 2018-2019.

Population group rating: Inadequate

People whose circumstances make them vulnerable

Findings

- The practice had a register of patients with a learning disability.
- The lead GP was the only clinician available to see patients at the practice. However, appointments were limited to between Monday to Friday 8.00am-10.00am and 4.00pm-06.00pm
- The provider could not demonstrate they had identified and assessed the needs of all patients who may be regarded as vulnerable within their patient population.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The provider told us they do not have a system or policy in place to monitor and follow-up patients with poor mental health who fail to attend or collect their medicines.
- The lead GP told us they did not use care plans for patients who experienced poor mental health.
- We reviewed evidence that the provider had not fully assessed the immediate and ongoing needs for patients' who experienced poor mental health. This included their clinical needs, mental and physical wellbeing. For example, we saw that blood and cardiovascular monitoring for antipsychotic medicines, for patients with mental health concerns, had not been carried out

appropriately. This is not in line with national guidance. We are not assured regarding patient safety.

- The provider could not demonstrate they had identified and assessed the needs of all patients who experienced poor mental health within their patient population.
- All staff had undertaken dementia awareness training.

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)	25.0%	87.9%	89.4%	Variation (negative)
Exception rate (number of exceptions).	20.0% (1)	12.2%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	89.5%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	9.5%	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) (QOF)	100.0%	82.8%	83.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.0% (0)	7.6%	6.7%	N/A

Mental Health additional evidence		
Indicator	Achievement rate for period 01/04/2017 to 31/03/2018)	Achievement rate for period 01/04/2018 to 31/03/2019
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	0.0% (NHS Digital)	25.0% (QOF)

Mental Health additional comments
<ul style="list-style-type: none"> • The patient achievement data recorded related to a patient that had been exception reported for this indicator.

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)	457.5	524.7	539.2
Overall QOF score (as a percentage of maximum)	83.2%	94.0%	96.7%
Overall QOF exception reporting (all domains)	6.2%	7.4%	5.9%

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

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

1. The provider could not demonstrate examples of improvements as a result of clinical audits or other improvement activity in past two years.
2. The provider could not demonstrate they had a comprehensive programme of quality improvement in place and used information about care and treatment to drive improvements in patient care. Therefore, the provider could not demonstrate that quality improvement activity was targeted at the areas where concerns had been identified. For example, patients with hypertension, Type Two Diabetes, childhood immunisations and cervical screening.
3. The lead GP told us they did not review unplanned admissions and readmissions and did not benchmark themselves with local practices. Following the inspection, the provider submitted evidence of three reports provided by the CCG regarding data for unplanned admissions and readmissions.

Effective staffing

The practice was unable 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.	N 1
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y 2
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	N 3
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N 4
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 5
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<ol style="list-style-type: none"> 1. The provider could not demonstrate the healthcare assistant's (HCA) specific core training; that they had been competency checked or that they had clinical oversight of their work. For example, long term condition management. 2. We reviewed evidence that all staff had undertaken regular training. For example, basic life support, information governance and fire safety. 3. We reviewed six recruitment records and saw evidence of gaps in staff files. For example, the provider could not demonstrate they had an induction programme in place for new members of staff. 4. Staff told us the healthcare assistant (HCA) had undertaken an NVQ level 3 care qualification. However, they had not assured themselves that the HCA had undertaken the Care Certificate qualification if this was appropriate. 5. The provider could not demonstrate that the HCA had appropriate regular clinical supervision in place and had undertaken regular appraisals. 	

Coordinating care and treatment

The provider could not demonstrate that staff worked with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y 1
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.	N 2
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	N 2

Patients received consistent, coordinated, person-centred care when they moved between services.	N 2
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<ol style="list-style-type: none"> 1. The provider told us that regular meetings were held to discuss patients on the palliative care register. Following the inspection, the provider submitted evidence of minutes from multi-disciplinary meetings. 2. The provider could not demonstrate a coordinated approach to the management of patients including regular and minuted multi-disciplinary meetings or that accurate information was available and shared with relevant professionals. 	

Helping patients to live healthier lives

Staff were not 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.	Partial 1
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.	N 3
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Partial 4
<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, smoking cessation. 2. Patients had access to appropriate health assessments and checks. However, the healthcare assistant had not undertaken appropriate training and been competency checked to carry out these patient reviews. 3. The provider could not demonstrate they discussed changes to care or treatment with patients and their carers as necessary. 4. The healthcare assistant had been trained to offer smoking cessation advice. However, the provider could not otherwise demonstrate how they supported national priorities and initiatives to improve the population's health. For example, tackling obesity. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions:	96.6%	94.5%	95.0%	No statistical variation

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>				
Exception rate (number of exceptions).	3.3% (9)	1.4%	0.8%	N/A

Any additional evidence or comments

- The exception reporting rate for this indicator was more than twice the local average and four times the national rate. The provider could not explain this.

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial ¹
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 ²
Policies for any online services offered were in line with national guidance.	N/A
1. We reviewed evidence in patients records that consent was obtained by the healthcare assistant, when undertaking care and treatment with patients. 2. The provider could not demonstrate they had a system in place to monitor 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
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CQC comments cards	
Total comments cards received.	83
Number of CQC comments received which were positive about the service.	83
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 the lead GP.
Comments cards	Several patients commented on the professionalism and kindness of practice staff.

National GP Survey results

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)	86.4%	86.2%	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)	86.4%	83.1%	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)	96.6%	93.5%	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)	83.9%	80.3%	82.9%	No statistical variation

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

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)	96.7%	91.4%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y ₁
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y 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.	11 carers: 0.96%
How the practice supported carers (including young carers).	Carers: 1. Carers are proactively identified by the practice. 2. Offered double appointments when required. 3. Signposted to the carer's network. 4. Leaflets for carers and young carers are available at the practice.
How the practice supported recently bereaved patients.	The provider could not demonstrate what support they offered to patients who have been recently bereaved.

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 concerns we found during our inspection affected all population groups; so we rated all population groups in the responsive domain as requires improvement.

Services did not 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.	N 2
The facilities and premises were appropriate for the services being delivered.	N 3
The practice made reasonable adjustments when patients found it hard to access services.	N 4
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<ol style="list-style-type: none"> 1. The provider could not demonstrate they had assessed the needs of the patient population groups or had otherwise considered what services were required to support and address the needs of the patients in the practice. 2. There was limited opportunity for patients to access a GP at the practice as they worked 8am-10am and 4pm-6pm, Monday to Friday. No other GP clinical cover was available. There is no practice nursing service available at this practice. A healthcare assistant provides one session per week undertaking various roles. The provider could not demonstrate this member of staff had been appropriately trained and competency checked. 3. The practice premises has a complex building structure, there are several floors, including a basement. There is a stair lift attached to the staircase leading to the basement, which itself is a hazard for people with limited mobility. The health care assistant and a Diabetes Nurse Specialist run clinics and see patients for long term conditions reviews in the basement consultation rooms. 4. When necessary, the provider conducted home visits for patients. Patients were otherwise signposted to pre-bookable appointments 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). This included practice nurse appointments. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00am-6.30pm
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-10.00am and 4.00pm-6.00pm
Tuesday	08:00am-10.00am and 4.00pm-6.00pm
Wednesday	08:00am-10.00am and 4.00pm-6.00pm
Thursday	08:00am-10.00am and 4.00pm-6.00pm
Friday	08:00am-10.00am and 4.00pm-6.00pm

National GP Survey results

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)	100.0%	92.1%	94.5%	Tending towards variation (positive)

Older people

Population group rating: Requires improvement

Findings
<ol style="list-style-type: none"> 1. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday. 2. The practice offered home visits for those with enhanced needs and complex medical issues. 3. 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). There is no practice nursing provision provided at this practice currently. 4. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to respond to and address those needs.

People with long-term conditions

Population group rating: Requires improvement

Findings
<ol style="list-style-type: none"> 1. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday. 2. 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). There is no practice nursing provision provided at this practice currently. 3. The provider employs a healthcare assistant for one session per week. They undertake various tasks. For example, long term condition reviews for patients with diabetes, asthma and chronic obstructive pulmonary disease (COPD). They could not demonstrate they had undertaken appropriate training and had been competency checked to allow them to safely undertake these roles. 4. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to respond to and address those needs.

Families, children and young people

Population group rating: Requires improvement

Findings

1. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday.
2. Same day appointments are prioritised for this patient population group. There is no practice nursing provision provided at this practice currently.
3. 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).
4. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to support and address those needs.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

1. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday.
2. 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.
3. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to support and address those needs.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

1. The provider was aware of support groups within the area and signposted their patients on to these accordingly.
2. Practice staff told us they offered patients with a learning disability and carers appointment times that were convenient.
3. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday.
4. 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).
5. Staff told us the practice accessed interpreter services for patients when required.

6. There was limited identification of patients in vulnerable circumstances. For example, the provider did not hold a specific register for patients for whom there are safeguarding concerns. On the day of inspection, the provider created a register regarding this. However, they could not demonstrate when they had reviewed any patients on the register.
7. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to support and address those needs.
8. The provider could not demonstrate they utilised social prescribing to support patients who were isolated or otherwise vulnerable.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

1. The provider could not otherwise demonstrate they had assessed the needs of this patient population group and had an action plan in place to support and address those needs.
2. There was limited identification of patients who experienced poor mental health. For example, the provider did not hold a specific register for patients for whom there are safeguarding concerns. On the day of inspection, the provider created a register regarding this. However, they could not demonstrate when they had reviewed any patients on the register.
3. Appointments with a GP were offered to patients between 8am-10am and 4pm-6pm, Monday to Friday.
4. 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).

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. 	

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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)	98.0%	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)	85.1%	68.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	74.2%	65.4%	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)	85.2%	69.8%	73.6%	No statistical variation

Listening and learning from concerns and complaints

There was a limited system in place to review learning and improvement in the quality of care from complaints.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial 1
1. It was not possible to determine whether complaints were used to drive continuous improvement as staff told us they had received only one complaint during the previous 12 months.	

Well-led

Rating: Inadequate

Leadership capacity and capability

At our inspection on 11 February 2020 we found concerns regarding:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care
- The provider could not demonstrate they had a clear vision, set of values or a mission statement in place.
- 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.
- 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 and cervical screening.
- The practice could not demonstrate who had oversight of all systems and processes to ensure effective care and to drive quality improvement.
- We were not assured that comprehensive and effective systems and process were in place and regularly reviewed to manage risk and some performance data.
- The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective.
- The practice was aware that a significant proportion of their quality and outcomes framework (QOF) and Public Health England (PHE) achievement rates were poor. However, there were no systematic processes to improve and manage patient outcomes on an ongoing basis through a structured recall system.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

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.	N 4
1. 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. 2. Leaders could not demonstrate the capacity to prioritise safety and quality improvement. Several systems and processes had been found to be unsafe. For example, the management of antipsychotic and hypnotic medicines; two week wait urgent referrals and premises risk assessments.	

3. We found the practice was reactive rather than proactive and some actions had been undertaken immediately following the inspection. For example, a safeguarding register had been created whilst we were on site at the inspection. The provider could not demonstrate when patients had been reviewed.
4. The provider could not demonstrate they had a leadership development programme, including a succession plan, in place.

Vision and strategy

The practice could not demonstrate they had a clear vision or 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.	Partial 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 provider could not demonstrate they had a clear vision, set of values or a mission statement in place. Following the inspection, the provider submitted their statement of purpose (SOP), to demonstrate they had a clear vision and set of values. The SOP contained out of date information. Patient data was poor in some clinical areas and governance arrangement 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 any 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. 3. We were not assured that staff knew and understood the vision, values and strategy and their role in achieving them. It was not possible to determine if staff we spoke with were aware of the practice vision and values. They referred any questions we asked of them to the lead GP and temporary deputy practice manager. 4. The provider could not demonstrate they had a clear vision, set of values. Therefore, they could not assure us they monitored progress of any strategy to drive improvements. 	

Culture

The practice culture limited their ability to deliver effective 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.	N 1
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.	Partial 1
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N 2
Staff had undertaken equality and diversity training.	Y
1. The provider has a policy in place regarding the duty of candour. However, it was not possible to determine if staff we spoke with felt able to raise concerns without fear of retribution. They referred any questions we asked of them to the lead GP and temporary deputy practice manager. 2. The practice could not demonstrate that staff had access to a Freedom to Speak Up Guardian.	

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

Source	Feedback
Non-clinical staff	Staff we spoke to had worked at the practice for several years. They state they felt supported and can ask for help if needed.

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

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 and cervical screening.
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, premises risk assessments for legionella and asbestos.

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 1
There were processes to manage performance.	N 2
There was a systematic programme of clinical and internal audit.	N 2
There were effective arrangements for identifying, managing and mitigating risks.	Partial 3
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N 4
When considering service developments or changes, the impact on quality and sustainability was assessed.	N 5
<ol style="list-style-type: none"> 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, on the day of inspection we found the provider had not undertaken regular audits to assure themselves that all patients who had been referred via the two-week wait urgent referral pathway had been followed up. In addition, they had not undertaken regular audits to assure themselves that results had been obtained for female patients who had undertaken cervical screening. We found the provider did not have oversight of patients for whom there are safeguarding concerns. They did not hold a register of patients regarding this. Therefore, they could not demonstrate patients were regularly reviewed. 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 was a single-handed GP. They did not employ any salaried or locum GPs. There was no practice nurse provision at the practice. They could not demonstrate they had self-evaluated poor or variable performance data and implemented action plans to drive improvement. For example, the 	

lack of clinical audits in place to drive improvement in the achievement rate for cervical screening since our last inspection.

3. The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective. For example, a safeguarding register for patients for whom there are concerns; the two-week wait urgent referral and cervical screening safety netting systems.
4. The provider could not demonstrate that staff had been trained in preparation for major incidents.
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 long-term locum GP had 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.	N 1
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N 2
There were effective arrangements for identifying, managing and mitigating risks.	Partial 3
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<ol style="list-style-type: none"> 1. The practice was aware a significant proportion of their quality and outcomes framework (QOF) and Public Health England (PHE) achievement rates were poor. However, there were no systematic processes to improve and manage patient outcomes on an ongoing basis through a structured recall system. In particular, care plans for patients who suffered serious mental illness (SMI); cervical screening and childhood immunisations. 2. We could not be assured that information held by the provider was accurate, valid, reliable and timely as we had found gaps in their systems. For example, the provider could not demonstrate they had assured themselves that all patients who had been referred via the two-week wait urgent referral pathway had been followed up. They could not demonstrate they had undertaken regular audits to evidence this. 3. 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, fire safety risk assessment and the infection control risk assessment. 	

Engagement with patients, the public, staff and external partners

The practice did not 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.	N 1
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial 2 3
<ol style="list-style-type: none"> 1. The provider could not demonstrate that staff views had been reflected in planning and delivering services for patients. 2. The provider had identified a challenge to delivering good quality care, for example, recruiting practice nursing staff. However, they could not demonstrate they had worked collaboratively with key stakeholders to analyse the needs of the patient population group and developed an action plan to address any challenges they had identified. 3. The practice was part of the South Fulham Primary Care Network (PCN) with several other local practices. 	

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 1
Learning was shared effectively and used to make improvements.	Partial 2
<ol style="list-style-type: none"> 1. We were not assured that systems and process for learning and continuous improvement were developed and implemented. For example, the safeguarding register for patients for whom there are concerns and regular auditing of their two-week wait urgent referral and cervical screening safety netting systems. 2. The provider could not demonstrate that learning was shared effectively and used to make improvements. For example, the provider had recorded only one significant event in the previous 12 months and had not shared these with the national reporting and learning system (NRLS). Following the inspection, the provider submitted evidence of a second significant event. 	

Examples of continuous learning and improvement

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.