

# Care Quality Commission

## Inspection Evidence Table

### The Sunflower Medical Centre (1-537914202)

Inspection date: 23 January 2020

Date of data download: 05 February 2020

## Overall rating: Inadequate

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

**The practice is rated Inadequate overall due to issues with safe care and treatment and overall governance arrangements.**

## Safe

## Rating: Inadequate

The practice is rated as Inadequate for providing safe services because:

- There were no clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were not met.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not always have the information they needed to deliver safe care and treatment.
- There were inadequate systems to learn and make improvements when things went wrong.

### 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.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	Y

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	N
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N

**Explanation of any answers and additional evidence:**

- Safeguarding systems, processes and practices were not effectively developed, implemented and communicated to staff. Nursing staff told us learning from safeguarding incidents was not shared with them and there was no evidence of regular safeguarding discussions. For example, when we reviewed the monthly practice meeting minutes, we saw safeguarding discussions took place on one out of 10 occasions; however, not all staff were in attendance on the one occasion it was discussed and there was no evidence of a system to distribute this learning.
- We saw evidence of a safeguarding concern highlighted by the GP on inspection; however, there was no evidence provided to show it had been shared with staff.
- There was a safeguarding register in place and the practice told us this was regularly reviewed. However, not all clinicians were involved in any safeguarding discussions. There was no evidence provided to when this register was reviewed.
- The safeguarding policies in place were not effectively implemented. For example, the safeguarding adults' policy did not contain any lead names and both policies did not provide sufficient contact details for the local authority safeguarding team.
- Not all staff were aware of Female Genitalia Mutilation (FGM) and none of the adult or child safeguarding policies made reference to this or their responsibilities around reporting this.
- The practice was unable to demonstrate how they would inform the Out of Hours service of relevant safeguarding information.
- The practice told us there were no regular meetings with the health visitors or school nurses but they could contact them when required.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<b>Explanation of any answers and additional evidence:</b> <ul style="list-style-type: none"> <li>When we reviewed staff immunisation records, there was no evidence staff received all required immunisations as per PHE guidelines, or a system to ensure staff were up to date with their immunisations. This included measles despite an outbreak in the area and meeting minutes from May 2019 advising staff not immunised against this measles to contact their GP. Other immunisation gaps for staff included mumps, rubella, varicella, diphtheria, polio, tetanus and typhoid.</li> </ul>	

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: 8 January 2019	Y
There was a record of equipment calibration. Date of last calibration: 8 January 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: September 2019	Y
There was a log of fire drills. Date of last drill: not provided	Partial
There was a record of fire alarm checks. Date of last check: weekly	Y
There was a record of fire training for staff. Date of last training: adhoc	N
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 1 September 2019	Y
Actions from fire risk assessment were identified and completed.	Partial

**Explanation of any answers and additional evidence:**

- There was a Control of Substances Hazardous to Health (COSHH) policy which was last reviewed in September 2018, not yearly as per practice policy. There was no available risk assessment on request. The practice told us the risk assessment documents were maintained by NHS Property Co, the building owners not the practice; therefore, they were not aware of what actions had been identified.
- The practice told us a fire drill for the building was carried out on 3 January 2019 but no other detail of this fire drill was provided on inspection. We were also not provided with evidence of regular fire drill logs. Three of the staff we spoke to on the day of inspection were not aware of when they were involved in a fire drill.
- There were gaps in fire safety training for staff. For example, training records showed four clinicians had not received any fire safety training and there was only one trained fire marshal in the practice.
- A formal fire risk assessment was carried out by the building owners on 9 December 2018; however, the practice did not maintain a copy of this risk assessment. They told us no actions had been identified; however, we were not provided with a copy of this assessment on inspection.
- The practice had carried out their own inhouse fire risk assessment on 1 September 2019 and actions identified included to switch off electrical items and improve signage.

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

**Explanation of any answers and additional evidence:**

- The practice told us the building owners had carried out a premises/security risk assessment and a health and safety risk assessment; however, the practice was not aware of the action required as they did not maintain copies of these assessments and had to request them from the building owners. We were not provided with copies on request.
- A legionella risk assessment was last carried out in December 2017 and had a recommended review date of December 2019. This risk assessment had not been carried out at the time of inspection. After inspection, the practice sent evidence showing a legionella risk assessment was carried out on 23 January 2020.
- The practice told us the legionella risk assessment of December 2017 had identified medium risk and they were required to maintain water temperature logs. When we reviewed the water temperature logs, we found records between August 2019 and January 2020 only.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were not met.

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

#### Explanation of any answers and additional evidence:

- There were gaps in infection control training for staff; for example, training records showed four clinical staff had not completed their infection control training.
- Not all staff were aware of their responsibilities regarding infection control. For example, one clinician was not aware of their role as the infection control lead.
- The practice told us an infection control audit was carried out and kept by the building owners, NHS Property Co; however, they told us they did not maintain any copies of this audit and therefore could not identify what action was required. We were not provided with evidence of this audit.
- We saw evidence the practice had carried out their own internal infection control audits in May and September 2019; however, one of the audits identified there was no segregation area for infectious diseases but staff were unable to explain how this would be effectively managed and there was no evidence of an action plan in place.
- Prior to the inspection, the practice scheduled an external infection control audit to take place on 12 February 2020.
- There was no cleaning log for the spirometer, nebuliser or ear irrigator.
- There were no purple lidded sharps bins available despite having cytotoxic waste.

## 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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Partial
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<b>Explanation of any answers and additional evidence:</b>	
<ul style="list-style-type: none"> <li>The practice nurse told us there was no cover for nurse sickness absence; therefore, sessions were cancelled in the event of sickness. There was nurse cover provided for planned absence.</li> <li>We saw evidence of sepsis training for staff, including at one team meeting in May 2019, with the exception of one non-clinical staff who had not received this training.</li> <li>There were ineffective plans to manage risk relating to yellow fever vaccinations. The practice was not aware of the latest guidance and risk assessment required in relation to administering yellow fever vaccines.</li> <li>The practice had not ensured they were fully equipped to deal with medical emergency procedures. For example, a previous significant event had identified a panic button was not working when required during an emergency in the practice. At this inspection, we found not all panic buttons were working and no action had been taken to resolve this.</li> </ul>	

#### Information to deliver safe care and treatment

#### Staff did not always 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
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
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
<b>Explanation of any answers and additional evidence:</b>	
<ul style="list-style-type: none"> <li>We saw evidence staff knew how to handle clinical data; however, training records showed three clinical staff had not received up to date information governance training. Records showed one</li> </ul>	

clinician had last received this training in 2013.

- One of the clinicians responsible for carrying out cervical smears was not aware of their uptake and inadequate smear rate. They did not have a system in place to follow up results of every sample sent. The practice told us this role was undertaken by the practice manager and the clinician was not aware of this.

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.46	0.59	0.87	Significant 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)	7.5%	10.0%	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)	6.98	5.89	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)	0.27	1.06	2.08	Significant Variation (positive)

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.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical	n/a

Medicines management	Y/N/Partial
supervision or peer review.	
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N
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
<p><b>Explanation of any answers and additional evidence:</b></p> <ul style="list-style-type: none"> <li>• Blank prescription forms were not kept securely and their use was not appropriately monitored as per guidance. For example, boxes of blank prescriptions were stored in an area also accessible to a neighbouring practice. We observed the serial numbers recorded were incorrect and there were no lockable printer trays although doors could be locked when not in use.</li> <li>• Although there were Patient Group Directions (PGDs), we saw up to five of them had not been appropriately signed or dated by the relevant staff. For example, one PGD had a signature only but had no name or designation and was not dated.</li> <li>• There was no evidence of arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.</li> <li>• The practice did not hold all appropriate emergency medicines; for example, dexamethasone (croup in children), naloxone (for opioid overdose) and morphine (severe pain). There was no risk assessment carried out to determine the range of medicines held.</li> <li>• There was no second vaccines fridge thermometer independent of the mains power in line with national guidance. The practice calibrated the vaccines fridge temperature annually and the last calibration was carried out on</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>Vaccines were not appropriately monitored. There was occasional cold chain monitoring between August and November 2019. The practice told us this was due to a limited number of trained staff. Staff were trained by the practice nurse and we saw evidence of improved readings, although there continued to be small gaps in monitoring in December 2019 and January 2020. For example, cold chain monitoring took place on eight occasions in August 2019 and following training, there was one occasion in January 2020 when monitoring had not taken place.</li> </ul>	

### Track record on safety and lessons learned and improvements made

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

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

### Explanation of any answers and additional evidence:

- We were not assured staff understood how to identify incidents or near misses as the significant event policy was not effectively implemented. For example, staff told us they would follow the significant event policy in place; however, the policy had no indication of what would be classed as a significant event/incident or near miss.
- There was a system in place for recording significant events; however, we were not assured they were always acted on. For example, one of the three significant events in July 2019 records an incident involving an aggressive patient where they found the panic button was not working. The action taken was the main reception was informed of the panic button not working and this was recorded as has being resolved. However, on the day of inspection, when asked about emergency procedures, we found one of the emergency panic buttons was not working and there were no evidence this had been raised or any plans in place to have this resolved.
- There was inconsistent evidence relating to sharing learning from significant events. We reviewed seven meeting minutes and found some significant event discussions were vague and learning was not clear. There was no evidence staff unable to attend the meetings; for example, nurses were provided with learning from significant events. Two of the staff we spoke to were unable to recall learning from any significant events and we found they did not attend practice meetings due to their working hours. There was no system in place to ensure lessons from significant events were shared with them.

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

Event	Specific action taken
Pharmacy issued incorrect prescription	Patient contacted surgery and they contacted the pharmacy on behalf of the patient and matter was resolved.
Hospital letter received with incorrect patient information	Hospital notified and apology issued. Positive outcome due to early identification and aversion of error.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	N

**Explanation of any answers and additional evidence:**

- The practice told us safety alerts were received via email and an alerts log was maintained. When we reviewed the safety alerts log for 2019/20, the practice informed us they were not receiving some of the drug safety alerts for 2018/19 despite being signed up for drug safety alerts. This included the alert for Carbimazole, sodium valproate and the yellow fever vaccine alert from November 2019. These alerts had not been acted on.
- When we reviewed the safety alerts log, we found the practice had received the recent Ranitidine safety alerts but had not acted on them. For example, they had recorded, 'all clinicians were informed/nil actions taken by the practice'. However, when we reviewed the number of patients prescribed this medicine, we found 146 patients without any evidence of any action being taken to identify and review if treatment was still required as a result of the alert. After the inspection, the practice provided evidence to show 14 out of the 146 patients identified on inspection were eligible for a review. They had been contacted, reviewed and changed to alternative medicines where appropriate.
- The practice nurse we spoke to and the healthcare assistant were not aware of any safety alerts. The practice safety alerts protocol reviewed in September 2019 recorded that all nurses and healthcare assistants would be emailed a copy of the alert message and subsequent discussion of the alerts would be at the next available clinical policy meeting. However, there were no clinical meetings and whole practice meetings took place once a month. The practice nurse and healthcare assistant did not attend these meetings due to their working hours and upon review of the practice meeting minutes, there were no discussions relating to safety alerts.

## Effective

## Rating: Inadequate

The practice is rated inadequate for providing responsive services because:

- There were no systems in place to keep clinicians up to date with current evidence-based guidance.
- The practice was unable to show that staff had the skills, knowledge and experience to carry out their roles.
- The practice was unable to adequately demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.
- Some performance data was significantly below local and national averages.

This affected all population groups which were rated inadequate overall.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
<b>Explanation of any answers and additional evidence:</b>	
<ul style="list-style-type: none"><li>• There was no evidence of systems in place to keep clinicians up to date with current evidence-based practice. Clinical meetings were not taking place and nursing staff we spoke to did not attend meetings due to their working hours and could not recall the latest guidelines.</li></ul>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.36	0.40	0.74	Tending towards variation (positive)

## Older people

## Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> <li>• This population group was rated requires improvement as the concerns identified within effective affected all population groups.</li> <li>• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li> <li>• The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. This included implementation of the Integrated Care Pathway (ICP).</li> <li>• The practice liaised with the Short-term assessment, rehabilitation and reablement service (STARRS) rapid response team for prevention of hospital admission, treatment at home and short-term rehabilitations.</li> <li>• The practice carried out structured annual medication reviews for older patients, including polypharmacy.</li> <li>• Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- This population group was rated inadequate as the concerns identified within effective affected all population groups and there were additional concerns; specifically, in relation to the QOF indicators, for people with long term conditions.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were referred for ambulatory blood pressure monitoring at the neighbouring practice.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	65.1%	76.4%	79.3%	Variation (negative)
Exception rate (number of exceptions).	4.6% (14)	10.8%	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>	63.3%	78.6%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.6% (17)	7.6%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.0%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	6.6% (20)	7.9%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	64.0%	78.0%	75.9%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.8% (1)	2.5%	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)	71.0%	92.6%	89.6%	Variation (negative)
Exception rate (number of exceptions).	3.1% (1)	6.9%	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)	74.8%	82.2%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.9% (13)	3.9%	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)	62.5%	86.5%	91.1%	Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	9.1%	5.9%	N/A

Any additional evidence or comments
The practice acknowledged their QOF performance and explained this had been due to a lack of adequate staff training on computer skills and read coding. The practice had taken steps to improve and told us staff had received training and new administration staff skilled in this area had been employed. The clinical pharmacist and practice manager were new in post and part of their role was to monitor appropriate coding. Although the practice provided unvalidated data that suggested improvement, the data was not verified or comparable.

**Findings**

- This population group was rated inadequate as the concerns identified within effective affected all population groups and there were additional concerns in relation to the population group of families, children and young people.
- The practice has not met the minimum 90% target for all four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people were referred to the local sexual health clinic sexual health and contraception.

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)	34	41	82.9%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	28	37	75.7%	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)	28	37	75.7%	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)	28	37	75.7%	Below 80% uptake

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

## Any additional evidence or comments

- The practice told us performance for childhood immunisations had improved for the last quarter; however, data provided was not validated immunisation data. The practice stated for preschool boosters, there was a significant struggle to ensure patients attended their immunisation appointments.
- The practice stated they have a monitoring system in place to ensure children were vaccinated on schedule. They sent out text messages and used the surgery envisage system to broadcast information about childhood immunisations.

## Working age people (including those recently retired and students)

## Population group rating: Inadequate

### Findings

- This population group was rated inadequate as the concerns identified within effective affected all population groups and there were additional concerns: specifically, in relation cancer screening, for people of working age.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online, view test results and order repeat medication without the need to attend the surgery.
- NHS health checks were offered to patients aged 40-70 with no long-term health conditions.

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)	66.0%	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)	53.4%	60.4%	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)	42.6%	43.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	75.0%	75.0%	68.1%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) <small>(PHE)</small>	60.0%	53.8%	53.8%	No statistical variation
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### Any additional evidence or comments

The practice felt the lack of a nurse previously had an impact on the 17/18 cervical screening figures. They stated that more admin staff were undertaking recalls.

### People whose circumstances make them vulnerable

### Population group rating: Requires Improvement

#### Findings

- The practice was rated requires improvement for providing effective services and this affected all population groups.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

### Population group rating: Inadequate

#### Findings

- This population group was rated inadequate as the concerns identified within effective affected all population groups and there were additional concerns, specifically in relation to QOF performance, for people experiencing poor mental health (including people with dementia).
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	70.5%	90.3%	89.4%	Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	6.6%	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>	56.8%	91.1%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	5.8%	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>	50.0%	84.6%	83.6%	Variation (negative)
Exception rate (number of exceptions).	6.7% (1)	3.5%	6.7%	N/A
Any additional evidence or comments				
<ul style="list-style-type: none"> <li>The practice acknowledged their QOF performance and explained this had been due to a lack of adequate staff training on computer skills and read coding. The practice took steps to improve and told us staff had received training and new administration staff skilled in this area of work had been employed. The clinical pharmacist and practice manager were new in post and part of their role was to monitor appropriate coding.</li> </ul>				

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	438.9	536.2	539.2
Overall QOF score (as a percentage of maximum)	79.8%	96.0%	96.7%
Overall QOF exception reporting (all domains)	2.6%	5.7%	5.9%
Y/N/Partial			
Clinicians took part in national and local quality improvement initiatives.	Y		
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y		
Quality improvement activity was targeted at the areas where there were concerns.	Y		
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y		

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

- There was evidence of clinical audits and quality improvement activity in the past two years. We saw evidence of several audits such as prescribing audits and heart failure management audits.
- The practice carried out an asthma audit where patients who were issued more than six short acting inhalers in the previous 12 months were reviewed by the GPs and medication reviews were carried out. Patients with asthma who had an exacerbation of asthma in the previous 12 months were audited to see if they had been reviewed and step up medicines as per national guidance were implemented as necessary.

**Any additional evidence or comments**

The practice had undertaken QOF improvement activity by recruiting skilled staff to undertake coding duties where this had previously been an issue and had an impact on performance.

**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
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	n/a
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N

**Explanation of any answers and additional evidence:**

- We were not assured relevant staff had the skills to deliver effective care. For example, nurses responsible for sample taking for the cervical screening programme were not aware of their uptake rate and were not carrying out their own inadequate smear audits despite undergoing training.
- There was no clear policy on how the learning and development needs of staff were assessed and there were gaps in the training programme. For example, the training matrix provided showed gaps in staff training such as equality and diversity, consent, infection control and fire safety.

- Not all staff had protected time for learning and development; for example, part-time staff told us any online training was carried out in their own time.
- We saw evidence the nurses had undertaken yellow fever and childhood immunisation training; however, there was no evidence of training records to show they had received specific training relating to long-term condition reviews.
- There was no clear policy provided to show an appropriate approach for supporting and managing staff when performance was poor or variable.

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

## Helping patients to live healthier lives

### Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.1%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (3)	0.5%	0.8%	N/A

### Consent to care and treatment

**The practice was unable to adequately 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
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
The practice monitored the process for seeking consent appropriately.	N
Policies for any online services offered were in line with national guidance.	Y

#### Explanation of any answers and additional evidence:

- Not all clinicians understood the requirements of legislation and guidance when considering consent and decision making. When we spoke to one clinician, they were unable to demonstrate understanding of decision making and when we reviewed their training records, we saw they had last received consent training in May 2015. There was no evidence of how the practice monitored the process of seeking consent appropriately.
- There was also no record of up to date consent training for two of the GPs and non-clinical staff.

## Caring

## Rating: Requires Improvement

The patient is rates requires improvement for providing caring services because:

- Feedback from patients was mostly negative about the way staff treated people and there was no evidence provided to show how the practice had acted to improve patient satisfaction with the service.

### Kindness, respect and compassion

**Feedback from patients was mostly negative about the way staff treated people.**

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

### CQC comments cards

Total comments cards received.	9
Number of CQC comments received which were positive about the service.	8
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Positive comments stated the practice was good. Mixed comments related to staff attitude and a delay in responding to a written complaint.
NHS Choices	Rating of 1.9 stars of 12 reviews, with eight reviews in the last year. Feedback related to staff attitude and appointment delays,

## 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)	78.3%	84.8%	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)	80.2%	82.7%	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)	89.7%	93.0%	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)	64.4%	78.0%	82.9%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice carried out their own inhouse survey to improve the services they offered to patients and to identify areas of improvement within the practice. It was unclear when the practice inhouse survey was carried out; however, it related to patient satisfaction with care received from different staff such as the GPs, nursing and reception staff. 150 questionnaires were distributed to patients and 50 responses were received. The overall results showed patients were generally satisfied with the care they received; for example, the survey results showed 53% of patients rated the GP and the service provided as good and 59% of patients rated the nurse as good and 30% rated the nurse as excellent. Improvements made by the practice in response to the survey related to appointment provision only. There was no information provided to show how the practice would improve on patient satisfaction with care and there was no action taken in response to the national survey.
- Issues relating to staff attitude were raised at practice meetings following patient complaints. However, there was no evidence of effective action taken to improve patient experience.

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

### Any additional evidence

- The practice also carried out the Friends and Family test survey. Results for November 2019 showed 81% of patients would recommend the service to friends and family and the results for December 2019 showed an improvement of 89% of patients.

### Involvement in decisions about care and treatment

**Staff helped patients to be involved in decisions about care and treatment / patients were not involved in decisions about care and treatment.**

		Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.		Y
Staff helped patients and their carers find further information and access community and advocacy services.		Y
Source	Feedback	
Interviews with patients.	We did not speak to any patients on the day of inspection.	

### 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)	82.7%	89.2%	93.4%	Tending towards variation (negative)

### Any additional evidence or comments

There was no evidence provided of what action the practice had taken to improve patient satisfaction with being involved in decisions about their care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	N
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y

### Explanation of any answers and additional evidence:

- There were no information leaflets such as bereavement services, mental health services or clinics displayed in the waiting area.
- There were no information leaflets in other languages displayed; however, the practice stated that they were available on request.

Carers	Narrative
Percentage and number of carers identified.	47 patients
How the practice supported carers (including young carers).	Carers were offered health checks and flu and pneumonia immunisations. Carers were signposted to Brent carers centre. There was a carers information board displayed in the reception area.
How the practice supported recently bereaved patients.	The practice sent sympathy cards and arranged visits where required.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Requires Improvement

The practice is rated requires improvement for providing responsive services because:

- Patient satisfaction scores with access to the service were lower than average.
- Complaints were not always used to improve the quality of care.

Responding to and meeting people's needs

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

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

### Practice Opening Times

Day	Time
<b>Opening times:</b>	
Monday	8:30am – 6:30pm
Tuesday	8:30am – 6:30pm
Wednesday	8:30am – 6:30pm
Thursday	8:30am – 6:30pm
Friday	8:30am – 6:30pm
<b>Appointment times:</b>	
<b>GPs:</b>	
Monday	9:00am – 6:30pm
Tuesday	9:00am – 6:30pm
Wednesday	9:00am – 6:30pm
Thursday	9:00am – 6:30pm
Friday	9:00am – 6:30pm
<b>Practice Nurses:</b>	
Monday	2:00pm – 6:30pm
Tuesday	2:00pm – 7:00pm
Thursday	2:00pm – 6:30pm

<b>HCA:</b>	
Monday	8:30am – 11:30am
Thursday	8:30am – 11:30am
<b>Extended hours:</b>	
Tuesday	6:30pm – 7:30pm
Thursday	7:30am – 8:00am
Friday	7:30am – 8:00am

### 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)	89.8%	91.5%	94.5%	No statistical variation

### Older people

### Population group rating: Requires Improvement

#### Findings

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services. They liaised with the STARRS team for prevention of hospital admission, treatment at home and short-term rehabilitations.
- The practice ensured housebound patients received an emergency information pack which provided information about their medical history and emergency contacts.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community specialist nurses to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- Additional nurse appointments were available until 7pm on a Tuesday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

### Findings

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, they provided online access allowing patients to book appointments, order their prescriptions and view test results.
- The practice also offered e-consults to improve patient access to the GP.
- The practice offered a Measles, Mumps, Rubella (MMR) catch up immunisation campaign to all eligible patients.

**People whose circumstances make them vulnerable**

**Population group rating: Requires Improvement**

**Findings**

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice ensured vulnerable patients received annual health reviews and medication reviews.
- The practice worked with other healthcare professionals to manage these patients care; for example, community learning disability team and social services.

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

**Population group rating: Requires Improvement**

**Findings**

- The practice was rated requires improvement for providing responsive services and this affected all population groups.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. For example, patients were referred to Brent talking therapies and counselling.

## Timely access to the service

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

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	55.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	48.8%	63.9%	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)	48.0%	63.5%	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)	58.6%	66.8%	73.6%	No statistical variation

#### Any additional evidence or comments

The practice was aware of issues surrounding patient access to the service and had made the following changes:

- Extended hours clinics with the GPs were available on Tuesday and Thursday and the practice was now open on Wednesdays.
- E-Consults were available for administrative concerns which freed appointments with preferred GP.
- Patients were sent SMS text message reminders to reduce the number of appointments wasted through DNAs (Did not Attend).
- The GPs are also offering booked telephone consultations with the preferred GP.
- The practice introduced a second phone line to improve access for patients.

Source	Feedback
For example, NHS Choices	Five patient reviews on NHS Choices highlighted issues with access to the service.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to; however, they were not always used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial

#### Explanation of any answers and additional evidence:

- Not all staff we spoke to were aware of what learning took place from complaints received.
- When we reviewed practice meeting minutes, we found sharing from complaints was not always clear. For example, three of the meeting minutes only had patient names without any information provided of what the complaint was and action taken.
- There was no evidence of what action was taken on one complaint relating to staff attitude.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complaint relating to extended hours	Action taken to advise patients of the extended hours protocol.

## Well-led

## Rating: Inadequate

The practice is rated as inadequate for providing well-led services because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- While the practice had a clear vision, that vision was not supported by a credible strategy.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation.

### 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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N

#### **Explanation of any answers and additional evidence:**

- We found that leaders were aware of the external and some internal challenges and priorities relating to the quality and future of services' such as increasing practice population and increased demand in primary care. They had taken action where necessary to address these challenges. However, they had not recognised and acted on some current issues with the quality of care they provided; particularly, relating to safety and the management of staff performance.
- The practice had identified some actions necessary to address these challenges; for example, they were part of a resilience training provided by CCG to enhance the practice performance and network with other practices in the area.
- However, there was no recorded evidence of partnership meetings taking place.

## 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.	Y
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
<b>Explanation of any answers and additional evidence:</b> <ul style="list-style-type: none"> <li>The practice had an ethos is to improve the health &amp; wellbeing and lives of the patients they care for in an environment of openness in partnership with the wider multi-disciplinary team. Whilst we saw evidence of a realistic strategy to improve on patient care such as, recruiting skilled staff to improve QOF performance, there were other areas where they had not established effective and sustainable systems.</li> <li>The practice was now part of a Primary Care Network (PCN) and had access to a clinical pharmacist. However, there was ineffective collaboration with some members of the clinical staff, as they were not involved in practice meetings and there was limited evidence to show lessons were shared with them.</li> <li>Not all clinicians understood the vision, value and strategy in achieving them. There were no clinical meetings that took place or evidence of nursing staff collaborating together.</li> </ul>	

## Culture

**The practice culture did not effectively support high quality sustainable care.**

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

**Explanation of any answers and additional evidence:**

- There was no evidence of arrangements to deal with any behaviour inconsistent with the vision and values.
- The practice's speaking up policies were not in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.
- Not all staff had received equality and diversity training. When we reviewed training records, we found three clinicians had not received this training.

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

Source	Feedback
Clinical staff	Staff felt the leaders were supportive and helpful.
Non-clinical staff	Staff felt there was a good relationship between staff and felt roles and responsibilities were clear.

**Governance arrangements**

**The overall governance arrangements were ineffective.**

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

**Explanation of any answers and additional evidence:**

- Structures, processes and systems to support good governance were not well embedded in the practice. Although there were policies in place, some were not reviewed yearly as per the practice policy and some policies such as the safeguarding policy omitted safeguarding leads and contact details.
- Further ineffective governance arrangements were found in relation to safeguarding processes, patient safety alerts, sharing guidelines, mandatory staff training and lack of adequate monitoring of CPD training for the nurses, medicines management, significant events and learning from complaints.
- Staff were not always clear on their roles and responsibilities. For example, one clinician was not aware of their role as the infection control lead and they were not aware of their responsibilities relating to cervical smears.
- We also found the practice was not aware of their responsibilities in ensuring they received and acted on and mitigated all risk related to the safety related risk assessments carried out by the building owners. On inspection, the practice did not maintain any records and therefore could not demonstrate understanding of what actions were required to reduce the safety risk in the practice.

## 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
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<b>Explanation of any answers and additional evidence:</b>	
<ul style="list-style-type: none"> <li>• There were no comprehensive assurance systems in place to identify, manage and mitigate risk. This was in relation to staff immunisations, health and safety risk assessments, fire safety, infection control, yellow fever vaccines, dealing with emergencies and medicines management.</li> <li>• There were some processes to manage performance such as appraisals; however, this was sufficient. There were no systems to monitor performance for the nursing staff.</li> <li>• There were ineffective arrangements to mitigate risk. The practice had no systems to ensure they had access to the recommendations from all risk assessments carried out at the practice.</li> </ul>	

## 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.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<b>Explanation of any answers and additional evidence:</b>	
<ul style="list-style-type: none"> <li>• Our inspection indicated that information was not always reliable and timely. This was in relation to the lack of recorded partnership meeting minutes.</li> </ul>	

## Engagement with patients, the public, staff and external partners

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

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

Feedback from Patient Participation Group.

Feedback
The practice had an active Patient Participation Group.

## 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
<b>Explanation of any answers and additional evidence:</b>	
There was limited evidence of continuous improvement and innovation and learning was not shared effectively and used to make improvements.	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.