

# Care Quality Commission

## Inspection Evidence Table

### HMC Health Bedfont (1-6339994778)

Inspection date: 21, 22 and 23 September 2021

Date of data download: 15 September 2021

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

### Safe

### Rating: Requires improvement

At the previous inspection in January 2020, we rated the practice as requires improvement for providing safe services, because:

- Risk to patients were assessed and well managed in some areas, with the exception of those relating to the fire safety procedures, recruitment checks, emergency medicines and staff vaccinations.

At this inspection in September 2021, we found improvements had been made, however, we found additional concerns and the practice was required to make further improvements. We rated the practice as **requires improvement** for providing safe services because:

- The practice had a system in place to manage safety alerts but it did not work effectively as we found some safety alerts were not actioned as required to ensure the safe care and treatment of patients.
- We found the prescription box for uncollected prescriptions was not monitored effectively and a number of repeat prescriptions from July 2021 were still waiting to be collected.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in January 2020, we found that the safeguarding children policy was reviewed, but not updated correctly. At this inspection in September 2021, we found that the safeguarding children policy was reviewed and updated in line with intercollegiate guidance for all staff working in healthcare settings. Adult and child safeguarding policies included the name of the lead member of staff responsible for safeguarding processes and procedures.</li> <li>At the previous inspection in January 2020, we found that the Disclosure and Barring Service (DBS) checks were not always undertaken appropriately where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). At this inspection in September 2021, we found that the Disclosure and Barring Service (DBS) checks were undertaken where required.</li> <li>All staff had received up-to-date safeguarding and safety training appropriate to their role.</li> <li>Staff who acted as chaperones were trained for their role and had received a DBS check.</li> <li>The practice had shared with us an excellent example of how they had managed an incident related to female genital mutilation (FGM).</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in January 2020, we found that the risks related to some recruitment checks and staff vaccinations were not managed appropriately. At this inspection in September 2021, we found that the recruitment checks were carried out in accordance with regulations and staff vaccination was maintained in line with current Public Health England (PHE) guidance.</li> <li>The two staff files we reviewed demonstrated that appropriate recruitment checks had been undertaken prior to employment in accordance with regulations.</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: 08 January 2021	Y
There was a record of equipment calibration. Date of last calibration: 08 January 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 20 August 2021	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the previous inspection in January 2020, the practice was unable to provide evidence of documented fire risk assessment for the premises. At this inspection in September 2021, we saw that a fire risk assessment had been completed on 20 August 2021.</li> <li>The practice had carried out fire drills twice a year and maintained the list of staff who took part in fire drills as required by their fire risk assessment.</li> <li>The fire system was serviced in May 2021.</li> <li>Emergency lighting was inspected on 28 August 2021.</li> <li>All staff had received fire safety training.</li> </ul>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 17 August 2021.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17 August 2021.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Health and safety policy was in place.</li> <li>Quarterly health and safety checks were carried out by a dedicated member of staff and records were maintained.</li> <li>A gas safety check was carried out in March 2021.</li> <li>The fixed electrical installation checks of the premises had been carried out on 10 March 2018.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 26 May 2021.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
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: <ul style="list-style-type: none"><li>• At the previous inspection in January 2020, we noted the infection control policy was not signed off by a clinician. At this inspection in September 2021, we found that the infection control policy was signed off by a clinician.</li><li>• Clinical equipment was cleaned on a regular basis and records were maintained.</li><li>• We saw a cleaning schedule was in place and records were maintained.</li><li>• The practice had up to date legionella risk assessment (27 December 2020) in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).</li><li>• We noted an experienced health care assistant was the infection control lead at the organisation level and a health care assistant nurse was the infection control lead at the practice level. We saw both leads had received relevant infection control training. In addition, the health care assistant had completed a level six infection control and prevention training.</li><li>• The practice had developed an 'infection prevention and control Covid-19 restart checklist' to mitigate the risk of infection before resuming clinical activities.</li></ul>	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice operated a system to organise annual leave and cover for unexpected absences.</li><li>• All requests for home visits were triaged by the duty GP.</li><li>• There were public awareness posters in the waiting area and on the screen.</li><li>• All staff had received sepsis awareness training.</li></ul>	

## Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• All test results and referrals were managed and checked on a regular basis to ensure all were appropriate and actioned. Any abnormal or concerning test results were actioned by one of the clinicians in a timely manner.</li><li>• The practice had maintained a failsafe system to manage and monitor urgent two-week wait referrals.</li><li>• The practice had a failsafe system in place to manage and monitor cervical smear screening.</li></ul>	

## Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimization.**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.69	0.49	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	6.5%	10.8%	10.0%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.29	5.60	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	81.5‰	58.1‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.44	0.50	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	5.9‰	4.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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

Medicines management	Y/N/Partial
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.	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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in January 2020, we noted most of the emergency medicines were available, with the exception of medicines used to treat seizures and croup (severe cough in the children caused by the viral infection) and some administrative staff we spoke with did not know correct storage location of emergency medicines. At this inspection in September 2021, the practice held appropriate emergency medicines and all the administrative staff we spoke with knew of their correct storage location.</li> <li>During the inspection, our clinical records searches showed that the practice had an effective process for monitoring patients' health in relation to the use of medicines including high risk medicines.</li> <li>The practice had a system to support vulnerable patients with requesting and collecting prescriptions. This involved checking the prescription box weekly. However, we found that this system was not working effectively and a number of repeat prescriptions from July 2021 were still waiting to be collected. We checked online records on the clinical system and noted some of those prescriptions were already issued electronically or prescriptions were issued twice. On the day of the inspection, the practice acted proactively, revised the protocol and appointed dedicated staff members to check the prescription box for uncollected prescriptions. The practice informed us they were going to implement monthly audits to ensure effective monitoring. After the inspection, the practice informed us that they were in the process of contacting the patients' to check if they still required the medication or if a new prescription was issued.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• The practice had an effective system to identify and monitor who was collecting the repeat prescriptions for controlled drugs from the reception.</li> <li>• The practice worked closely with the local CCG medicines management team regarding safe prescribing of antibiotics, within national guidance, and medicines optimisation.</li> <li>• The practice had employed a clinical pharmacist. This had a positive impact to ensure effective management of long-term conditions and medicines safety.</li> <li>• The practice offered travel vaccination.</li> <li>• The practice had secondary thermometers in all the fridges used to store vaccines, which logged all the data and provided assurance that temperatures had been within the required range, as recommended in Public Health England guidance. The practice informed us that a text message alert had been sent on the registered mobile number if fridge temperatures had been recorded outside the required range.</li> </ul>	



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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	2
Number of events that required action:	2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw in staff meeting minutes significant events were discussed and documented. The staff we spoke with informed us that learning from significant events had been shared with them on a regular basis.</li> </ul>	

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

Event	Specific action taken
During the patient's registration process, a child's birth certificate was not cross checked with the mother's identity.	The practice had investigated the incident, revised the protocol and advised all staff to check the mother's identity when registering a child and also linked the mother's records with the child's record.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was a system in place to receive and share all safety alerts. Most of the safety alerts were managed well, however, we found some safety alerts had not been managed effectively to ensure that all action had been taken as required.</li> <li>For example, our clinical searches identified the practice had not acted adequately on safety alerts for four out of five women of childbearing age on teratogenic medicines (These medicines presents a significant risk of birth defects and developmental disorders in babies born to women who take these medicines during pregnancy and must no longer be used in any woman or girl able to have children unless she had a pregnancy prevention programme in place). On the day of the inspection, the practice informed us they were going to take immediate steps to fully review the safety alerts and provide assurance that they would be reviewing the women taking medicine contraindicated during pregnancy.</li> </ul>	

## Effective

## Rating: Good

At the previous inspection in January 2020, we rated the practice as requires improvement for providing effective services, because:

- The practice was unable to demonstrate that all clinical staff had received annual appraisals, and childhood immunisations and travel immunisations training updates. Not all staff had received formal clinical supervision on a regular basis.
- The practice's uptake of the national screening programme for cervical cancer screening and childhood immunisations rates were below the national averages.

At this inspection in September 2021, we found that the practice had demonstrated improvements and is rated as **good** for providing effective services.

### Effective needs assessment, care and treatment

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

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

### Older people

### Population group rating: Good

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from the hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in the hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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. (01/04/2019 to 31/03/2020) (QOF)	70.4%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	0.8% (2)	7.6%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	95.1%	90.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	9.4%	12.7%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	71.4%	83.4%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	0.0% (0)	4.2%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	57.6%	66.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	4.8% (16)	12.9%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	65.5%	73.7%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.5% (27)	6.3%	7.1%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.7%	90.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.2% (1)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.3%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	5.4% (18)	8.7%	10.4%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

### Any additional evidence or comments

- We noted during the current Quality Outcomes Framework (QOF) year (2021/22), 72% of patients aged 79 years or under with coronary heart disease had the last blood pressure reading monitored. The practice informed us they had plans in place to improve outcomes for this patient group.

**Findings**

- Childhood immunisations were carried out in line with the national childhood vaccination programme. However, childhood immunisation uptake rates were below the World Health Organisation (WHO) targets for five out of five immunisations measured in 2019/20). The practice explained that this was due to the transient population and known challenges within the practice population. This had an impact on the national childhood vaccination programme. The practice informed us that a number of patients were from a European background and they might have childhood immunisation carried out in their native European countries, but this information was not shared with the practice. In addition, the practice had faced additional challenges due to ongoing pandemic restrictions. The practice had taken steps to improve the childhood immunisation uptake and informed us they were working.
- We noted childhood immunisation uptake rates (for all three indicators aged two years old) had improved in 2019/20 when compared to the data from 2018/19 (included in the previous inspection report). The practice had conducted a thorough analysis of the data and identified targeted areas to improve performance. These areas included: management of data; staff knowledge and awareness; monitoring targets; immunisation history being requested at registration; recall system; follow-up of nonattenders; educating families; access to appointments; and removal of patients who have moved out of the area. Progress against delivery of the action plan was monitored.
- At this inspection, the practice had provided data held in Open Exeter for the quarter up to October 2020, which demonstrated improvement. The practice percentage had increased to 94% for immunisations and 91% for boosters. However, this data was not comparable to the data included in the table below.
- The practice informed us that Open Exeter had been closed since May 2021 and now they were monitoring childhood immunization via clinical software used in the practice. The practice had maintained the register and a dedicated team was employed to deal with recalls at the organization level. The practice had provided recent data of children aged one who either had completed a primary course of immunization or appointment was booked to receive childhood immunization.
- The practice informed us there was a high refusal rate for immunisation for measles, mumps and rubella (MMR). The practice had maintained a register and a dedicated practice nurse contacted the parents or guardians of children and encouraging childhood immunisation uptake. After three contacts the parents were asked to sign a form which was scanned and saved in the patients' records.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.

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) (01/04/2019 to 31/03/2020) (NHS England)	54	60	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	68	83	81.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	74	83	89.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	73	83	88.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	59	73	80.8%	Below 90% minimum

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

### Any additional evidence or comments

- At the previous inspection in January 2020, we noted the practice nurses had not received regular annual training updates relevant to childhood and travel immunisations. At this inspection in September 2021, we found staff had the appropriate skills and training to carry out reviews for this population group. The practice nurse had received regular annual training updates relevant to childhood and travel immunisations.

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

## Population group rating: Requires improvement

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) <small>(Public Health England)</small>	64.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	66.7%	62.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	55.7%	51.4%	63.8%	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 (01/04/2019 to 31/03/2020) <small>(QoF)</small>	100.0%	93.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	65.0%	57.6%	54.2%	No statistical variation

### Any additional evidence or comments

- The practice was aware of these results and explained that this was due to the transient population and known cultural challenges within the practice population, which had an impact on the cervical cancer screening uptake. The practice had taken steps to encourage uptake. For example, there was a policy to offer telephone reminders and send text messages to patients who did not attend for their cervical screening test. All non-attendance is flagged on the patient's record so that the clinicians opportunistically encouraged patients to make their appointments. However, further improvements were required to meet the 80% coverage target for the national screening programme.
- The practice informed us that the practice boundaries included the most deprived area of Feltham, which had an impact on their cancer screening uptake.



- According to the local data (March 2021) shared by the local Clinical Commissioning Group (CCG), the practice's uptake for cervical screening had increased to 68%. This included patients who had screening recorded within 3.5 years (for women aged 25 to 49), and within 5.5 years (for women aged 50 to 64).
- The practice had shared recent Quality Outcomes Framework (QOF) results (2021/22) and informed us they had achieved 77% cervical cancer screening rates for patients aged 25-49 years and 84% screening rates for patients aged 50-64 years old. However, this unverified QOF data 2021/22 was not comparable with the Public Health England published data (Snapshot date: 31/03/2021) included in this report. The cervical screening QOF indicator was used to calculate the payment the practice received, not the number of women screened. It included women who had been invited but who had not attended. In addition, it did not measure whether women had been screened at the appropriate time according to their age.
- The practice offered appointments during weekdays and on Saturdays. The practice informed us patients were able to book cervical screening appointments on Saturdays, which were offered under the Primary Care Network (PCN) arrangement.
- We noted the practice had offered 286 cervical screening appointments since 1 April 2021 at the practice. This did not include appointments offered during extended hours.
- The practice had a system to ensure results were received for all samples sent for the cervical screening programme. The practice had established failsafe systems to follow up women who were referred to as a result of abnormal results.
- We noted a practice nurse had received specific training for nurses on sample taking for the cervical screening programme.
- We noted bowel cancer screening rates had increased from 47% in 2018/19 to 56% in 2019/20 (according to the Public Health England data).
- The practice had maintained the register and a dedicated team was employed to deal with recalls at the organization level.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

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



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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.7%	85.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	4.4% (2)	10.0%	16.6%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	82.6%	81.4%	Variation (positive)
PCA rate (number of PCAs).	23.1% (3)	5.5%	8.0%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

## Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	535.2	533.9
Overall QOF score (as a percentage of maximum)	95.8%	95.5%
Overall QOF PCA reporting (all domains)	3.3%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The practice had carried out repeated clinical audits of high-risk medicines to ensure all patients were monitored in accordance to national guidelines. The clinical audits demonstrated that all patients were being monitored appropriately either by the practice or the hospital.
- The practice had carried out a recent clinical audit for patients with atrial fibrillation. We noted 51 patients with atrial fibrillation (with a record of a CHA2DS2-VASc score of 2 or more) were treated with anti-coagulation drug therapy. However, one out of 51 patients was abroad for a long time (confirmed by the patient's next of kin) and one other patient was not contactable and they had not received anticoagulant medicine from the practice in the last few months. The practice informed us they would contact them after three months to find out if patients returned to the UK and would offer them a medicine review and blood test, so the medicine dosage could be adjusted if required.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>At the previous inspection in January 2020, the practice was unable to demonstrate that all staff had received annual appraisals and childhood immunisations and travel immunisations training updates in the last 12 months relevant to their role. At this inspection in September 2021, we found that all staff had received annual appraisals in a timely manner, with the exception of an administrative staff who had received an appraisal on the day of the inspection. We noted a practice nurse had received regular annual training updates relevant to travel immunisations and childhood immunisations in the last 12 months.</li></ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
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

## 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 and tackling obesity.	Y

## Consent to care and treatment

### The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff we spoke to were complimentary about the leadership at the practice. We were told that the leaders were approachable, supportive and inclusive.</li><li>• The provider had taken the necessary steps to resolve the Care Quality Commission (CQC) registration issues and their CQC registration was up to date.</li></ul>	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a mission statement that stated 'each and every patient matters'. This included to provide high quality healthcare in a responsive, supportive and courteous manner.</li></ul>	

## Culture

### The practice had a culture which drove high quality sustainable care.

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

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

Source	Feedback
Staff feedback	<p>We spoke with a mix of staff during the inspection:</p> <ul style="list-style-type: none"> <li>• All the staff interviewed reported a positive experience of working at the practice.</li> <li>• Staff described a positive learning environment where they were supported and encouraged to complete training and professional development.</li> <li>• Staff felt they were treated equally.</li> <li>• We were informed that the practice culture was one of being open and supportive of one another.</li> <li>• Clinical staff said they had prompt access to the senior GP when they needed clinical advice.</li> </ul>

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management. However, some improvements were required.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had demonstrated improvements in governance arrangements compared to the previous inspection, however, the prescription box for uncollected prescriptions was not monitored effectively and staff we spoke with were not clear about their roles and responsibilities in this area.</li><li>• The practice had established proper policies and procedures.</li><li>• Infection control and fire safety procedures were implemented and monitored effectively.</li></ul>	

## Managing risks, issues and performance

**There were processes for managing risks, issues and performance. However, some improvements were required.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to safety alerts.</li><li>• The practice had implemented adequate processes to monitor clinical performance and quality of care within the practice.</li><li>• The practice had a business continuity plan in place.</li></ul>	

**The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had undertaken internal risk assessments in response to the Coronavirus pandemic. This included reviewing on-site activity, protecting people at high risk, handwashing, social distancing, and managing transmission risk.</li> <li>Due to the COVID-19 pandemic, appointments were offered and undertaken by telephone, video consultation and on a face to face basis when necessary.</li> </ul>	

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y



## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

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

**The practice involved the public, staff and external partners to sustain high quality and sustainable care. However, some improvements were required.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Patients had a variety of means of engaging with the practice all of which were effective: text messages, emails and complaints/comments.</li><li>• Staff feedback highlighted a strong team with a positive supporting ethos.</li><li>• Staff said the leadership team asked for their feedback and suggestions about the way the service was delivered. Staff meetings were held regularly.</li><li>• The practice worked closely with their Primary Care Network (PCN). This was particularly evident at the onset of the pandemic when communication with the PCN was regular.</li></ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• The practice had not had an active Patient Participation Group.</li><li>• The practice informed us that no active patient participation group (PPG) existed when they took over the long-term contract in October 2018. The practice held a patient engagement event on 21 September 2019, which was attended by 37 patients. The practice promoted awareness and encouraged each patient to join the PPG, but no patient followed up on this. The practice was unable to plan another patient engagement event last year due to the pandemic. However, they had arranged one for 16 October 2021 and were trying hard to establish the patient participation group (PPG).</li><li>• The practice had displayed posters in the waiting area encouraging patients to join the PPG.</li></ul>

Any additional evidence
<ul style="list-style-type: none"><li>• We noted the NHS friends and family test (FFT) results for the last six months (April 2021 to September 2021) and 88% of patients (out of 638 responses) were likely or extremely likely recommending this practice.</li><li>• Three patients we spoke with praised the practice for efficiently adapting the service in line with the evolving pandemic, whilst maintaining an accessible and supportive service.</li><li>• They were satisfied with the online access provided by the practice.</li></ul>

- Some patients with spoke with raised dissatisfaction regarding the poor telephone access. However, the practice informed us they were going to install a new telephone system in early October 2021 and had recruited additional administrative staff to improve the telephone access.

## Continuous improvement and innovation

**There were evidence of systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

## Examples of continuous learning and improvement

- The practice was forward thinking and planning to address the lack of space issue.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- We noted the infection control lead (at the provider level) was supported to complete a level six infection control and prevention training course.
- The practice had taken part in clinical research projects during the pandemic. The aim was to deal with the need to ensure that patients who were at high risk of complications if they had COVID were well managed, and their treatment was optimised effectively.

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
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.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
- 
- % = per thousand.