Care Quality Commission

Inspection Evidence Table

Parkview Practice (1-4445962348)

Inspection dates: 11 March 2019 and 19 March 2019

Overall rating: Requires improvement

Safe — Rating: Requires improvement

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Partial
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.	Partial
Explanation of any answers and additional evidence: • Staff gave us conflicting information as to which GPs had lead roles for safeguarding adults and children. During the inspection, safeguarding posters did not identify who staff leads were and staff we interviewed were not aware. • Following the inspection, the provider submitted practice lead posters to evidence that this area	

Safeguarding	Y/N/Partial
of concern has been addressed. • The practice is situated in an area of high social deprivation and had a diverse patient population. There was a register for vulnerable adults and for children for whom there were safeguarding concerns. We reviewed evidence that only one child was on the register. Following the inspection and during the factual accuracy process, the provider submitted further evidence regarding active safeguarding registers for children and vulnerable adults. • The practice policy we reviewed was dated 2012. Following the inspection and during the factual accuracy process, the provider submitted the latest version of their safeguarding policy. However, this did not contain information regarding female genital mutilation (FGM), the legal requirement to report any instances of FGM and the necessity to carry out safeguarding assessments for the children of women who have been subjected to FGM. • Information contained in the locum pack referred GPs to review safeguarding posters in clinical rooms. However, the posters did not provide relevant information if senior staff were unavailable. Following the inspection and during the factual accuracy process the provider submitted additional information regarding appropriate safeguarding resources for staff. • Safeguarding training was comprehensive and DBS checks were undertaken on all staff and these were renewed on a three-yearly basis. • Chaperone training was undertaken by all staff and was provided by the practice, but we did not see evidence of the content of that training. Posters in clinical rooms regarding the availability of chaperones was displayed in several languages. Following the inspection and during the factual accuracy process the provider submitted further information to us on chaperone training. • Staff were unsure when and how frequently safeguarding meetings took place with the wider professional team and told us the practice does not hold meetings with health visitors which would have provided a system to safety net and protect children. Following the inspection and during the factual accuracy process, the provider submitted information regarding their open-door policy with the health visiting team and clarified their meeting arrangements with the wider multi-disciplinary team.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	N
Explanation of any answers and additional evidence: • We asked the practice for information from practice records, regarding specific training undertaken by the practice nurse, to demonstrate competency at the time of recruitment. We have not received evidence in relation to this to date.	

- We asked the practice for information to demonstrate that staff had completed required blood tests and immunisations in line with PHE guidance. Following the inspection, the provider submitted information regarding staff immunisations but these records remained incomplete.
- Although systems were in place to ensure the registration of clinical staff, including the practice nurse, was current at the time of recruitment, there was no system in place to regularly monitor this. Following the inspection, the provider submitted some information regarding a system for monitoring the registration of clinical staff but this was incomplete in that it had not been regularly reviewed and did not contain details of all professional clinical staff.
- We asked the practice for information to demonstrate evidence of medical indemnity insurance for the practice nurse or HCAs, but they have not submitted evidence regarding this. Following the inspection, the provider submitted information regarding medical indemnity insurance but this was incomplete in that it did not demonstrate evidence of current medical indemnity insurance and related to 2017.

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: 31 March 2018	Y
There was a record of equipment calibration. Date of last calibration: 26 March 2018	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
There was a record of fire extinguisher checks. Date of last check:	Y
There was a log of fire drills. Date of last drill: 5 March 2019	Y
There was a record of fire alarm checks. Date of last check: November 2018	Y
There was a record of fire training for staff. Date of last training: differing dates for staff	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 10 January 2019	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

- We asked the practice for information to demonstrate that portable appliance testing and calibration for medical devices had been undertaken, but they have not submitted evidence of this. Following the inspection and during the factual accuracy process the provider submitted information regarding portable appliance testing and calibration of equipment.

- The practice was situated within a purpose-built NHSE property building. The practice did not maintain oversight of maintenance and risk assessments undertaken by NHSE and they had not undertaken risk assessments of its own premises area.
- During the inspection we were not provided with copies of any risk assessments. During the factual process the provider told us they had undertaken their own risk assessments and submitted information regarding this. The provider submitted the following risk assessments: COSHH; health and safety; premises and security and fire safety.
- The overarching fire safety risk assessment had been completed by NHS Property Services and had outstanding action points, some of which were the responsibility of the tenant i.e. the provider. There were additional outstanding action points and the provider has not demonstrated they have oversight of this process. The provider submitted evidence of a fire risk assessment, however the 'action plan' included did not have any action points documented.
- We had been unable to review records that fire extinguishers were regularly checked; that a log of fire drills was maintained, and that fire alarm checks had been conducted appropriately. Following the inspection and during the factual accuracy process, the provider submitted the required information.
- We reviewed evidence from practice records that four out of fourteen staff had not completed fire safety training. During the inspection the provider could not demonstrate that all staff had completed fire safety training. Following the inspection and during the factual accuracy process, the provider told us that all staff had undertaken fire safety training but no appropriate certificated evidence has been provided to demonstrate that four staff have completed fire safety training.

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

Explanation of any answers and additional evidence:

- We were told that the property management company had conducted appropriate premises and security and health and safety risk assessments', but the practice did not hold a copy which they could show us during the inspection. The practice staff did not record their own health and safety monitoring checks of the premises. During the inspection we were not provided with copies of any risk assessments. During the factual accuracy process the provider submitted risk assessments for health and safety and premises and security.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: NHSE IPC audit dated 2017	Y

The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- We have been unable to review evidence that all staff have undertaken infection prevention and control (IPC) training, including cleaning staff and enhanced training for the IPC lead. Following the inspection, the provider could not demonstrate that all staff had undertaken appropriate IPC training including enhanced training for the IPC lead and appropriate certificated evidence has not been provided.
- The practice provided information for one internal IPC audit with completed actions.
- The health centre premises were clean, however during the inspection the provider did not provide evidence of cleaning schedules (which identify what, how and when cleaning should take place) and cleaning audits. Following the inspection and during the factual accuracy process, the provider submitted information regarding cleaning audits.

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
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial

Explanation of any answers and additional evidence:

- There was limited evidence that comprehensive risk assessments, for patients with long term conditions, were embedded into practice systems. During the inspection the provider did not demonstrate they had embedded risk assessment systems in place for patients with long term conditions. Following the inspection the practice submitted appropriate information regarding a

development plan and a Call and Recall protocol to address identified areas for improvement.

- Posters containing information about sepsis were displayed, but staff told us they had not undertaken 'red flag' training. Patients were not triaged or screened for red flag signs or urgency when they called the practice or attended to request an appointment with a GP or signposted to NHS 111, an Urgent Care Centre or other medical help. However, staff stated patients would be referred to the clinicians on duty if they regarded someone to be unwell or if they thought it was an urgent matter.
- Following the inspection and during the factual accuracy process the provider has instigated informal guidance training for all staff and has made arrangements for staff to undertake online sepsis training later in the year.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
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.	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

Explanation of any answers and additional evidence:

- The management of test results was tracked through the electronic records system. There was no evidence of a back log of test results for review, but the practice did not have a documented system to safely manage this. Following the inspection the provider has submitted evidence of an appropriate protocol regarding the safe management of test results.

Appropriate and safe use of medicines

The practice had 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) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	0.55	0.64	0.94	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). (01/10/2017 to 30/09/2018) (NHSBSA)	8.9%	11.0%	8.7%	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 (01/04/2018 to 30/09/2018) (NHSBSA)	4.41	5.53	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	1.02	0.99	2.22	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
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	Y

Medicines management	Y/N/Partial
unusual prescribing, quantities, dose, formulations and strength).	
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- There were no locks on the prescription trays in each room. We were unable to review evidence that the practice monitors the serial number of prescriptions and tracks this to each printer. Following the inspection and during the factual accuracy process the provider has submitted appropriate information regarding prescription safety.
- We reviewed evidence that Patient Specific Directions (PSDs) were appropriate, but a healthcare assistant was unable to articulate the process to our inspector or show evidence in patients records regarding these authorisations. During the inspection we interviewed a healthcare assistant who was unable to describe the process by which PSD's were authorised by a GP but could demonstrate that medicines given had been documented appropriately in patients' records. Following the inspection and during the factual accuracy process the provider submitted information to further demonstrate that medicines given by the healthcare assistant had been documented appropriately in patients' records.
- The practice employed a locum pharmacist as part of the diabetes multi-disciplinary team, and there was appropriate supervision and support in place from the lead GP.

Track record on safety and lessons learned and improvements made

There was limited evidence 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.	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.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	12
Number of events that required action:	11

Explanation of any answers and additional evidence:

- Staff were confused regarding the system and process for recording SEAs, and only clinical events were recorded as such. Information related to non-clinical SEA's was recorded in an incident book, and staff seemed unaware of the potential difficulty of operating a dual system for recording SEAs.
- We have been unable to review whether learning was shared externally with the National Reporting and Learning System (NRLS).

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

Event	Specific action taken
Blood tests were being requested under incorrect clinician's names	Discussed at clinical meeting, staff asked to take more care regarding this when selecting tests in ICE system. The lead GP has actioned test results involved.
Reception staff were booking incorrect appointment lengths for the practice nurse and HCA.	Discussed at clinical meeting. Staff were reminded of appointment times and a laminated aide memoire has been placed in each room.

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

Explanation of any answers and additional evidence:

- Clinicians received safety alerts electronically. The practice did not have an effective system for ensuring that these were acted on. Following our second site visit we saw evidence the provider had put plans in place to rectify this, however, we did not see evidence searches for the most recent alerts. Following the inspection and during the factual accuracy process the provider submitted evidence regarding the safe management of patient safety alerts.

Effective Rating: Requires improvement

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
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways were in place 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

Explanation of any answers and additional evidence:

- Clinical staff told us they followed a consistent approach in relation to evidence-based practice.
- The practice largely relied on individual clinicians (and patients) to instigate reviews and update treatment as appropriate. The quality and outcomes framework (QOF) triggered the practice to invite patients with longer term conditions for review but the practice had high exception reporting rates for this programme, potentially reducing its reliability as a recall mechanism. The lead GP told us they had reduced the exception reporting rate from 47% to 35% and continued to work towards reducing this further. Following the inspection and during the factual accuracy process the practice submitted information regarding a development plan and a Call and Recall protocol to address identified areas for improvement.

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) (01/10/2017 to 30/09/2018) (NHSBSA)	0.77	0.88	0.81	No statistical variation

Older people — Population group rating: Good

Findings

- Clinicians had access to an appropriate tool to identify patients aged 65 and over living with moderate or severe frailty. Those identified as having a frailty issue had a clinical review.
- For patients with the most complex needs, we were told that the GPs worked with other health and care professionals to deliver a coordinated package of care. There were monthly multi-disciplinary team meetings to which the local community nurse representatives were invited.

People with long-term conditions — Population group rating: Requires improvement

Findings

- The practice could not demonstrate that it was systematically providing patients with long-term

conditions with a structured annual review to check their health and medicines needs were being met. Following the inspection and during the factual accuracy process the practice submitted information regarding a development plan and a Call and Recall protocol to address identified areas for improvement .

- For patients with the most complex needs, we were told that the GPs worked with other health and care professionals to deliver a coordinated package of care. The practice had introduced a specialist multi-diabetes clinic with a Diabetes Clinical Nurse Specialist and a clinical pharmacist once per week to improve health outcomes for patients with diabetes. There were monthly multi-disciplinary team meetings to which the local community nurse representatives were invited.
- There was no evidence that the practice nurse and HCAs who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice tended to score highly on the quality and outcomes framework for its management of long-term conditions. However, the practice also recorded consistently high exception reporting rates for these indicators. The lead GP told us they had reduced the exception reporting rate from 47% to 35% and continued to work towards reducing this further. Following the inspection, the practice has submitted information regarding a development plan and a Call and Recall protocol to address areas they have identified for improvement.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

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 (01/04/2017 to 31/03/2018) (QOF)	82.2%	77.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	25.4% (88)	12.7%	13.2%	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 (01/04/2017 to 31/03/2018) (QOF)	64.8%	72.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	11.5% (40)	11.3%	9.8%	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 (01/04/2017 to 31/03/2018) (QOF)	74.2%	76.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.3% (60)	11.9%	13.5%	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 (01/04/2017 to 31/03/2018) (QOF)	73.6%	74.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.5% (10)	6.9%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	95.6%	88.5%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.9% (2)	11.1%	11.5%	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 (01/04/2017 to 31/03/2018) (QOF)	67.6%	78.6%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	3.3% (23)	5.2%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	86.8%	88.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.0%	6.7%	N/A

Any additional evidence or comments
• The practice offered practice nurse and HCA appointments to patients with suspected or confirmed hypertension (including Ambulatory Blood Pressure Monitoring), but from data we reviewed, the practice achievement rate of 67.6% varied significantly from CCG and national averages of 78.6% and 82.6% respectively. Following the inspection and during the factual accuracy process the practice submitted information regarding increased resources they have secured to address this.

Families, children and young people

Population group rating: requires improvement

Findings
• Childhood immunisation rates were below World Health Organisation target rates and was a finding from our previous report. Following the inspection, the practice sent us a development plan which highlighted this as an area for improvement. • We saw the practice nurse worked one day per week, which would impact on the nurse's capacity offer appointments, and this was having a direct impact on childhood immunisations achievement rates. Following the inspection, the practice submitted information regarding increased practice nurse resources they have secured to address this.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	87	110	79.1%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	58	69	84.1%	Below 90% minimum (variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	58	69	84.1%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	57	69	82.6%	Below 90% minimum (variation negative)

Any additional evidence or comments

Working age people (including those recently retired and students)

Population group rating: requires improvement

Findings

- The cervical screening achievement rate of 56.6% was recorded as a negative variation, and was below the national rate of 71.7%. This was a finding from our previous report.
- We reviewed evidence that the practice nurse worked one day per week, which would impact on the nurse's ability to offer appointments, and this was having a direct impact on cervical screening achievement rates. Following the inspection the practice has submitted information regarding increased practice nurse resources they have secured to address this.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	56.6%	56.0%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	56.3%	59.4%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	35.5%	42.1%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	70.0%	62.4%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	35.0%	50.0%	51.9%	No statistical variation

Any additional evidence or comments

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice provides GP services for Syrian refugees, for the whole of Hammersmith and Fulham

borough.

- The practice works together with St Mungo's Homeless Shelter to register homeless clients and improve access to GP services for this patient population.
- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability.
- We reviewed evidence that the practice is developing a joint clinic for patients with a learning disability, with the Learning Disability team on site in the health centre.

People experiencing poor mental health (including people with dementia)

Population group rating: good

Findings

- We reviewed care plans for people experiencing poor mental health, which were comprehensive.

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 (01/04/2017 to 31/03/2018) (QOF)	96.4%	88.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	3.4% (2)	10.7%	12.7%	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 (01/04/2017 to 31/03/2018) (QOF)	98.2%	89.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.7% (1)	9.1%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	85.7%	83.0%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	6.5%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	535.5	516.2	537.5
Overall QOF exception reporting (all domains)	10.9%	6.5%	5.8%

	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

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

- The practice participated in national quality improvement initiatives. For example, NHS health checks.
- The practice had undertaken three completed two-cycle audits. One audit related to osteoporosis and patients being prescribed correct treatment for this condition, which was undertaken in 2017 and consisted of a retrospective audit of patients. An increase in patient numbers receiving the correct treatment was achieved. A further two audits related to high-risk medicines.
- We did not see evidence of an audit to demonstrate improvement in how patient outcomes were improving as a result of the diabetes service provided by the practice. Following the inspection and during the factual accuracy process the provider submitted information to demonstrate they are monitoring this.

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.	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

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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The practice could not demonstrate how they assured themselves of the competence of clinical staff who carried out medication reviews, long-term condition reviews, cervical screening, vaccinations and immunisations.
- The locum clinical pharmacist told us they have regular supervision and support in relation to prescribing from the GPs' at the practice. However, we have not seen evidence that other clinical staff including the practice nurse and HCAs have access to this support on a regular basis. Following the inspection and during the factual accuracy process the provider submitted evidence of messages between the healthcare assistant and medical staff from June/July 2018 regarding specific instances of patient care. They have not submitted evidence of documented 1:1 and supervision/support for the practice nurse and healthcare assistant.
- The practice told us the HCAs performed phlebotomy, blood pressure checks, pill checks and health checks but there were no clinical protocols in place to support the HCAs in this role. Following the inspection, the practice submitted two flow charts for asthma and hypertension for the HCA.

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 (01/04/2017 to 31/03/2018) (QOF)	Yes
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	N/A

processes to make referrals to other services.	

Explanation of any answers and additional evidence:

- We saw evidence that GPs coordinated the care provided to patients and liaised with other professionals.
- Although the practice worked together with the multi-disciplinary team to deliver end of life care to patients, we saw that the palliative care register had not been regularly reviewed. Following the inspection the provider submitted information to demonstrate clinical oversight for two individual patients. The provider has not submitted evidence regarding overall clinical oversight and review for this patient population group.

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
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Explanation of any answers and additional evidence:

- The health care assistants were able to provide health care support and advice.
- The practice was participating in a local scheme to identify patients at risk of developing diabetes.
- The clinicians were aware of local social prescribing opportunities.

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 (01/04/2017 to 31/03/2018) (QOF)	99.9%	94.7%	95.1%	Significant Variation (positive)

Exception rate (number of exceptions).	1.1% (12)	1.2%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Caring Rating: Good

Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: • The practice provided care to a diverse population of patients. Staff told us they were committed to providing care that respected patients' rights, beliefs, preferences and individual autonomy and were able to provide examples.	

CQC comments cards	
Total comments cards received.	30
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comments cards	Patients were consistently complimentary about the professionalism of the clinical staff at the practice.
Comments cards	Patients consistently stated that staff listened and were kind and helpful.
Comments cards	Issues raised in the 4 mixed responses we received related consistently to availability of appointments at the practice.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7121	420	77	18.3%	1.08%

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 (01/01/2018 to 31/03/2018)	70.5%	85.3%	89.0%	Variation (negative)
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 (01/01/2018 to 31/03/2018)	65.1%	82.5%	87.4%	Significant Variation (negative)
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 (01/01/2018 to 31/03/2018)	93.9%	94.2%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	73.7%	79.9%	83.8%	No statistical variation

Any additional evidence or comments
• Following the inspection, the provider submitted an action plan to address the issues identified in

the national GP survey. However, this information did not address the negative and significant negative variations highlighted in the GP survey.

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

Any additional evidence
• The practice told us they conducted their own patient feedback exercises, but they have not submitted evidence regarding this. Following the inspection, the provider submitted evidence regarding patient feedback that related to NHS Choices website. However the provider could not demonstrate they had initiated feedback exercises and made positive changes as a result.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
• Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
• Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	• In patient interviews, we identified consistent themes regarding access to the practice via telephone and being able to book appointments. Patients were very positive about staff and were generally happy with their care.

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 (01/01/2018 to 31/03/2018)	92.4%	90.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y

Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Y
• Information regarding the availability of chaperone posters was available in several different languages. • Staff spoke several different languages including Hindi, Arabic, Cantonese, Sinhalese, and Urdu.	

Carers	Narrative
Percentage and number of carers identified.	1.2% (86)
How the practice supported carers.	We were told that carers had priority access to appointments and were advised about local carers services.
How the practice supported recently bereaved patients.	The practice maintained a register of patients who have been bereaved, GPs would provide support and signposting to specialist bereavement services.

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: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
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
The practice provided effective care coordination for patients who were more vulnerable	Y

or who had complex needs. They supported them to access services both within and outside the practice.	
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Explanation of any answers and additional evidence:

- We reviewed evidence that the practice operated, at times, under insufficient clinical GP capacity, and the locum practice nurse worked one day per week. The practice used locum GPs to fill the staff rota. The practice was working to address this although no formal plans were in place.
- The practice had extended its opening hours in addition to providing more GP sessions by opening on Saturday morning.
- The practice provided an extended hours service under the Weekend Plus service, from 6.30pm-8pm Monday to Friday, and Saturday and Sunday, to all patients across Hammersmith and Fulham Borough. This included access to a practice nurse on Saturdays.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am-8pm
Tuesday	8am-8pm
Wednesday	8am-8pm
Thursday	8am-8pm
Friday	8am-8pm
Saturday	9am-5.30pm
Sunday	9am-1pm
Appointments available:	
Monday	9am-4pm
Tuesday	9am-4pm
Wednesday	9am-4pm
Thursday	9am-4pm
Friday	9am-4pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7121	420	77	18.3%	1.08%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last	89.6%	93.2%	94.8%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
general practice appointment, their needs were met (01/01/2018 to 31/03/2018)				

Any additional evidence or comments

Older people — Population group rating: Good

Findings

- The practice offered services for patients including automatic blood pressure monitoring (ABPM), warfarin monitoring, COPD and asthma management.
- The practice offered a range of primary care services targeting older patients, for example the flu, shingles and pneumococcal vaccinations.

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

Findings

- The practice provided a Diabetes clinic on Friday each week, and patients with diabetes were able to have their needs reviewed by a multi-disciplinary team. The practice was the first in the Northern Network to provide a service for the initiation of insulin.
- The practice offered services for patients including automatic blood pressure monitoring (ABPM), warfarin monitoring, COPD and asthma management.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

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

Findings

- The practice offered appointments outside of school hours on Saturday morning and via the extended hours service as appointments during core hours were unavailable after 4pm. The practice nurse was available on Fridays, and on Saturday via the extended hours service.

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

Findings

- The practice offered appointments outside of work hours on Saturday morning and via the extended hours service as appointments during core hours were unavailable Monday to Friday after 4pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• We found that staff were aware of and committed to meeting the needs of this population group. • Staff had completed equality and diversity training.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• We found that staff were aware of and committed to meeting the needs of this population group. • 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. • Staff had completed dementia awareness training.

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.	Partial
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
• The National GP survey 2018 highlighted frustration that patients experienced trying to telephone the practice. Forty-eight per cent of patients responded positively to being asked this question which a negative variation was compared to the national average.	

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 (01/01/2018 to 31/03/2018)	47.7%	N/A	70.3%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	47.7%	64.6%	68.6%	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 (01/01/2018 to 31/03/2018)	46.8%	63.8%	65.9%	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 (01/01/2018 to 31/03/2018)	48.6%	68.3%	74.4%	Variation (negative)

Any additional evidence or comments

- Following the inspection, the provider submitted an action plan in response to the GP survey results. However, the information sent to us did not directly address all the points in the survey.

Source	Feedback
For example, NHS Choices	Current overall rating was 2.5 stars (out of five). Ratings viewed on 10 March 2019 and 8 April 2019 Comments have included: • The staff are professional and caring, there are modern, clean facilities with staff who are helpful and friendly and care given was second to none. • The GPs provided a good service and involved patients in decisions about their care. • Staff can be uncaring and rude, and it was generally an unpleasant and upsetting experience. • Waiting times are absurd, it is very difficult to access appointments.
Google review	2.5* 50 reviews Comments have included: • I have had a good experience here and I found the staff went out of their way to help • ZERO* stars. I have had numerous bad experiences here. I waited nearly 12 months for a referral which they kept losing. I was also told on the phone there's no "bookable" appointments, so you need to just call at 8am and hope for the best. If they cannot meet demand, don't take new patients on. • Regardless of pressures on NHS and the staff. Doctors are Fab. Park view surgery immense! • Hang up on patients very rude staff. • Great team, GP was amazing and the admin staff are well mannered and

	professional. Thank so much for your great service.

Listening and learning from concerns and complaints

There is limited evidence to demonstrate complaints were used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	7
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	Y
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: • We reviewed evidence from practice records of seven complaints. Four were written complaints, two were verbal and one was not a complaint. We found the complaints summary does not include who learning is shared with, how and when it is shared. • The complaint we reviewed was handled in a timely fashion. We have reviewed written information that the provider would record this complaint as an SEA, but there is no evidence that has been done. • We reviewed evidence related to making a complaint online, which was contained within the practice policies page on the provider's website, so it was not easy to find. Complaints leaflets were not on display within the practice premises.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained about a repeat prescription request being stopped.	The reasons for this were discussed with the patient, who understood once this had been explained.
Patient's prescription had been lost in the surgery, which had to be re-issued.	Practice apologised to the patient and advised them to register for online services and the Electronic Prescription Service.

Well-led Rating: Requires improvement

Leadership capacity and capability

There was limited evidence that leaders could demonstrate 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:

- The lead GP was clear about the challenges they faced, and were developing plans and priorities to improve. For example, following the inspection, the provider told us they had plans to re-introduce telephone triage in a bid to improve access to a GP for patients.
- The lead GP told us they were hopeful of being able to secure partnership arrangements with salaried GPs at the practice. Following the inspection and during the factual accuracy process the provider told us they have recruited a new GP partner.

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.	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.	N

Explanation of any answers and additional evidence:

- We found that staff were committed to providing a good service to all patients. Following the inspection and during the factual accuracy process the provider submitted information that demonstrated they had considered the needs of patients whose circumstances made them vulnerable; people who are experiencing poor mental health (including people with dementia) and older people. The provider told us they carry out a range of activities and work in partnership with a range of stakeholders regarding these patient population groups.
- Following the inspection, the practice submitted information regarding a development plan and a Call and Recall protocol to address areas they have identified for improvement.

• However, arrangements as to how they will measure the progress of the development plan were not recorded.

Culture

The practice had a culture that promoted 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.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: • We reviewed evidence that the practice duty of candour policy contained out of date information and referred to Outcome 18, which was replaced in 2014 by CQC's fundamental standards. It is a healthcare provider's responsibility to ensure they remain updated with the latest evidence and information available. Following the inspection, the provider submitted evidence to demonstrate they had updated this policy.	

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

Source	Feedback
Non-clinical staff	• We work as a team, we are like a family.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence: • Information submitted during the inspection process did not reassure us that governance structures and systems in the practice were regularly reviewed. We have been unable to review some evidence as this has not been submitted to us by the provider. Following the inspection and during the factual accuracy process the provider submitted further evidence to demonstrate they have appropriate governance structures and systems in place. For example, risk assessments relating to fire safety and COSHH. • The provider is a single-handed GP providing services to a diverse patient population in excess	

of seven thousand people and did not have formal plans in place to add GP partners to strengthen the leadership team and jointly address the challenges facing the practice. Following the inspection and during the factual accuracy process the provider told us they have recruited a new GP partner.

- We found evidence that staff were confused at times as to which clinician was practice lead in various areas, for example, the lead clinician for safeguarding children and adults. Following the inspection the provider submitted information to demonstrate that this area of concern has been addressed.
- There was no overarching policy and protocols related to the scope and role of the HCAs. Following the inspection, the practice sent us information containing two flow charts regarding asthma and hypertension regarding this. On the day of inspection and on subsequent occasions by email we have requested evidence regarding the healthcare assistant's specific roles. We have not received evidence in relation to this to date.
- The practice had not taken account of all the responses included in the GP Patient survey and this not been included in their action plan. Following the inspection, the provider told us they were addressing the GP patient survey through their practice development plan and prioritising actions for the most important feedback.
- We were unable to review evidence that the practice had responded to patient feedback. Following the inspection, the provider submitted evidence regarding patient feedback that related to NHS Choices website. However, the provider could not demonstrate they had initiated feedback exercises and made positive changes as a result.
- We were unable to review evidence of working with third parties, for example, the landlord regarding premises checks. The provider has submitted some evidence during the inspection and factual accuracy processes to demonstrate that they work with third parties.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Partial
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.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

Explanation of any answers and additional evidence:

- Some systems were in place were in place to manage quality assurance, but we were concerned the practice had a reactive rather than a proactive approach. For example, the practice had

submitted evidence of a development plan which detailed advance planning and systematic risk assessments for patients with long term conditions. Following the inspection, the practice submitted information regarding a development plan and a Call and Recall protocol to address areas they have identified for improvement.

- During the inspection process staff told us they were unaware of quality audits being undertaken at the practice. The provider sent us information regarding clinical audit they had undertaken. The information provided was limited and did not include for example, evidence of an audit to demonstrate improvement in patient outcomes as a result of the diabetes service provided by the practice. However, during the factual accuracy process the provider submitted evidence to demonstrate improvement in patient outcomes as a result of the diabetes service provided by the practice.
- We saw evidence that the provider had responded to external drivers of change, for example, following the inspection, some issues raised during our visits were acted upon. However, they could not produce evidence that it proactively identified and responded to risks and assessed the impact on safety and quality.
- The practice's oversight of risk management was inconsistent. During the factual accuracy process the provider told us they had always undertaken their own risk assessments and have submitted information regarding this. The provider submitted the following risk assessments: COSHH, health and safety, premises and security, and fire safety.
- The overarching fire risk assessment had been completed by NHS Property Services and has outstanding action points, some of which are the responsibility of the tenant i.e. the provider. There are additional outstanding action points and the provider has not demonstrated they have oversight of this process. The provider submitted evidence of a fire risk assessment and this has an 'action plan' included that has no action points documented within it.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- Clinical information was available to support patient care. The lead GP was aware of the high exception reporting rates and was working to reduce this. The practice however could not explain why its exception reporting rates were consistently very high on the Quality and Outcomes Framework. Following the inspection, the practice submitted information regarding a development plan and a Call and Recall protocol to address areas they have identified for improvement.
- The practice's oversight of risk management was inconsistent. During the factual process the provider has submitted information regarding the following risk assessments: COSHH; health and safety; premises and security and fire safety.

Engagement with patients, the public, staff and external partners

The practice did not involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence: • The lead GP told us about efforts they had made to improve patients' access to appointments due to feedback they had received.	

Feedback from Patient Participation Group.

Feedback
• Due to time constraints we were unable to speak with the PPG during and following the inspection.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: • Systems for recording clinical and non-clinically significant events were managed separately, there was limited analysis and learning from this process. Not all significant events were recorded. • Complaints were dealt with predominantly on a verbal basis and recorded in such a way that at times lacked clarity. There was limited evidence of learning. • Following the inspection, the practice sent us a development plan which highlighted this as an area for improvement.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	No statistical variation	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.
- 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.

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

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.