Care Quality Commission

Inspection Evidence Table

The Stanmore Medical Centre (1-541846216)

Inspection date: 25 April 2019

Date of data download: 16 April 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Requires Improvement

Safety systems and processes

The practice did not have effective 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.	N
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).	Partial
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.	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

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence: • The lead GP was the local safeguarding lead and had been trained to safeguarding level four. The practice told us that they would usually provide whole practice safeguarding training. However, we found that not all staff were aware of the safeguarding lead or the deputy lead. • The child safeguarding policy did not have a review date and the policies did not take in to account patients accessing any online services. • Chaperone signs were not clearly displayed around the practice. • Some of the nursing staff had only received level two child safeguarding training.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Partial
Explanation of any answers and additional evidence: • We reviewed three new staff employment records and saw that there was no interview summary for one new administration member of staff. There was no full employment history and second references for all three staff, as well as signed confidentiality records and signed contracts for two staff. • There was no evidence that all staff were vaccinated in line with current guidance. There were no immunisation records for three new staff when we reviewed their records. • The practice needed to ensure that they checked clinical staff indemnity when there was a change in their circumstances.	

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: Crowshott Avenue: 9 February 2019 William Drive: 26 January 2019	Partial
There was a record of equipment calibration. Date of last calibration: Crowshott Avenue: 30 May 2018 William Drive: 30 May 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: Crowshott Avenue: 2 April 2019 William Drive: 2 April 2019	Y
There was a log of fire drills. Date of last drill: n/a	N
There was a record of fire alarm checks. Date of last check: Crowshott Avenue: 26 February 2019 William Drive: 26 February 2019	Y
There was a record of fire training for staff. Date of last training: adhoc training on bluestream	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 24 April 2019	Partial
Actions from fire risk assessment were identified and completed.	n/a

Explanation of any answers and additional evidence:

- Although there was a record of PAT testing, not all equipment, such as one coffee machine had been PAT tested.
- The equipment calibration identified that one fridge had not passed the calibration test. There was no evidence provided to show what action had been taken to rectify this. One thermometer had not been calibrated and had last been tested in 2016.
- There was no evidence of a recent fire drill. Staff told us that a fire drill had not been carried out in the last 12 months.
- When we reviewed online training records, we saw that only three staff had received up to date

fire safety training.

- There was evidence that a fire risk assessment had been carried out a day before the inspection and the practice was awaiting the fire risk assessment report. Therefore, the inspection team were unable to review the actions identified from this latest report. On the day of inspection, we identified fire risk in relation to the lack of a fire door in the waiting room, the lack of a visible fire alarm in the disabled patient toilet and overloaded sockets in some of the rooms. The inspection team were also not provided with a previous fire risk assessment report to review if any identified actions from that assessment had been completed.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: n/a	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 24 April 2019	Partial

Explanation of any answers and additional evidence:

- There was evidence that a health and safety risk assessment had been carried out a day before the inspection and the practice was awaiting the health and safety risk assessment report. Therefore, the inspection team were unable to review the actions identified from this latest report.
- A legionella risk assessment had been carried out on the day of inspection. However, when we reviewed the previous risk assessment for both sites dated March 2015, we found that the recommended actions had not been carried out. Recommended actions included ensuring monthly water checks were carried out and a site log book completion. The legionella policy also stipulated that risk assessments were to be carried out annually and water temperature checks carried out monthly; however, this had not been carried out.
- There was a disability access protocol which was overdue a review in August 2017. A risk assessment had not been carried out despite the policy stating an annual audit would be carried out.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: n/a	N
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Partial

Explanation of any answers and additional evidence:

- There was an infection control policy but there was no up to date infection control audit. However, we saw evidence the Clinical Commissioning Group (CCG) infection control nurse was

scheduled to visit the practice in May 2019.

- There were gaps in infection control training for some clinical and non-clinical staff.
- There was no up to date cleaning schedule for the spirometer. We saw evidence that this had last been cleaned in October 2018. One privacy curtain in the clinical room was not dated and some sharps bins were not labelled. There were insufficient hand gel dispensers situated around the practice.
- The practice did not install privacy curtains in all the clinical rooms due to the way the clinical room lights were laid out. They provided privacy screens instead; however, there was no cleaning schedule provided for these screens to ensure their condition was maintained.
- There were issues identified in relation to managing clinical specimens. For example, one clinician was incorrectly disposing of clinical samples in the sink after testing.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
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.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	N
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Partial
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.	N

Explanation of any answers and additional evidence:

- Although we saw evidence that sepsis had been discussed at a practice meeting, not all clinical and non-clinical staff had received training and not all non-clinical staff we spoke to were able to identify the sepsis red flags.
- There were gaps in basic life support training. On the day of inspection, there had been no child pulse oximeter available at the practice. However, we saw evidence at the end of the inspection

that one had been purchased.

- The practice had not assessed the impact on safety when members of staff raise health concerns that might affect their performance.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment but this system was not monitored effectively.

	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:

- There was no buddy system in place for reviewing pathology results. The practice told us that blood test results were allocated to the individual doctors and a duty doctor would usually review the results in the requesting GP's absence. However, we found that this system was not operating effectively. One abnormal blood test result had not been picked up by the practice when the requesting GP was not present and had only been picked up when the GP returned to work. This resulted in the affected patient being referred to the hospital.

Appropriate and safe use of medicines

The practice did not have effective 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) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.79	0.75	0.91	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). (01/01/2018 to 31/12/2018) (NHSBSA)	14.5%	12.3%	8.7%	Variation (negative)
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 (01/07/2018 to 31/12/2018) (NHSBSA)	5.99	6.32	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	0.72	1.03	2.13	Significant Variation (positive)

Explanation of any answers and additional evidence:

- The practice was aware of their higher than average antibiotic prescribing and the need to improve in this area. They had carried out audits together with the CCG clinical pharmacist. Initial audits had shown that the practice overall antibiotic prescribing rate was higher than average. At the time of inspection, a disease specific prescribing review was due to take place; therefore, there was no evidence available to show how their rate of antibiotic prescribing had improved.

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.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	N
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.	Partial

Explanation of any answers and additional evidence:

- Although there was a system to monitor blank prescriptions, they were left in printers in an unlocked room overnight.
- Although we saw signed Patient Specific Directions, they were not recorded in the individual patient records.
- The practice did not store all appropriate emergency medicines. For example, there was no

Medicines management	Y/N/Partial
atropine (used for low heart rate during coil fittings), dexamethasone (used for croup in children), midazolam (used for epilepsy), opiates (for severe pain) and naloxone (opioid overdose) despite caring for patients with opiate dependence. A risk assessment had not been carried out to determine the range of medicines held. • There was no signage where the oxygen was stored. • The nitrogen (for cryotherapy) was not appropriately stored. There was insufficient ventilation and stored in a store room of unused equipment. A risk assessment had not been carried out to ensure its safe storage. • The vaccines fridge only contained one thermometer and not the recommended two thermometer which included one independent of the mains power. There was no sign on the fridge to prevent it from being accidentally switched off.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	5
Number of events that required action:	4

Explanation of any answers and additional evidence:

- We were not assured that all significant events were being reported and recorded in accordance with the policy. For example, the practice described an event where a patient became unwell in the waiting room and required the use of emergency equipment. This had not been reported as a significant event, despite the significant event policy stating that an emergency involving a patient would be classified as a significant event. Two other significant events relating to patient medical emergencies at the practice had not been reported as such.
- A significant event that occurred in the last year where a patient had been issued the incorrect medicine had not been reported to the National Reporting and Learning System (NRLS). Two other medication errors in the past two years had not been reported to the NRLS. There was no stipulation in the significant event policy for reporting near misses, safety incidents or concerns to the NRLS.
- When we reviewed three of the significant events, we saw evidence of learning. However, the significant event summary analysis in place did not record what learning had taken place.

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

Event	Specific action taken
Clinicians had not appropriately monitored signs of a deteriorating patient	Significant event identified as an oversight, leading to an urgent referral. Clinicians advised to always check and verify the trends of results.
Unable to issue urgent certification due to the relevant clinician's absence and incomplete records.	Certificate eventually issued by an external hospital as clinicians at the practice were not aware of the patient. Family was supported by the practice. Changes put in place that visiting clinician to ring the surgery and provide a handover to the duty clinician.

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

Effective Rating: Good

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.	Y
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

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) (01/01/2018 to 31/12/2018) (NHSBSA)	0.99	0.57	0.79	No statistical variation

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 hospital. Follow up visits were carried out by the GPs and enhanced practice nurses. Integrated care plans were in place and updated. Prescriptions were updated to reflect any extra or changed needs.
- There was close working with the rapid response team and virtual ward.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

People with long-term conditions Population group rating: Good

Findings

- The practice held chronic disease clinics in the summer months to reduce winter pressure. Patients with long-term conditions had 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 hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- There was no 24-hour ambulatory blood pressure monitoring at the practice, patients were referred to an external service. Patients with suspected hypertension were able to check their blood pressure at the practice by using the blood pressure machine in the waiting room.
- Patients with atrial fibrillation were assessed for stroke risk and treated or referred appropriately.

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)	80.1%	79.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.0% (66)	8.8%	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)	76.6%	78.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	5.8% (55)	7.6%	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 5mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	81.3%	80.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.1% (86)	9.6%	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)	79.2%	79.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.5% (11)	4.8%	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)	93.0%	92.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	1.7% (2)	8.3%	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)	81.5%	83.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.5% (66)	3.2%	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)	86.5%	83.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	18.3% (38)	8.2%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- The childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. The practice told us that parents were called or sent text message reminders to encourage attendance and educate them on the benefits of immunisations. All non-attenders were also followed up and appointments were booked in advance.
- 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.
- 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.
- Young people could access services for sexual health and contraception.

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)	147	168	87.5%	Below 90% minimum (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)	130	160	81.3%	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)	129	160	80.6%	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)	125	160	78.1%	Below 80% (Significant variation negative)

Working age people (including those recently retired and students)

Population group rating: Good

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) (01/04/2017 to 31/03/2018) (Public Health England)	62.7%	62.4%	71.7%	Tending towards variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	77.1%	69.4%	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)	54.2%	48.5%	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)	78.3%	75.4%	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)	59.5%	57.9%	51.9%	No statistical variation

Any additional evidence or comments

The practice had taken steps to improve their cervical cancer screening uptake. The practice explained that as they had a large Romanian patient population group, they assigned one of the Romanian speaking practice nurses to invite these patients to attend their screening. The practice also sent text message invites for screening and two of the GPs offered screening. The practice provided unverified data that showed that screening uptake had improved to 73%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

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.
- 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.

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)	95.7%	92.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	12.7% (17)	8.3%	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)	94.0%	92.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	13.4% (18)	6.3%	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)	81.5%	88.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.2% (4)	6.1%	6.6%	N/A

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	CCG average	England average
Overall QOF score (out of maximum 559)	552.8	540.9	537.5
Overall QOF exception reporting (all domains)	5.0%	5.8%	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

- We saw two examples of quality audits, one of which was an ophthalmology (red-eye) audit. The audit was carried out to ensure that 100% of consultations documented the presence or absence of all four red flag symptoms for red-eye. The first cycle audit showed that only four (6%) of the 66 consultations had all the four symptoms checked and documented. Results showed that the practice was falling short of NICE guidelines and improvement was made. At the second cycle audit, the documentation of all four symptoms had increased to 37%. A third cycle to was planned to review whether actions taken were effective.

Effective staffing

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

	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.	Y
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.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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:

- Although there was an induction policy, we did not see completed individual induction records for all three new members of staff.
- The Health Care Assistant (HCA) had not completed the Care Certificate training. The practice provided evidence that showed that they had completed a professional skills for HCA training; however, there was no evidence that this course had met the required standards as laid out in the Care Certificate training.

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)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: • The lead GP and enhanced practice nurses held weekly meetings to review the care plans for housebound patients.	

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

Smoking Indicator	Practice	CCG	England	England

		average	average	comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.2%	96.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (17)	0.6%	0.8%	N/A

Consent to care and treatment

The practice always obtained 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: Requires Improvement

Kindness, respect and compassion

Staff treated patients with 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

CQC comments cards	
Total comments cards received.	14
Number of CQC comments received which were positive about the service.	7
Number of comments cards received which were mixed about the service.	7
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Patients were happy with the care provided and felt staff were caring and helpful. Mixed comments related to issues with access.
Patient interviews	Patients were satisfied overall with the service and felt they were listened to and treated with dignity and respect. However, some patients highlighted issues with some reception staff attitude.

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
14147	304	103	33.9%	0.73%

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)	78.9%	87.4%	89.0%	Tending towards 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)	75.8%	84.6%	87.4%	Tending towards 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)	91.3%	94.6%	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)	72.2%	79.7%	83.8%	No statistical variation

Any additional evidence or comments
• The practice was unable to demonstrate what action had been taken to improve patient experience in relation to listening to patients and treating them with care and concern.

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

Any additional evidence
• The practice carried out their own friends and family test survey, although results were not made available to the inspection team. • There was no suggestion box displayed at the practice.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Patients were satisfied overall with the service and felt they were involved in decisions about their care and treatment.

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)	90.1%	91.7%	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.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	373 carers (3% of the practice population).
How the practice supported carers.	Carers were offered annual health checks, flu immunisations and priority appointments. Carers were referred to the local carers support network.
How the practice supported recently bereaved patients.	The lead GP would usually contact the bereaved family a month later to offer support. These cases were reviewed for any learning.

Privacy and dignity

The practice respected patients' privacy and dignity; however, monitoring was required.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Partial
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

Explanation of any answers and additional evidence:

- The practice did not provide privacy curtains due to the way the clinical room lights were laid out. They provided privacy screens instead; however, we observed that there were no privacy screens in at least three clinical rooms.

Responsive Rating: Requires Improvement

Although we saw examples of some good care, the practice is rated requires improvement for providing safe, caring, responsive and well-led services, which affects all six population groups.

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.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
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 or who had complex needs. They supported them to access services both within and outside the practice.	Y
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:

- **There was an area of notable practice.** The practice worked collaboratively with the consultant cardiologist and the Patient Participation Group (PPG) to host a cardiology event. This event was attended by approximately 300 patients and included a cardiopulmonary resuscitation (CPR) training session. Fifteen boys and girls from the local school who aspired to work in the medical field were invited to this event and were invited to speak to the cardiologist on a one to one basis.
- The practice demonstrated how they assisted patients with a visual impairment and a staff member would at times accompany them to their homes.
- The practice used easy to read visual cards.
- There was no hearing loop installed at both practices.

Practice Opening Times	
Day	**Time**
Opening times Crowshott Avenue:	
Monday	8:00am – 6.30pm
Tuesday	8:00am – 6.30pm
Wednesday	8:00am – 6.30pm
Thursday	8:00am – 6.30pm
Friday	8:00am – 6.30pm
William Drive:	
Monday	8:30am – 2:00pm

Tuesday	8:00am – 6.30pm
Wednesday	8:30am – 2:00pm
Thursday	8:00am – 6.30pm
Friday	8:30am – 2:00pm
Harrow School (not open to whole practice population):	
Monday	7:30am – 10:30am
Tuesday	7:30am – 10:30am
Wednesday	7:30am – 10:30am
Thursday	7:30am – 10:30am
Friday	7:30am – 10:30am
Extended hours at Crowshott Avenue:	
Tuesday	6:30pm – 8:00pm
Saturday (alternate)	9:00am – 10:30am
Extended hours at Harrow School	
Saturday	7:30am – 8:30am

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14147	304	103	33.9%	0.73%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	93.8%	93.3%	94.8%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice looked after two nursing homes and one residential care home and carried out weekly ward rounds.
- The practice enhanced nurses also carried out home visits for patients over 65 years of age.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with members of the multi-disciplinary team including, the consultant cardiologist, local district nursing team and tissue viability nurse to discuss and manage the needs of patients with complex medical issues.
- The practice was proactive in disease prevention and took part in the diabetes prevention programme and screening and exercise on prescription.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice provided care to approximately 800 students at the local school for boys. Patients had access to the surgery GPs and nurses and there was joint working with the child mental health teams and physiotherapists. GP appointments were provided at the school between 7.30am and 10.30am on Monday to Friday and between 7.30am and 8.30am on Saturday. The lead GP was a member of the pastoral committee at the boys' school.
- Additional appointments were available at the main practice until 8.30pm on a Tuesday for school age children so that they did not need to miss school. Nurse appointments were available until 6pm, four days a week.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high

number of accident and emergency (A&E) attendances.

- All parents or guardians calling with concerns about a child were offered a same day appointment or signposted to the walk-in clinic when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients could book appointments online, as well as send prescription queries via email to the practice.
- The practice was open until 8.30pm on a Tuesday at the branch practice. Appointments were available at the main practice on Saturday between 9am and 11am.
- Patients were offered telephone appointments.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. There was a lead GP for learning disability patients. Annual health checks were carried out for patients with a learning disability. They were offered double appointments or home visits.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients had access to a counsellor and in-house mental health nurse. There was joint working with the community mental health team.
- The practice was aware of support groups within the area and signposted their patients to these

accordingly.

Timely access to the service

People were able to access care and treatment; however, this was not always in a timely way.

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	54.8%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	57.8%	64.8%	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)	55.5%	63.1%	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)	70.6%	69.0%	74.4%	No statistical variation

Any additional evidence or comments

The practice had analysed the survey results and took the following action to improve patient access:

- They told us that discussions were underway with their telephone provider, to improve their telephone system and implement alternative line options and introduce a queueing system. This was due be completed in August 2019.

- The practice was developing a new website that would enable online consultations.
- The practice introduced both booked and emergency telephone consultations.
- The practice set up a text message service. This service enabled the practice to send text messages to the patients regarding their blood test results, as well as send an offer of an appointment slot when the patient's review was overdue.

Source	Feedback
For example, NHS Choices	Patient feedback highlighted significant issues with access to appointments at both sites. Some patients expressed concerns with delayed access to nurse appointments, leading to delayed childhood immunisation appointments. Patients also expressed their dissatisfaction with the way complaints were handled at the practice.
Patient interviews	We spoke with three patients who highlighted concerns with patient access. One patient told us that they were unable to get through to the practice telephone after attempting over 100 times. One patient stated that there was a lengthy wait for appointments and felt that more staff were required. Other patients raised concerns with access after trying to book appointments for their cervical smears. Some patients also felt consultation times could be longer.

Listening and learning from concerns and complaints

Complaints were listened and responded to; however, there was limited evidence to show how they were used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	3

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

Explanation of any answers and additional evidence:

- There was no complaints leaflet displayed in the practice.
- There was some evidence of learning from complaints, although this was not always clear. The complaints reviewed on inspection, including the complaints summary and minutes of practice meetings provided by the practice did not provide information relating to what learning had taken place as a result of complaints.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy with how a clinical procedure was undertaken.	The provided a full response to the patient; however, there was no evidence of what learning had taken place as a result of this complaint.
Complaint regarding care provided to a palliative care patient.	Full response provided to the family and learning included undertaking a training session and change of policy.

Well-led Rating: Requires Improvement

Leadership capacity and capability

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

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

Explanation of any answers and additional evidence:

- We found that leaders were aware of the external challenges and priorities relating to the quality and future of services and had taken action where necessary to address these challenges. However, they had not recognised and acted on some current issues with the quality of care provided; particularly, relating to safety and the management of staff. The practice had taken action on some of the areas highlighted at the last inspection; for example, improving the uptake of cervical cytology.
- There was a leadership development programme but evidence was no succession plan.

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.	N
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.	Partial
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

- The practice had a vision and staff were clear that their roles involved meeting patients' needs. They aspired to deliver high-quality care but had not established effective and sustainable systems to deliver it.
- The practice worked with external stakeholders on improvement projects. This included inhouse cardiology events, joint working with network practices, the NHS diabetes prevention programme and medical services to a school.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial

Explanation of any answers and additional evidence:

- The approach to managing staff when their performance was poor was not effective. We were not assured that appropriate action had been taken when to address one staff member's health related poor performance. There were insufficient measures taken to ensure their wellbeing and safety.
- Although there was a whistleblowing policy in place, it did not refer to the NHS Improvement Raising Concerns policy.

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

Source	Feedback
Non-clinical and clinical staff	Staff felt supported and felt they had a good team and communication. However, some staff felt additional staff were required to keep up with the demand for the service.

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.	Partial
There were appropriate governance arrangements with third parties.	Partial

Explanation of any answers and additional evidence:

- The practice was in the process of reviewing all policies due to key staff leaving. Policies such as the child safeguarding policy did not have a review date and had not been signed. The Control of Substances Hazardous to Health (COSHH) and disability access policies were overdue a review since 2017.
- Structures, processes and systems to support good governance were not well embedded in the practice. This included reporting significant events and ensuring that there was a buddy system in place for reviewing pathology results.

- Not all staff were clear on their roles and accountabilities in respect of safeguarding and sepsis awareness.
- Senior staff were not always aware of their responsibilities in relation to changes to staff due to ill health.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	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.	N

Explanation of any answers and additional evidence:

- Assurance systems were not operating effectively. Examples we saw included, recruitment and induction records, staff immunisations, infection control, medicines and significant events.
- Premises risks were not well managed and there was no systematic programme for internal audit. This related to concerns found in relation to fire and health and safety. Actions identified from risk assessments such as the legionella risk assessment had not been carried out, despite the recommendations.
- Staff received appraisals; however, the processes to manage performance were not monitored effectively. There were gaps in mandatory training for both clinical and non-clinical staff, as well as gaps in knowledge of sepsis red flags. Arrangements to manage poor staff performance due to ill health concerns were not implemented effectively throughout the practice.
- Three of the staff we spoke to were not aware of the major incident or business continuity plan in place.

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.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial

Explanation of any answers and additional evidence:

- We saw evidence that steps had been taken to improve the low cervical immunisation uptake. However, there was insufficient evidence to show how the childhood immunisations low uptake and the higher than average antibiotic prescribing data had been used to improve performance.
- Information was not always timely. Examples included the delay in reviewing a pathology result due to the lack of a buddy system in place and the recommended actions from risk assessments not being carried out in a timely manner.

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, improvement was required.

	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.	Y

Explanation of any answers and additional evidence:

- We saw examples of notable practice where the practice worked collaboratively with the consultant cardiologist and the Patient Participation Group (PPG) to deliver a cardiologist-led event, which included a cardiopulmonary resuscitation (CPR) training session and an open invitation to children aspiring to work in the medical field.
- The practice was unable to demonstrate what action had been taken to improve patient experience in relation to listening to patients and treating them with care and concern.

Feedback from Patient Participation Group.

Feedback
We saw evidence that the PPG was actively involved with the practice. They worked with the practice to create newsletters and leaflets for their flu campaigns. They also worked with the practice to organise an evening cardiology event, in conjunction with the consultant cardiologist.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and

innovation; however, they were not implemented effectively.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: • We saw some evidence of continuous improvement and this included providing care for patients in their community. However, there was little evidence of learning and improvement in relation to the safety systems of the practice.	

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)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.