

Care Quality Commission

Inspection Evidence Table

Peel Precinct Surgery (1-6585753199)

Inspection date: 29 May 2019

Date of data download: 29 May 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial ¹
There were policies covering adult and child safeguarding.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial ²
There was active and appropriate engagement in local safeguarding processes.	Partial ³
There were systems to identify vulnerable patients on record.	Partial ⁴
There was a risk register of specific patients.	Partial ⁵
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Partial ⁶
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 ⁷
Explanation of any answers and additional evidence: 1. We were not assured that safeguarding systems and practices were fully developed and implemented in a way that kept people safe. The Lead GP had sole oversight of the safeguarding processes and we found some gaps in its management.	

Safeguarding	Y/N/Partial
<p>2. The practice was unable to provide evidence that a practice nurse, who commenced employment in November 2018, had undertaken safeguarding children and safeguarding adult training. We spoke with the practice nurse who told us she thought they had undertaken training prior to joining the practice but were unsure of the level and had been unable to locate the certificates. We saw that the GPs had been trained to safeguarding children level 3. The practice was not aware of the recent intercollegiate guidance update regarding training requirements for some clinical and non-clinical staff.</p> <p>3. The Lead GP told us he would provide a safeguarding report if requested. There had been no recent safeguarding concerns recorded. Therefore, we could not review what systems the practice had in place to share reports and learning from safeguarding incidents with staff.</p> <p>4. The practice provided a vulnerable children risk register of 25 patients of which we reviewed 12 patients. We found that the clinical records of five patients did not have the appropriate safeguarding flags which would instantly alert someone who did not know the patient, such as a locum doctor, that there were safeguarding concerns for the child or the family. The practice did not have a system in place to share safeguarding information with out of hours services and were not aware of how other services would identify patients who were on their safeguarding register.</p> <p>5. The practice provided a list of 20 patients on their learning disability register but could not demonstrate that other vulnerable adults had been appropriately coded (identified on the clinical system), for example, female genital mutilation (FGM).</p> <p>6. We saw evidence that non-clinical staff had undertaken on-line chaperone training. However, a member of staff we spoke with was unsure where to stand to observe an examination or procedure and indicated that they would stand outside the curtained area.</p> <p>7. The practice did not hold regular multi-disciplinary meetings with health visitors due to limited resources but told us there was a named health visitor for the practice should they need to liaise.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial ²
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial ³
Staff had any necessary medical indemnity insurance.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1. We reviewed recruitment records for two non-clinical and one clinical member of staff who had been recruited since our previous inspection in 2017 and found gaps in the checks for a practice nurse recruited in December 2018 which included a CV, interview summary, photo-ID, references and hepatitis B status.</p> <p>2. The practice manager was aware of the requirement to maintain a record of staff immunisations in line with the 'Green Book' guidance. However, there was a gap in the record for one of the practice nurses.</p> <p>3. The practice manager told us the registration status of clinical staff was checked at the time of recruitment and we saw the professional registration of a recently recruited practice nurse had been recorded. However, no system had been established to check and monitor these regularly. The practice manager told us she planned to do this annually.</p>	

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: 01.01.19	Yes
There was a record of equipment calibration. Date of last calibration: 08.01.19 and 11.01.19	Yes
There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire alarm maintenance checks. Date of last check: 03.12.18	Yes
There was a record of fire extinguisher checks. Date of last check: September 2018	Yes
There was a log of fire drills. Date of last drill: March 2019	Yes
There was a record of fire alarm checks. Date of last check: 23.05.19	Yes
There was a record of fire training for staff. Date of last training: Variable (on-line training)	Yes
There were fire marshals.	Partial ¹
A fire risk assessment had been completed. Date of completion: 25.09.2018	Yes
Actions from fire risk assessment were identified and completed.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice manager told us that the Lead GP was the fire marshal. However, it was unclear who would act as a fire marshal if the nominated marshal was not at the practice. All staff worked part-time. 2. A recent fire risk assessment included an action plan of 13 points with recommended timeframes for completion. The plan had not been completed with the date each action had been addressed. We asked the Lead GP for an updated plan which indicated completion dates, but we were told no actions had been taken to date. We did not further review the action plan. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 01.03.19	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01.03.19	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A legionella risk assessment had been undertaken on 6 March 2019 which included an action plan. The Lead GP told us that no actions had been taken to date. For example, the risk assessment noted that the temperature of some of the hot water outlets were too low and were in a temperature range for legionella bacteria to grow. The practice was unaware of the guidance for the temperature 	

of hot water for healthcare premises. A water sample test undertaken at the time of the legionella risk assessment was negative.

- We saw evidence of an electrical fixed installation condition report undertaken on 10.09.18 and boiler maintenance had been undertaken on 25.04.19.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit:	13.03.19
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • An infection prevention and control (IPC) audit had been undertaken by the Primary Care IPC Team on 28 March 2019. We reviewed the action plan and found some of the actions had not been addressed. For example, a recommendation had been made for the Lead GP to register with TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) within a two-week timeframe and a four-week timeframe to complete the self-assessment check list. When we spoke with the Lead GP about what toolkits were used to support antimicrobial stewardship, for example TARGET, he had not heard of this. • The practice had implemented a cleaning schedule log for medical equipment requiring cleaning, for example, ear irrigator, but this was not equipment specific. The practice nurse we spoke with was unaware of the equipment cleaning log or the need to maintain a record when individual equipment had been cleaned. • The practice told us that the two practice nurses, who worked five hours each per week on alternate days, were the IPC leads. However, the practice nurse we spoke with on the day was not aware that this was their role. The IPC policy indicated that the principal lead had overall clinical responsibility for IPC. 	

Risks to patients

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

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

There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	No ⁶
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial ⁷
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The Lead GP worked 11 clinical sessions per week which included Saturday morning. A female GP worked one session per week. When the Lead GP was on scheduled leave the practice engaged a locum which was arranged by the Lead GP. The practice told us it was a different locum each time. It was not clear if the practice had considered the resilience of this arrangement and how the practice would respond if the Lead GP was unable perform his clinical responsibilities at short-notice, as all support staff were part-time. 2. We saw induction paperwork for recently recruited clinical and non-clinical staff but some staff who had received an induction were still unclear around how to appropriately raise the alarm in an emergency and some role-specific responsibilities. We saw that the practice had a locum induction pack. 3. We found that the outcomes of some risk assessments undertaken to ensure the safety of the premises for patients and staff had not been actioned, for example the legionella risk assessment. 4. There were wall-mounted panic alarms in the clinical rooms, but these were positioned behind where the patient sat and so were not easily accessible in an emergency. Not all staff we spoke with were aware of the panic alarm system via the clinical system. All staff we spoke with knew the location of the emergency medicines and equipment. 5. Reception staff we spoke with, when prompted, recalled that they had received sepsis training and were aware of 'red flag' symptoms. Staff told us they would contact a GP or nurse immediately if they had any concerns. Reception staff were able to see all patients in the waiting room from the reception desk. 6. There was no sepsis protocol or formal systems in place to enable assessment, for example, link to NICE guidance or the Royal College of General Practitioners (RCGP) sepsis toolkit. We were unable to determine, therefore, how other GPs who worked at the practice would access best practice guidance. 7. The practice had recently moved premises and recruited new staff which had resulted in some systems and process, which had been in place at our previous inspection, lapsing, for example systems to safety-net two-week wait referrals. 	

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial ²

Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	No ³
There was a system to monitor delays in referrals.	No ³
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial ⁴

Explanation of any answers and additional evidence:

1. The practice utilised an approved software platform that managed incoming clinical correspondence. The Lead GP told us that all correspondence, both paper and electronic, was reviewed and actioned by him. We saw that there were 458 active electronic documents on the system with the oldest dated August 2018. The Lead GP told us that all correspondence now came electronically and so duplicated some correspondence received in paper copy. However, the practice did not have a system in place to check and 'file' all duplicate correspondence or review correspondence which had only been received electronically. The practice could not tell us how much of the correspondence had not been seen and/or actioned. We reviewed the active documents summary and saw that the correspondence included discharge summaries, clinic letters, general administrative correspondence and national screening correspondence. We selected 10 documents which related to a discharge summary or clinic letter and reviewed the patient medical record to ascertain if it had been seen and actioned, where appropriate. We found a patient discharge summary from 15 May 2019 with a request to change medication, but this was not on the clinical system, there was no indication that it had been seen and checked and the medicines had not been updated.
2. We saw that the practice provided relevant information in referral letters when patients were referred to other services. However, the practice had been unable to demonstrate an effective system to flag safeguarding concerns in the clinical system and there was a backlog of reviewed and actioned patient correspondence. As such, we could not be assured that staff and other agencies had all the information to enable them to deliver safe care and treatment.
3. The Lead GP and the practice manager told us that there was no log maintained or failsafe system in place to manage and monitor urgent two-week wait referrals. We saw that Public Health England (PHE) data available for 1 April 2017 to 31 March 2018 for the number of new cancer cases treated (detection rate % of which resulted from a two-week wait referral) was zero per cent (CCG average 55.2%; England average 51.9%). The practice was not aware of this data.
4. The Lead GP told us that he reviewed and managed all test results daily. We reviewed the clinical system and found 36 urgent (red flagged) test results on the system from the previous two days. We did not review these individually. In addition, we were told there was no failsafe system in place to manage and monitor cervical smear screening. The practice had two practice nurses both working five hours per week on separate days. The practice nurse we spoke with on the day did not have a system in place to monitor the smears undertaken. She told us results were reviewed by the Lead GP.

Appropriate and safe use of medicines

The practice did not have 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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.87	0.58	0.88	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). (01/04/2018 to 31/03/2019) (NHSBSA)	20.6%	10.5%	8.7%	Significant 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 (01/10/2018 to 31/03/2019) (NHSBSA)	6.70	5.89	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	4.01	1.06	2.07	Tending towards variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	No ¹
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.	No ²
There was a process for monitoring patients' health in relation to the use of medicines	Partial ³

Medicines management	Y/N/Partial
including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No ⁴
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Not asked
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.	No ⁵
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial ⁶
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice did not have a system in place to monitor uncollected paper prescriptions to ensure that prescribers had the relevant information available at the time of a medication review or when prescribing medication. There was no process in place to ensure vulnerable patients collected their prescriptions regularly. 2. The practice did not have a system in place to review electronic discharge summaries received and so could not demonstrate the effective management of information about changes to a patient's medicines including changes made by other services. 3. The practice had an undated protocol for the high-risk medicine monitoring but there was no consistent system in place for monitoring patients. On review of patients on high-risk medicines, we found that some patients had not received the appropriate monitoring and clinical review prior to prescribing. We were told by the Lead GP that there was no process in place to ensure high-risk medicines prescribed or administered in secondary care were visible on the clinical system to ensure patient care could be managed safely when additional medicines were prescribed in the practice. 4. The practice did not monitor the prescribing of controlled drugs and had not undertaken any audit. We found a patient receiving a controlled drug since 2009 with no clear indication on their records to explain the reason for its use. 5. The Lead GP was not aware that the antibiotic prescribing of the practice was significantly different from the CCG and England averages. We were told he did not look at prescribing data from the medicine optimisation team and had not undertaken any antibiotic audits. In addition, he had not heard of TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) and did not use any toolkit to support antimicrobial stewardship. 	

Medicines management	Y/N/Partial
6. The practice told us that they checked the defibrillator and oxygen cylinder monthly. On the day of the inspection we could not locate the log sheet. We found the defibrillator to be in working order and the oxygen cylinder to be full and adult and child masks were available.	

Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial ¹
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial ²
Number of events recorded in last 12 months:	3
Number of events that required action:	3

Explanation of any answers and additional evidence:

1. We were not assured that systems to learn and make improvements when things went wrong were fully developed and implemented. The Lead GP told us he was aware that there was a backlog of electronic documents to be reviewed and non-clinical staff told us that some systems and processes had lapsed since the move to the new premises, for example checking uncollected prescriptions. However, these had not been raised and discussed as incidents. Staff we spoke with told us they would tell the Lead GP if there was an incident. However, none of the staff we spoke with had needed to raise an incident. All three significant events had been raised and completed by the Lead GP.
2. We saw that significant events had been discussed and minuted in a meeting held in January 2019 but not all staff attended meetings and/or had seen the minutes.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	No ²

Explanation of any answers and additional evidence:

1. The Lead GP told us he relied on patient safety alert updates through the CCG's 'Prescribing Snippets Bulletin' received by email. The GP kept a spreadsheet of alerts which we reviewed but could not see any evidence of action taken, for example a patient search, for those alerts potentially relevant to the practice service type and patient population. We specifically asked the Lead GP about two recent alerts relevant to primary care. He was not aware of one of these alerts and told us that no action had been taken for either of them.
2. The practice manager was unsure of the procedure for managing patient safety alerts and told us the Lead GP managed them. The practice nurse we spoke with did not know the procedure and had not received any alert updates. We asked the practice nurse if she attended meetings where these might be discussed. She told us she did not attend any meetings and had not been given any minutes of meetings.

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

Patients' were not assessed, and care and treatment was not 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.	No ¹
Patients' treatment was regularly reviewed and updated.	No ²
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Partial ³
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Explanation of any answers and additional evidence:

1. The practice could not demonstrate a system in place to keep clinicians up-to-date with current evidence-based practice. We discussed and reviewed the management of care with the Lead GP and found he was not aware of some current evidence-based guidance. For example, that patients who receive treatment (steroids) in hospital or through out-of-hours services for an acute exacerbation of asthma should be followed-up by their own GP practice within two working days of treatment.
2. The practice did not have a process in place to recall patients systematically and the Lead GP told us patients were seen opportunistically. The Quality and Outcomes Framework (QOF) triggered the practice to see patients towards the end of the financial year. The practice's achievement for QOF for 2017/18 was 93.8% (524.5 out of 599 QOF points available) which was comparable with the CCG average of 96% and England average of 96.4%. Overall exception reporting was 6.3% (CCG average 5.9%; England average 5.8%). We noted that some clinical indicators had high exception reporting, For example:
 - Heart failure 20% (CCG average 6.8%; England average 8.5%).
 - Peripheral arterial disease 16.7% (CCG average 6.6%; England average 5.8%).
 - Stroke and transient ischaemic disease 24.1% (CCG average 10.9%; England average 10.1%).
 - Chronic obstructive pulmonary disease 28.6% (CCG average 11.8%; England average 12.6%).
 - Mental health 16.1% (CCG average 6.8%; England average 11%).

We asked the Lead GP if he could access the clinical system to review QOF outcomes, including QOF data for 2018/19, to see if there had been improvements in any of the clinical indicators and to review exception reporting. We were told he did not know how to access the clinical system to demonstrate this. As such, we were not able to ascertain if there had been improvement and if the exception rates had been justified. The practice was able to tell us that overall QOF attainment for 2018/19, which was currently unvalidated, was 499/599 QOF points which was a reduction in attainment on the previous year.

3. We saw some examples that patients had been referred to other services with appropriate information, but we could not be assured that all patients were referred in line with best practice guidelines or that referral systems and processes were safe and effective.

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) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.56	0.40	0.77	No statistical variation

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice told us it had a proactive approach to managing this cohort of patients. However, it was not possible to determine this as the practice could not demonstrate that it systematically provided follow-up after hospital discharge as there was a backlog of electronic discharge letters and we were told patients were seen opportunistically as there was no formal recall process. The practice told us they referred into the STARRS (short-term assessment, rehabilitation and reablement service) which was a rapid response service for patients in crisis or at urgent risk of hospital admission. The Lead GP could not demonstrate an automatically generated screening score for frailty, but we were able to see an example of one patient where the risk had been calculated on a template.

People with long-term conditions

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice could not demonstrate that it was systematically providing patients with long-term conditions a structured annual review to check their health and medicines needs were being met. The Lead GP told us patients were predominantly seen opportunistically. The Lead GP was unaware of current guidance to follow-up on patients who had received treatment (steroids) in hospital or through out of hours services for an acute exacerbation of asthma. Patients with suspected hypertension were not consistently offered ambulatory blood pressure monitoring in line with guidance. The Lead GP told us he had his own way of diagnosing hypertension. Patients were told to come to surgery over a two-week period and use the waiting room blood pressure monitor and give the result to the receptionist to be documented. The practice could not demonstrate that all staff who were responsible for reviews of patients with long-term conditions, for example asthma, diabetes and chronic obstructive pulmonary disease (COPD) had received appropriate and up-to-date training.

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) <small>(QOF)</small>	63.6%	77.0%	78.8%	Tending towards variation (negative)

Exception rate (number of exceptions).	10.0% (11)	11.4%	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) <small>(QOF)</small>	90.3%	79.3%	77.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	6.4% (7)	8.1%	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) <small>(QOF)</small>	73.5%	78.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	10.9% (12)	8.9%	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) <small>(QOF)</small>	85.5%	78.9%	76.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	0 (0)	2.6%	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) <small>(QOF)</small>	95.7%	93.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	20.7% (6)	9.5%	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) <small>(QOF)</small>	84.0%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.8% (6)	3.7%	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)	75.0%	85.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	10.6%	6.7%	N/A

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The Lead GP told us he followed-up on failed attendance for immunisation and secondary care by phone, text or letter. The practice nurse we spoke with told us they did not follow-up on any patients as it was done by the GP. It was not possible to ascertain if failed attendance of children's appointments following an appointment in secondary care were effectively followed-up as there was a backlog of electronic correspondence.
- The practice provided intrauterine contraceptive device (IUCD) insertion and removal, contraceptive implants and chlamydia screening.

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)	21	22	95.5%	Met 95% WHO based target (significant variation positive)
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)	6	6	100.0%	Met 95% WHO based target (significant variation positive)
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)	6	6	100.0%	Met 95% WHO based target (significant variation positive)
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)	6	6	100.0%	Met 95% WHO based target (significant variation positive)

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice told us they did not routinely undertake NHS health checks for patients aged 40 to 74 as this was no longer funded separately. The practice did not have systems in place to support the national screening programme, for example breast and bowel screening, including the follow-up of people who did not attend or engage. Data available showed that patient take-up was lower than the local and national averages. For example, females, 50-70, screened for breast cancer within six months of invitation was 32.6% (CCG average 52.6%; England average 60.5%) and persons, 60-69, screened for bowel cancer within six months of invitation was 31.1% (CCG average 41.4%; England average 53.3%). Patients could book and 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)	64.3%	63.7%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	35.8%	61.8%	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)	36.4%	42.0%	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)	66.7%	79.2%	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)	0.0%	55.2%	51.9%	Significant Variation (negative)

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> We saw that there were 40 patients on the cancer register but there was no up-to-date palliative care register and no evidence that these were discussed at meetings. We looked in the clinical system at two patients on the palliative care register, but it was unclear why they were on the register. The practice had a register of patients with a learning disability. We were told there were no drug-dependant patients or homeless patients registered with the practice.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice told us that patients at risk of dementia were offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral to the memory clinic for diagnosis. We saw an example of a referral with appropriate blood tests.
- The practice had four dementia patients coded on their register. The practice told us patients were seen opportunistically for care planning. We saw an example of recent care plan.
- The practice told us that patients diagnosed with depression were seen for review twice a year but said they were not meeting the target to review patients with a new diagnosis of depression within 10-56 days after diagnosis. Data showed that the practice had attained 53.3% (CCG 64.4%; England average 65.1%).
- The practice told us they referred patients to the mental health crisis team and the STARRS service for patients believed to be at risk of suicide or self-harm.

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)	100.0%	88.6%	89.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	11.1% (1)	7.1%	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)	100.0%	90.4%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	11.1% (1)	5.8%	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%	84.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	4.1%	6.6%	N/A

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)	524.5	536.7	537.5

Overall QOF exception reporting (all domains)	6.3%	5.9%	5.8%
-----------------------------------------------	------	------	------

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice provided a selection of single-cycle medicine optimisation audits undertaken as part of the Brent CCG 2017/18 prescribing QIPP (quality, innovation, productivity, prevention) initiative. The practice provided a two-cycle audit undertaken in May and December 2017 for women with gestational diabetes which it had provided at our previous inspection. This audit had not been repeated. The practice provided two single-cycle audits undertaken in February 2019 on diabetic patients with CKD 3-5 and outcomes of patients who had been seen for minor surgical procedures, IUCD insertion and removal, and contraceptive implants. It was not clear if there was a plan to repeat these audits. The Lead GP, as part of a clinical record-keeping performance review with NHS England, had undertaken some notes audits in conjunction with GP peer support meetings. We saw: <ul style="list-style-type: none"> The first audit undertaken on 26 February 2019 was to audit consultations with read coded problems recorded in the 'problem' section of the consultation. A random selection of 10 consultations found that zero records were read coded. The GP reflected on the audit that he was not aware that patient consultations should be read coded. A re-audit was undertaken on 26 March 2019 and reviewed the records of patients seen between 26 February 2019 and 26 March 2019. The results showed that of 370 consultations, 248 consultations included a read code (67% of consultations). A recommendation in the audit was to re-audit every 6-8 weeks.

Effective staffing

The practice was unable to demonstrate that all 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.	Partial ¹
The learning and development needs of staff were assessed.	Partial ²
The practice had a programme of learning and development.	Partial ²
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of	Yes

professional revalidation.	
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The practice could not demonstrate that all staff who were responsible for reviews of patients with long-term conditions, for example, asthma, diabetes and chronic obstructive pulmonary disease (COPD) had received appropriate and up-to-date training. We spoke with a practice nurse who told us she undertook diabetes and asthma reviews. However, we could not find any evidence of asthma training and no up-date training for Diabetes since April 2016. 2. The practice had a schedule of mandatory training and told us training and development was identified at induction and appraisal. However, we found some gaps in training records and some training had been completed on the day of our inspection. 	

Coordinating care and treatment

Staff did not consistently work 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)	No
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice could not demonstrate that regular meetings were held to discuss patients on the palliative care register. • The practice could not demonstrate a coordinated approach to the management of patients including regular and minuted multi-disciplinary meetings or that accurate information was available and shared with relevant professionals as systems and process to ensure patient information in the clinical records was up-to-date were ineffective. • The practice told us they referred patients where appropriate, for example to the STARRS (short-term assessment, rehabilitation and reablement service) which was a rapid response service for patients in crisis or at urgent risk of hospital admission. 	

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.	Partial ¹

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice told us they did not systematically offer health checks for people aged 40-74 as this was no longer funded separately. We saw evidence that carers had been identified and there were systems in place to signpost to relevant services. 2. The practice offered smoking cessation advice at the practice. However, the practice did not have systems in place to support the national screening programme, for example breast and bowel screening, and were not aware that patient outcomes were lower than local and national averages. We noted that in the backlog of electronic correspondence there were patient letters in relation to national screening programmes. 	

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) <small>(QOF)</small>	96.6%	95.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (1)	0.6%	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	No ¹
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Staff told us that they recorded consent, for example minor surgery but there was no system in place to monitor this. We noted that the Lead GP had undertaken an audit of minor surgery and contraceptive services, but these did not include a review of consent sought and recorded. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	47
Number of CQC comments received which were positive about the service.	47
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	All 47 comment cards received contained positive feedback. Patients commented that they thought the practice was excellent and a very good service. They said staff were professional, supportive, caring and friendly.
Patient Interviews	Patients we met on the day of the inspection spoke highly about the surgery and the Lead GP. They told us they could access appointments when they needed them. They felt the GP was very thorough and involved them in their treatment and care. They felt staff were friendly and approachable and treated them with dignity and respect.

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
1592	392	61	15.6%	3.83%

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)	79.8%	85.6%	89.0%	No statistical variation
The percentage of respondents to the GP	83.0%	82.8%	87.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)				
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)	92.8%	93.1%	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)	75.2%	78.2%	83.8%	No statistical variation

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

Any additional evidence

The practice had participated in an independent survey of patient feedback with outcome data dated March 2018 from 45 patients providing feedback in June 2017. Questions included patient satisfaction about the practice, the doctors and nurses and staff. An overview of the results showed:

- 72% of patients were satisfied with the visit to the doctor/nurse.
- 76% of patients were satisfied with the doctor/nurse's ability to listen.
- 76% of patients had confidence in the doctor/nurse's ability.
- 67% of patients were happy with the amount of time given at the visit.
- 76% would recommend the surgery to friends.

The practice sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period March to May 2019, based on 71 responses, showed that 63% of patients would be extremely likely or likely to recommend the service.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
CQC Comment Cards	Patients said they felt listened to by the doctor and they were treated with dignity and respect.

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)	88.5%	89.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff spoke several languages to assist patient whose first language was not English, which included Urdu, Hindi, Punjabi and the Arabic language. British Sign Language (BSL) interpreters were available, if required and the practice had installed a hearing loop for those with a hearing impairment. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 31 carers, which was approximately 2% of the practice population.
How the practice supported carers.	<ul style="list-style-type: none"> The practice told us they identified carers at the point of registration and on an on-going basis through clinical consultations. There was a carers' information in the waiting area and information on the practice website. The practice offered extended appointments and influenza vaccination for carers.
How the practice supported recently bereaved patients.	The practice would offer telephone support, a consultation or home visit. The practice told us they would signpost patients to the appropriate support services. Bereavement guidance was also available on the practice website, which had the functionality to translate to other languages.

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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes

A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a large waiting room and chairs were positioned away from the reception desk. We observed that computer screens were not visible to anyone standing at the reception desk and there was no patient identifiable information on view. We saw that equality and diversity training and privacy and dignity training was included for all staff as part of the mandatory training schedule. 	

Responsive

Rating: Inadequate

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.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Saturday	9am to 11am
Appointments available:	
Monday	8.30am to 11am and 4pm to 6.30pm
Tuesday	8.30am to 11am and 4pm to 6.30pm
Wednesday	8.30am to 11am and 4pm to 6.30pm
Thursday	8.30am to 11am and 4pm to 6.30pm
Friday	8.30am to 11am and 4pm to 6.30pm
Saturday	9am to 11am
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Patients were unable to access the surgery in person during normal core working hours of 8am to 8.30am. 	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1592	392	61	15.6%	3.83%

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)	94.2%	91.3%	94.8%	No statistical variation

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. Staff told us they were responsive to the needs of older patients and offered home visits, urgent and same day appointments for those with enhanced needs and complex medical issues. 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. There was a medicines delivery service for housebound patients through arrangements with the local pharmacy.

People with long-term conditions

Population group rating: inadequate

Findings
<ul style="list-style-type: none"> We were told that patients with multiple conditions had their needs reviewed in one appointment. The practice could not demonstrate that it liaised regularly with the local district nursing team and community matrons or engaged in local multi-disciplinary team meetings and the complex patient management group (CPMG) to discuss and manage the needs of patients with complex medical issues or people with long-term conditions approaching the end of life.

Families, children and young people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> The practice told us they followed up on 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. However, we were unable to determine if systems and processes were effective as there was a backlog of electronic discharge summaries and not all vulnerable patients were appropriately coded on the clinical system. The practice told us that all parents or guardians calling with concerns about a child were offered a same day appointment when necessary. Patients we spoke with confirmed appointments were available and children were seen on the day.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> 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. The practice was open on Saturday from 9am to 11am for those patients unable to attend during the weekdays.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The practice held a register of patients living in vulnerable circumstances, which included those with a learning disability. However, not all registers were up-to-date and appropriately flagged on the clinical system. • The practice told us they adjusted the delivery of its services to meet the needs of patients with a learning disability and offered carers appointment time that were convenient. • The practice accessed interpreter services and staff spoke languages which aligned to the patient demographic. • The practice had recently moved to new premises and consideration had been made for those patients with complex needs, for example accessibility for wheelchair users.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The practice was unable to demonstrate the responsive and proactive identification and management of vulnerable patients such as homeless and drug-dependant patients. • The practice could not demonstrate systems in place to follow-up on patients who failed to attend appointments, including secondary care appointments. • The practice told us that priority appointments were allocated when necessary to those experiencing poor mental health and dementia. • 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 in a timely way.

National GP Survey results

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

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)	92.8%	N/A	70.3%	Variation (positive)

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)	92.5%	63.3%	68.6%	Tending towards variation (positive)
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)	93.5%	65.0%	65.9%	Variation (positive)
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)	90.7%	67.4%	74.4%	No statistical variation

Source	Feedback
Patient interviews	Patients told us they were able to get appointments when they needed them, both routine and urgent and included Saturday morning appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No measurable
Explanation of any answers and additional evidence:	
The practice had only recorded one complaint in the last 12 months and so it was not possible to conclude that complaints were used to drive improvement.	

Example of learning from complaints.

Complaint	Specific action taken
GP clinic over-ran and patient appointment delayed.	To remind staff to advise patients when appointments were running late.

Well-led

Rating: Inadequate

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The Lead GP demonstrated awareness of the challenges to delivering care as a single-handed clinician. However, he could not demonstrate the capacity to prioritise safety and quality improvement. There was a poor track record in terms of maintaining improvement from previous inspections and some systems and processes had lapsed when staff had left and with the relocation to new premises.• The provider had failed to inform and submit registration paperwork to CQC when the location where regulatory activities were carried out changed. When prompted the provider submitted registration paperwork and the premises were inspected by the registration team and the location was formally registered.• The practice had recruited a practice manager in March 2019 who worked five hours per week. They told us they had focused on preparing the practice for the CQC inspection and had helped address the recommendations of the CQC registration inspection in March 2019. We noted that the new practice manager was the third since our last inspection in December 2017. At the time of our last inspection the practice manager had commenced on the day of our inspection. In October 2018, when we had contacted the practice regarding the change of location, we found the previous practice manager had left and there was a part-time practice manager who assisted the practice submit the CQC location registration paperwork. This person had since left the practice.• We found the practice was reactive rather than proactive and some actions had been undertaken immediately ahead of the inspection. For example, we saw that a clinical member of staff who had commenced in November 2018 had completed training considered mandatory (information governance and fire safety) on the day of our inspection.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy. Deficiencies in governance and oversight undermined the practice's ability to achieve their vision.

	Y/N/Partial
The practice had a clear vision and set of values.	Yes
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving	Partial

them.	
Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice described their vision as a 'holistic approach to achieving high quality health care outcomes from our inner-city populations. We promote and value continuity of care. Excellent patient care and high standards of service is out top priority.' Their mission was to 'provide excellence in responsive and anticipatory patient centre care by empowering our population, team and stakeholders to attain their potential through multi-professional education, collaborative working and use of information technology. We found that there was a lack of oversight in key areas relating to the safety systems in place, staff provision, and governance structures all of which had the ability to compromise the quality of care provided by the practice and impact on its vision, aims and objectives. Staff we spoke to were aware of the aim of the practice but were not involved in the creation of the strategy. We spoke with members of the patient participation group who told us they had felt involved with the planning and move to the new location. 	

Culture

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

	Y/N/Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was an emphasis on the safety and well-being of staff.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw that staff had access to training on health and safety, moving and handling, display screen equipment (DSE) and bullying and harassment training as part of the mandatory training schedule for the well-being of staff. There was a duty of candour policy which was available to staff. However, not all staff we spoke with understood the term duty of candour. When prompted staff told us they felt the practice was open. There was a whistleblowing policy and staff we spoke with understood the meaning of whistleblowing and felt they could raise concerns. 	

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

Source	Feedback
Staff interviews	Staff we spoke with told us they felt supported by the Lead GP.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial

Explanation of any answers and additional evidence:

- We found that structures, processes and systems to support good governance were not effective. The Lead GP had sole oversight of all processes. The clinical and non-clinical support team were all part-time. In particular, we found concerns around the management and monitoring of safeguarding, recruitment, premises risk assessments, urgent two-week wait referrals, cervical smear screening, prescribing, repeat prescriptions, incoming electronic patient-related correspondence, high-risk medicines, significant events and patient safety alerts.
- There was no regular meeting structure and not all staff attended meetings and had not seen minutes of meetings.

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.	No
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Partial
Explanation of any answers and additional evidence:	
<p>We were not assured that comprehensive and effective systems and process were in place and regularly reviewed to manage risk and performance. We found:</p> <ul style="list-style-type: none"> • The practice had done some clinical audit through the CCG QIPP initiative and the Lead GP had undertaken some clinical note audits as part of a performance review with NHS England. However, there was no programme of quality improvement, including clinical audit, to drive improvements. • The practice did not have effective systems in place to learn and make improvements when things went wrong. The Lead GP told us he was aware that there was a backlog of electronic patient-related correspondence and had commenced an audit of his clinical record keeping as part of a performance review, but this had not triggered a potential risk in patient care and was not investigated as a significant incident. • The practice had appropriate emergency medicine and equipment, but we found that basic life support training had lapsed from the annual recommended training requirement for a GP, wall-mounted panic alarms in the clinical rooms were not appropriately positioned and not all staff knew how to activate the panic alarm within the clinical system. 	

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.	No

Our inspection indicated that information was accurate, valid, reliable and timely.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was aware of their QOF achievement but there were no systematic processes to manage patient outcomes on an ongoing basis through a structured recall system. The practice was not aware of their achievement for antimicrobial prescribing and local benchmarking through the medicine optimisation team or outcomes through national cancer screening programmes. 	

Engagement with patients, the public, staff and external partners

The practice involved the public, external services and staff in sustaining high quality care at the practice.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice reviewed patient feedback through the NHS Friends and Family Test, national GP patient survey and had undertaken an independent survey of patient satisfaction. The practice had worked with stakeholders, for example Brent Council, NHS England, the Clinical Commissioning Group (CCG) and the patient participation group in the move to a new location. The practice was in an established Primary Care Network (PCN) with five other local practices. 	

Feedback from Patient Participation Group (PPG).

Feedback
The practice had an active PPG of approximately 20 members who met quarterly. We met with five members on the day of the inspection who told us they felt involved in the planning and delivery of services. In particular, they had been active in the planning for the relocation to new premises.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: <p>We were not assured that systems and process for learning and continuous improvement were fully developed and implemented. For example, following our previous inspection in December 2017 the provider submitted an action plan of how it had addressed the findings of the inspection with regards safe and appropriate recruitment checks. This included maintaining interview records, confirming proof of identity and obtaining at least two references. At this inspection we found the practice could not</p>	

demonstrate an up-to-date CV, interview summary, photo-ID and references for a practice nurse who commenced in November 2018.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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