

Care Quality Commission

Inspection Evidence Table

Jai Medical Centre (Brent) (1-545851372)

Inspection date: 1 October 2019

Date of data download: 28 October 2019

Overall rating: add overall rating Inadequate

The practice is rated as inadequate overall because patients were at risk of avoidable harm and the practice had not identified gaps in its clinical governance. There were weak systems in place to share information and learning with staff.

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

Safe

Rating: Inadequate

The practice was rated inadequate for providing safe services because:

- The practice did not have appropriate systems in place for the safe management of medicines.
- The practice did not have effective systems in place to follow-up urgent referrals.
- The practice did not have an effective system to learn and make improvements when things went wrong.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice provided evidence of a recent safeguarding concern they had referred immediately to the appropriate agency for follow-up. • Aside from information recorded in individual patient records, there were few formal mechanisms for sharing information within the practice about current safeguarding cases and concerns, for example at documented clinical meetings. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: The partners ran four practices across North and West London. They were able to use regular, locum GPs to cover absence.	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test:</p> <ul style="list-style-type: none"> Stag Holyrood surgery: 04/07/2019 Sheldon surgery: 27/09/2019 	Yes
<p>There was a record of equipment calibration.</p> <p>Date of last calibration:</p> <ul style="list-style-type: none"> Stag Holyrood surgery: 14/02/2019 Sheldon surgery: 27/09/2019 	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
<p>There was a record of fire extinguisher checks.</p> <p>Date of last check: 24/09/2019</p>	Yes
<p>There was a log of fire drills.</p> <p>Date of last drill:</p> <ul style="list-style-type: none"> Stag Holyrood surgery: 01/09/2019 Sheldon surgery: 01/09/2019 	Yes
<p>There was a record of fire alarm checks.</p> <p>Date of last check:</p> <ul style="list-style-type: none"> Stag Holyrood surgery: 26/09/2019 Sheldon surgery: 01/09/2019 	Yes
<p>There was a record of fire training for staff.</p> <p>Date of last training: 28/09/2019</p>	Yes
There were fire marshals.	Yes
<p>A fire risk assessment had been completed.</p> <p>Date of completion: In progress at time of inspection.</p>	Overdue
Actions from fire risk assessment were identified and completed.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>The practice was in the process of carrying out a new fire risk assessment with advice from a suitably qualified contractor as this was overdue.</p> <p>The practice carried out an internal monthly premises audit at both sites to monitor fire safety.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 27/09/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 03/08/2019	Yes
Explanation of any answers and additional evidence: The practice carried out specific risk assessments and drew up personal evacuation plans as required, for example, in relation to a pregnant employee.	

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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: <ul style="list-style-type: none"> Stag Holyrood surgery: 08/05/2019 Sheldon surgery: 25/07/2019 	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The local NHS infection prevention and control team had conducted independent infection prevention and control audits at both surgeries in the last 12 months. We saw evidence that recommendations had been prioritised and were being implemented.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence:	

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.	Yes
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.	No
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	No
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
Explanation of any answers and additional evidence: The practice had carried out an audit of two week wait referrals (across both sites) in September 2019 to identify all referrals made over the previous 12 months and to check there was a record of attendance/results or other forms of follow-up. This showed that several patients did not have a record of any appointment attended. This included one patient who was referred in February 2019 and for whom there was no record of attendance at referral. We were told that the practice had not yet followed these patients up. There was a cervical screening tracking system in place. The staff ran a routine search to check that a result was received for all cervical smears and they followed up cases where there were gaps.	

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.88	0.59	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	6.4%	10.2%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	8.38	5.89	5.63	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.29	1.05	2.08	No statistical variation

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.	No
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.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
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.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p data-bbox="57 1207 810 1245">Explanation of any answers and additional evidence:</p> <p data-bbox="57 1294 1536 1608">At the time of the inspection, 56 patients were prescribed medicines that required ongoing monitoring across both sites. We reviewed 15 of these patients' records. We identified concerns with the quality of monitoring information recorded for 12 of these cases and it was not possible to determine if the medicines were being prescribed safely. We spoke with two GPs about the procedures in place to monitor high risk medicines. Neither was able to explain the systems that were supposed to be in place. The practice contacted us after the inspection and verbally reported that they had reviewed and improved their processes for tracking patients on these medicines and had carried out a new audit to ensure that monitoring was now in place for all patients.</p> <p data-bbox="57 1675 1536 1944">The practice kept a log book to record the movement of prescription stationery around the practice. We found that this was not working properly at the Sheldon surgery. The original front pages of the book had been removed. There was a record of prescription reference numbers distributed to each room noted on the first remaining page in the book but these did not make logical sense. For example, the first and last noted serial numbers were out of sequence and could not have accurately represented the prescriptions distributed and collected. The practice managers confirmed that they would not be able to detect whether prescription stationery could have been removed or mislaid.</p> <p data-bbox="57 1966 1536 2033">Following the inspection, we were told that the practice had been in the process of implementing a new system to monitor prescription security and this had now been fully implemented.</p>	

Medicines management	Y/N/Partial
<p>The practice was aware that its prescribing of certain antibiotics for uncomplicated urinary tract infection was higher than average. The practice liaised with the clinical commissioning group medicines team to audit prescribing performance and improve.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	Four
Number of events that required action:	Four
<p>Explanation of any answers and additional evidence:</p> <p>We found there had been four recorded significant events at the branch surgery over the last 12 months. While incident forms had been completed, the information included was sparse with no evidence that learning had been identified or effectively shared. There were no notes of these discussions at clinical or practice meetings to which staff could refer. Both the GPs we interviewed (including the doctor who was the lead GP for the branch surgery) were unaware of these incidents.</p>	

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

Event	Specific action taken	
Patient attacked a member of staff outside the premises.	<p>This incident was highlighted to us by several staff members as an incident they recalled. The incident had been recorded but with minimal information and no actions had been recorded to minimise recurrence.</p> <p>Staff told us that the incident had been discussed at the time, but we could not find evidence that these discussions had been recorded.</p> <p>Staff found it difficult to recall the actions taken as a result of this incident, for example, whether the patient concerned was still registered with the practice and what protective measures were put in place if a patient presented a risk.</p>	
Safety alerts		Y/N/Partial
There was a system for recording and acting on safety alerts.		Yes
Staff understood how to deal with alerts.		No
Explanation of any answers and additional evidence:		
<p>We received mixed feedback from clinicians during our inspection about the extent to which they understood the practice's system for managing safety alerts. The practice submitted a log following the inspection showing the response to all relevant safety alerts received in 2018/19 including a record of actions taken. Alerts were managed centrally with the partners conducting searches and identifying any necessary actions. They communicated with the practice clinicians by email to share relevant information from safety alerts.</p>		

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: The practice had follow-up systems to track patients who were referred urgently under the 'two-week wait' system. However, these systems were not operating effectively and gaps had not been identified in a timely way.	

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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.37	0.40	0.75	Tending towards variation (positive)

Older people

Population group rating: Good

Findings

- The practice had recently introduced the use of a clinical tool to identify older patients who were living with moderate or severe frailty. The practice planned to offer these patients a full assessment of their physical, mental and social needs.
- The practice did not yet have a register of older patients requiring additional support although it maintained a register of patients who were housebound or living in residential care.
- The practice followed up on older patients discharged from hospital. It ensured that their prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured medication reviews for older patients.
- The practice carried out proactive home visits to older patients who had difficulty travelling to the practice and patients living in care homes.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Older patients were able to access the care coordinator for advice on available resources, for example to combat social isolation.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, the notes taken at these meetings did not specify actions to be taken in relation to individual patients. It was unclear from talking to clinical staff whether actions agreed at these meetings were recorded within the patient notes and there was no way of checking during the inspection.
- 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	80.6%	76.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	6.3% (24)	10.8%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.8%	78.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	2.4% (9)	7.6%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.3%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.5% (21)	7.9%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.6%	78.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	3.3% (5)	2.5%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.3%	92.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	4.2% (2)	6.9%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.3%	82.2%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.9% (12)	3.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.1%	86.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	16.3% (7)	9.1%	5.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice had not met the minimum 90% target for the two-year old cohort of children. The practice contacted the parents or guardians of children due to have childhood immunisations. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. Young people could access services for sexual health and contraception. Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	38	41	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	29	36	80.6%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	29	36	80.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	30	36	83.3%	Below 90% minimum

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

Any additional evidence or comments

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- Cervical screening rates were markedly below the national target of 80%. The practice had recently expanded the number of nurse appointments available and was reviewing the accuracy of its coding. The practice supplied unverified data for 2019/20 showing improvement.
- 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.
- The practice was participating in a pilot scheme to offer online consultations with the GPs.

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)	59.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	70.2%	61.8%	72.1%	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)	45.8%	42.0%	57.3%	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)	68.8%	79.2%	69.3%	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)	61.5%	55.2%	51.9%	No statistical variation

Any additional evidence or comments

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

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

Population group rating: Good

Findings

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

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.9%	90.3%	89.4%	No statistical variation
Exception rate (number of exceptions).	10.8% (4)	6.6%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	97.1%	91.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	5.4% (2)	5.8%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	87.9%	84.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	8.3% (3)	3.5%	6.7%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity but this was not comprehensive.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.5	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.8%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.5%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice submitted evidence of an audit carried out into its prescribing of anti-platelet therapy. This audit had been carried out in 2016 and repeated 2017 and 2019. The audit had resulted in recommendations for clinicians in the practice about the need for medicines reviews and recording of the management plan for this therapy.

Any additional evidence or comments

The practice submitted evidence of an audit of patients prescribed a medicine requiring ongoing monitoring. This had been carried out on 24 September 2019 and identified one patient without the appropriate tests on file. We found that no action had been taken by the time of our inspection on 1 October 2019. Our own review identified more than one patient who had been prescribed this medicine without adequate monitoring being recorded in their record.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
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.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: It was not always clear what the practice expectations were around internally defined roles. For example, the surgeries were described as having a 'lead GP' at each site. There was no clear definition of what this lead role entailed.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) <small>(QOF)</small>	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	No
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice actively engaged with other agencies and health professionals to provide coordinated care. However, it did not keep clear notes of meetings in relation to individual patients. We received mixed feedback from clinicians on whether the practice supported patients to make advance decisions about their care.</p>	

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	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.	Yes
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.1%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (5)	0.5%	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.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence:	

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
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	23
Number of CQC comments received which were positive about the service.	22
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	Patients said that the practice provided an excellent service which was accessible. The doctors, nurses and reception staff were described as kind and professional and taking the time to listen to patients. Several patients described examples of good care for longer term conditions including mental health problems.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6122.0	422.0	112.0	26.5%	1.83%

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 (01/01/2019 to 31/03/2019)	87.4%	84.8%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	88.1%	82.7%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	93.8%	93.0%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	84.2%	78.0%	82.9%	No statistical variation

Any additional evidence or comments

The practice had taken note of its results on the NHS 'Friends and family test' and the national GP patient survey. As a result, it had focused on how delays were managed in the waiting room to ensure patients were kept informed of any delay and the reasons. The practice score on this indicator had improved.

Question

Y/N

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

No

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
Explanation of any answers and additional evidence: Easy read and pictorial materials were available. The practice team spoke a range of languages which were commonly spoken in the local community.	

Source	Feedback
Comment cards	Patients commented that they were involved in care. For example, several commented that the doctors took the time to explain all options. Another person noted that they were always treated as a partner in any decisions.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	94.1%	89.2%	93.4%	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
Explanation of any answers and additional evidence:	
There was a range of information displayed in languages other than English in the waiting room.	

Carers	Narrative
Percentage and number of carers identified.	106 (1.8%)
How the practice supported carers (including young carers).	The practice had mechanisms to identify carers, for example when patients registered at the practice. The practice added flags to the electronic records system which alerted staff when a carer contacted the practice. Carers were given priority and flexibility over appointments. The practice provided information for carers about locally available support and services in the waiting area. The practice offered carers an annual flu vaccination and an annual health check.
How the practice supported recently bereaved patients.	The patient's GP normally contacted the family after a death. Bereavement support information was available in the waiting room and the clinical staff were also able to advise.

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:	
The practice seating area was located a little way away from the reception desk. Reception staff knew that the practice manager's office could be used should a patient wish to speak more privately.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: The practice was participating in a local initiative to provide online consultations in Brent. This was organised by the clinical commissioning group with appropriate safeguards in place.	

Well-led

Rating: Inadequate

The practice was rated inadequate for providing well-led services because while there were some governance systems in place these were not comprehensive. The practice had not identified clear gaps in governance and was not managing risks effectively. Systems and processes for sharing learning were weak.

Leadership capacity and capability

There was compassionate and inclusive leadership but leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">There was a lack of clarity about the division of responsibility for clinical oversight between the partners (who did not normally provide clinical sessions at the practice) and the local clinical leads. For example, one of the clinical leads told us they had not been involved in any clinical audit and were unaware of recent audit findings.	

Vision and strategy

The practice had a clear vision and credible strategy.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice partners had identified the merger of the Stag Holyrood and Sheldon sites as their key priority in 2019. The aims of the merger were to develop stronger governance, standardise policies and practice and centralise functions such as appointment booking for efficiency. The merger had been achieved in July 2019.	

Culture

The practice had a positive working culture.

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

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

Source	Feedback
Staff interviews	Staff we spoke with consistently told us that the practice was a good place to work and patients received a good service. Staff said that the partners were accessible and responsive to any concerns.

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.	No
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There were some governance systems in place. The partners required both sites to complete a daily report at the end of the day which included details of any incidents and activity, for example 	

the number of test results received and cleared. This gave the partners a good indication of demand and any potential backlogs before they built up.

- The practice had a comprehensive suite of policies which were regularly reviewed and were available to staff electronically and in hard copy. The practice managers provided health and safety policies to staff in the form of a handbook which they were asked to confirm they had read.
- However, in other areas, governance was lacking. Meetings were not routinely recorded. The notes that existed, for example, of multidisciplinary meetings held at the branch surgery were inadequate. For example, these did not specify actions to be taken in relation to individual patients. It was unclear from talking to clinical staff whether actions agreed at these meetings were recorded within the patient notes and there was no way of checking during the inspection.

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 were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
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.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
We found that the practice's systems to identify, manage and mitigate clinical risk were inconsistent. The partners monitored some levels of clinical activity closely, for example, the management of test results. However, there was little oversight of other risks. The practice was not following current guidelines and consistently following-up patients referred for urgent cancer investigation. The practice could not demonstrate that clinicians were safely prescribing medicines that required ongoing monitoring. This lack of assurance put patients at risk of avoidable harm.	
Following the inspection, the practice submitted evidence of a clinical meeting held to discuss issues raised during the inspection. It provided assurance that all patients had now been followed up and new systems would put in place to ensure that patients were effectively tracked in future.	

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.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	
We saw evidence to show data was used to adjust and improve performance but this was not applied in all areas, for example audits of high risk medicines had not been acted on at the time of the inspection.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain high quality and sustainable care. It had limited mechanisms to engage with patients.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Yes
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 had responded to patient survey feedback to improve access. For example, it had increased its opening times at both sites and was now open 8am-6.30pm throughout the week. Its national GP patient survey scores had improved in relation to delays in the waiting room.• The practice had an active patient participation group at the Stag Holyrood surgery and was in the process of developing the group to cover both sites.• The practice worked with stakeholders. For example, the practice hosted one of Brent's extended hours primary care hub services in the evenings and at weekends at the Stag Holyrood surgery.	

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>The practice provided evidence of recent clinical audits that had been carried out.</p> <ul style="list-style-type: none">• However, we were concerned that mechanisms for sharing learning from audit; incidents and complaints were ineffective. While incidents were recorded, details about any investigation, root causes and actions taken were sparse. We were told that incidents were discussed with staff and clinicians at meetings but again these discussions were not recorded. Some staff we spoke with – including two GPs – could not recall any recent incidents or any learning arising from them. One GP told us they had not been involved in any audits and they were unaware of recent audit findings.• We were told that the practice was operating fortnightly clinical teleconferences for clinicians across all the practices that were run by the partners (that is, four surgeries in total including the Sheldon and Stag Holyrood sites). These discussions were not yet being documented.	

- The practice presented the merger of the Stag Holyrood and Sheldon surgeries under one contract as a mechanism to improve governance, oversight and the quality of care. The salaried GP from the Stag Holyrood surgery was changing their shift pattern to enable them to work one session a week at the branch. At the time of the inspection, these changes had not yet come into effect and formal systems of clinical oversight and governance remained weak.

Examples of continuous learning and improvement

The practice was aware that their cervical screening rates had been below target. They were planning to hold an event at a local mosque to raise awareness about the importance of the test.

The practice could demonstrate some improvements to the service since our previous inspections in December 2015 (Stag Holyrood surgery) and July 2016 (the Sheldon surgery). These included:

- Reduced rates of antibiotic prescribing which was now in line with the local and national average.
- More comprehensive use of patient specific directions to govern vaccinations provided by the health care assistants.
- New staff communication tools, for example a smartphone app chat group for day to day communication not involving patient identifiable information.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.