

Care Quality Commission

Inspection Evidence Table

Dr Abdul-Razaq Abdullah (1-505444512)

Inspection date: 8 and 16 January 2020

Date of data download: 17 December 2019

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

At the previous inspection of the 4 and 13 June 2019 we rated safe as inadequate. This was because the practice had failed to ensure patient safety due to ineffective systems for safeguarding, high risk medicines, recruitment, significant events, safety alerts and the management of patient information. The practice submitted an updated action plan prior to this inspection, which included the concerns above and stated they had all been actioned.

At this inspection we rated safe as **requires improvement** because, although we found the practice had reviewed and improved areas of concern found in the inspection on the 4 and 13 June 2019, the practice had not fully embedded or completed the improvements in some areas. For example, regarding the health and safety of the premises and the continual review of safety alerts.

Safety systems and processes

The practice had 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
The Out of Hours service was informed of relevant safeguarding information .	Yes
There were systems to identify vulnerable patients on record.	Yes

Safeguarding	Y/N/Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous CQC inspection on 4 and 13 June 2019, the provider did not have an up to date child protection or vulnerable child register. We found the staff had completed Multi Agency Safeguarding Hub reports for the patients, but we found staff had not coded seven patients as vulnerable or as being under protection. This meant staff and other health care services would not have easily identified the children were at risk. In addition, staff did not have a system in place to identify and follow up children who did not attend hospital or doctor appointments and staff had not completed appropriate safeguarding training. The practice submitted an updated action plan prior to this inspection, which included reference to the concerns above and stated they had all been actioned. At this inspection we found the practice had identified Dr Abdullah as the safeguarding lead. The practice held a register of children who were on the child protection register and those who were of concern, which staff reviewed and updated regularly. Staff ensured all children at risk were appropriately coded in the patient records so they could be identified when they visited the practice. The practice now had a system in place to identify and follow up children who had not attended appointments and staff were aware of when this should be raised with the safeguarding lead and the local health visitor. The administration staff confirmed that hospital attendance was brought to the attention of the safeguarding administration lead and the GP lead. All staff had completed appropriate child and adult safeguarding training. The practice had carried out appropriate disclosure and barring service (DBS) checks to ensure staff were suitable for their roles. The practice had updated their safeguarding children's policy in 2019, however when we asked the practice nurse for the safeguarding policy they did not provide the current policy. The practice manager stated that the provider did not have regular contact with other agencies, but would contact them when an issue occurred. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection on 4 and 13 June 2019, recruitment checks were not carried out in accordance with the regulations. The practice submitted an updated action plan prior to this inspection, which included the concerns around recruitment and stated they had all been actioned. At this inspection the practice had: - 	

- Updated its recruitment policy in June 2019.
- Ensured all staff had the necessary recruitment details on file and completed a spreadsheet to provide an overall view for managers to review and update.
- The practice had a system in place to ensure staff had the correct immunisations for their role.
 - The practice told us they had professional indemnity cover through the NHS England scheme only and did not carry out any private work. Such as travel vaccinations, medical reports or complete medical forms for a fee.
 - The practice had introduced a new induction process.
 - We reviewed a recently recruited member of staff's records and found the practice had followed the recruitment procedure.

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: 8 August 2019	Yes
There was a record of equipment calibration. Date of last calibration: 8 August 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
There was a record of fire extinguisher checks. Date of last check: 2017 or 2018 – all were overdue according to the label	No
There was a log of fire drills. Date of last drill: January 2019 and next one due on January 2020 carried out by NELFT	Yes
There was a record of fire alarm checks. Date of last check: 16 January 2020	Yes
There was a record of fire training for staff. Date of last training: The staff completed on line training	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 8 November 2019	Yes
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The premises were owned and managed by North East London Foundation Trust (NELFT), who were responsible for the fire risk assessment. However, when we spoke with the practice manager we found they were unaware of any risks identified or if actions had been taken to address any risks. The practice manager requested a copy of the risk assessment from NELFT on the day of the inspection. • Following the inspection, the practice manager inform CQC that NELFT were planning to replace the fire extinguishers. • All but one member of staff had completed fire safety training. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 18 November 2019	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18 November 2019	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous CQC inspection of the 4 and 13 June 2019, we found that the practice did not have a health and safety or premises risk assessment. At this inspection we found the practice manager had completed an issue log on the 18 November 2019, that contained two identifies safety issues and had escalated the issues to the landlord for action. However, the premises risk assessment failed to include the lack of working space for both clinical and administration staff and checks of fire extinguishers being overdue. The practice did not have an accident book for staff. The practice did not have full oversight of the health and safety risk assessment for the building carried out by North East London Foundation Trust (NELFT). A copy of the assessment was obtained from NELFT on the day of the inspection. 	

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: 21 June 2019 by the practice.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous CQC inspection of the 4 and 13 June 2019 we found staff had not carried out an annual infection control risk assessment or completed infection control training. <p>At this inspection we found: -</p> <ul style="list-style-type: none"> Staff had completed infection control training. The practice had an infection control audit carried out by NHS England on 25 June 2019 and an internal audit carried out by the practice on 21 June 2019. The practice nurse had put into place room checks to ensure that appropriate standards of cleanliness and hygiene were met and maintained in the clinical rooms. However, on the day of inspection we observed the patient's couch in the practice nurses' room was damaged, which this could have been a source for infection. 	

Risks to patients

There were systems to assess, monitor and manage risks to patient safety, although there were still some gaps in relation to ensuring sufficient staff were in place.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our previous inspection on 4 and 13 June 2019 there were serious gaps in the staff induction process and in the systems to assess, monitor and manage risks to patient safety including staff's awareness of and management of sepsis and managing staff absences and busy periods. • At this inspection we found: - <ul style="list-style-type: none"> ➤ All staff had completed sepsis training. ➤ The practice nurse had introduced and was monitoring the system for safety alerts and was carrying out long-term condition patient medical reviews. ➤ The practice had introduced a new induction programme.. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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.	Yes
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.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection on 4 and 13 June 2019 staff did not have the information they needed to deliver safe care and treatment due to ineffective arrangements for summarising and coding patients records and backlogs of patients test results, including where patients had not been followed up appropriately. The practice submitted an updated action plan prior to the inspection, which included the concerns above and stated they had all been actioned. <p>At this inspection we found: -</p> <ul style="list-style-type: none"> The practice had devised and implemented a summarising policy dated July 2019 which set out the arrangements for appropriately summarising and coding patients records. We saw on the electronic record system that the percentage of patients with up to date summaries had increased to 71% and the practice had trained staff to complete this task. On 8 January 2020 the practice had 21 blood results received on that day to review and file. A doctor or advanced nurse practitioner was allocated to review test results daily. All patient documents awaiting scanning onto the electronic patient record was carried out promptly. The practice had allocated administration hours so that the health care assistant could assist with the coding of patient records and the reviewing of the patient note summaries. The practice had nominated a member of the administration team to lead on referrals. A review of the referral system found all urgent referrals were followed up and referral letters contained the necessary information. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.83	0.79	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). (01/10/2018 to 30/09/2019) (NHSBSA)	4.5%	9.4%	8.5%	Variation (positive)
Average daily quantity per item for	6.38	6.43	5.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	1.51	1.91	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.	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.	Yes
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 changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
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	Yes

Medicines management	Y/N/Partial
and expiry dates.	
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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection on 4 and 13 June 2019, we found examples of unsafe care in relation to patients prescribed high risk medicines such as warfarin, methotrexate and azathioprine. It was evident that National Institute for Health and Care Excellence (NICE) guidance was not being followed consistently. The practice had a 'Prescribing Policy' in place but there was no consistent system being followed for monitoring patients prescribed high risk medicines. The practice submitted an updated action plan prior to this inspection, which included the concerns in relation to high risk medicines and stated these had been addressed. <p>At this inspection we found: -</p> <ul style="list-style-type: none"> The practice had put into place a system to monitor and review all patients taking high risk medicines, which included regular audits. We checked the monitoring of azathioprine, methotrexate, warfarin and found all patients had the appropriate blood tests. Where patients had not received the appropriate test, staff had contacted the patient and refused further medication until the appropriate tests were carried out. However, the prescribing policy did not include the monitoring of warfarin, or the recall system that the practice followed. We reviewed the number of medication reviews which showed the practice had completed 86%. The practice carried out an antibiotic audit from October 2019 to December 2019 that included the prescribing of all clinical staff and demonstrated they were following the local clinical commissioning group recommendations. The practice had implemented a protocol for the safe management of blank prescriptions. Staff monitored the practice prescription collection box to ensure patients collected prescriptions promptly. The defibrillator and the oxygen were shared with North East London Foundation Trust, who were responsible for checking the equipment. For assurance the practice nurse also checked this equipment monthly. The appropriate patient group directions were in place for the practice nurse. The practice nurse was responsible for the checking the emergency medicines monthly. Although the practice did not have hydrocortisone for injection, we saw staff had ordered this. The practice had one fridge for vaccines which had been monitored by staff daily. However, the fridge had only one thermometer. This meant the practice could not cross check the accuracy of the temperature or have a failsafe should the fridge thermometers electricity supply be interrupted. The healthcare assistant administered flu immunisations, depot injections, and vitamin B12 injections and authorised patient specific directions were in place for these. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	10
Number of events that required action:	10
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 4 and 13 June 2019, the practice did not have an effective system in place to report, investigate and learn from significant events.</p> <p>At this inspection we found: -</p> <ul style="list-style-type: none"> • The practice had improved its arrangements for identifying significant events and had identified ten following our previous inspection. • The practice had reviewed ten significant events and had ensured these were cascaded to staff at clinical and practice meetings. • Staff were aware of the significant events and the actions taken. • The practice had updated the significant event policy on 20 June 2019. 	

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

When the healthcare assistant carried out a home visit to administer a flu vaccination to a registered patient they found the vaccination had already been administered by another practice.

The practice had failed to review and add information from a secondary service to the patient notes.

The practice followed this up with the other practice who agreed to carry out an investigation. They also reported this event to the local Care Commissioning Group.

This was identified when the patient visited the practice. A reminder was sent to staff to print off urgent letters and bring them to the doctor's attention. The practice ensured the specific member of staff was invited to attend further training.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our previous inspection on 4 and 13 June 2019 the provider did not have an effective system in place for the management and action of safety alerts, because the practice did not put into place cover arrangements for the practice nurse leave, who was responsible for the actioning of safety alerts. <p>At this inspection we found: -</p> <ul style="list-style-type: none"> • The practice nurse had a system in place to monitor, review and respond to medical safety alerts. They kept a detailed record of all the actions taken. 	

- However, they had not considered how they would review the safety alerts. At the time of the inspection they put into place a quarterly review to ensure any newly registered patients were identified if affected by the patient safety alert.
- The medical safety alert policy was reviewed in July 2019.
- We checked a sample of patient safety alerts and found all had been actioned.

Effective

Rating: Inadequate

At our previous inspection on 4 and 13 June 2019, we rated effective as inadequate because the provider had ineffective systems in place to ensure staff were appropriately trained for their role, and there was limited monitoring of the patient outcomes. The practice submitted an updated action plan prior to the inspection, which included the concerns above and stated they had all been actioned.

At this inspection, we rated effective as **Inadequate** because:

- The staff had reviewed and made changes to ensure that management of long-term conditions improved and ensured staff were appropriately trained for their roles.
- However, further improvements were required regarding: -
 - The management team had not reviewed the cause fully and put an action plan in place to mitigate for low uptake of long-term condition reviews, child immunisation, cervical screening.
 - The completion of patient care plans.
 - The management of the palliative care patients.
 - The offer of over 75 health checks for older people.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
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.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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: <ul style="list-style-type: none"> • The practice nurse explained they kept up-to-date through their University Course, regular Clinical Commissioning group (CCG) meetings and access to The National Institute for Health and Care Excellence guidelines. • The practice's low results of the quality outcomes framework for 2017 to 2018 and 2018 to 2019, which were below CCG and national averages, demonstrated that at the time of the inspection the 	

CQC inspection team could not be confident that all patient's treatment was reviewed and updated regularly.

- A review of patient notes demonstrated a record of the patient consultation was sometimes limited and that patient care plans were not always completed fully. At the inspection we reviewed 31 care plans and found 15 did not have a care plan in place.

prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	1.42	0.70	0.74	Tending towards variation (negative)

Older people

Population group rating: Requires Improvement

Findings

We have rated this population group as requires improvement because the practice did not offer health checks and did not follow up patients who are frail effectively. The practice did not have a system in place to offer health checks to patients over 75 years of age.

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty, however the practice did not carry out any audits to see how the patients were affected and did not use the tool effectively for the management of patients.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement.

Findings

We have rated this population group as requires improvement because although improvements had been made to the recall of patients for long-term condition reviews, the management team had not reviewed the reason for the poor uptake and put an action plan in place to mitigate any risks. The practice had also not completed some patient care plans.

- At the previous CQC inspection of the 4 and 13 June 2019 we found the provider did not have an effective system in place for the management and monitoring of medication reviews for patients with diabetes or chronic obstructive airway's disease (COPD) or asthma. The practice submitted an action plan prior to the inspection, which demonstrated that, despite improvements, further work was required.

At this inspection we found: -

- The healthcare assistant confirmed they had implemented a new system for the management of long-term condition reviews for patients following the previous inspection. They carried out daily and weekly searches of the patient records, which were shared with the administration team to ensure patients were invited for a review. Where necessary, they would also

telephone the patient to discuss their reasons for not attending.

- The practice nurse was responsible for carrying out most of the long-term condition reviews and explained they followed the local CCG templates. The doctor carried out some of the chronic obstructive airway's disease (COPD) patient reviews.
- The health care assistant carried out the blood pressures, the foot checks, height, weight and BP and smoking status for patients with diabetes. For asthma patients, they completed peak flow checks, however the practice nurse stated that they generally repeated these when they carried out the full asthma review.
- The practice nurse explained that the low COPD figures were due to the fact they had not excluded patients and the practice did not carry out spirometry.
- The practice nurse offered a 30-minute appointment for long-term condition patient reviews.
- The practice provided unverified data to demonstrate that the actions above had improved their long-term condition review results from April 1 2019 to 8 January 2020.
- The practice stated the lower than CCG and national averages quality outcome framework results were due to the practice nurse's leave from April 2018 to November 2018, where they had been unable to find cover. However, the practice had not fully considered the reasons for the lower results, such as the absence and roles of clinical staff and acted to mitigate the risk of this occurring again and did not have a specific action plan in place. This demonstrated that further improvements were required to provide confidence in a consistent approach from the management team.
- We reviewed four patients records with COPD and all had care plans in place.
- We reviewed six patients records with diabetes and three did not have a care plan in place.
- Patients with asthma were offered an asthma management plan. We reviewed 11 patients records with asthma and found six had care plans in place.
- 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.

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>	58.2%	75.8%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	4.1% (13)	11.7%	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>	54.0%	80.6%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	6.0% (19)	7.7%	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	70.3%	80.8%	81.3%	Variation (negative)

12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) ^(QOF)				
Exception rate (number of exceptions).	5.4% (17)	11.3%	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) ^(QOF)	52.6%	78.7%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	6.3% (18)	3.6%	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 Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) ^(QOF)	12.0%	90.6%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	4.9% (6)	8.4%	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) ^(QOF)	75.6%	83.9%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.0% (9)	3.4%	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) ^(QOF)	64.1%	89.2%	91.1%	Significant Variation (negative)
Exception rate (number of exceptions).	2.5% (1)	6.0%	5.9%	N/A

Any additional evidence or comments

During the previous inspection of the 4 and 13 June we saw that the practice did not have an effective system in place for the management and monitoring of long-term condition reviews for patients with diabetes or COPD. The Quality Outcomes Framework (QOF) results for diabetes and COPD for 2017 to 2018 was significantly below the local CCG and national averages. The results included in the evidence table above for 2018 to 2019 also demonstrated that the practice continued to be lower than the national or CCG average for most of the QOF indicators.

However, it should be noted that the improvements in the practices QOF results will only be seen in the 1 April 2019 to 31 March 2020 results, which will not be completed until 31 March 2020.

We found the practice had taken steps to improve the results and had implemented an effective recall system. The practice provided unverified data to demonstrate improvements from 1 April 2019 to 8 January 2020. For example: -

- For the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months, the practice had achieved 76% out of a target of 92%.
- For 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, the practice had achieved 65% out of a target of 78%.
- For 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, the practice had achieved 75% (202 patients out of 271).
- For 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, the practice had achieved 81%.
- In patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of these patients who are currently treated with anti-coagulation drug therapy, the practice had achieved 68%.

The practice stated the low figures were due to the practice nurse's leave from April 2018 to November 2018, where they had been unable to find cover.

Families, children and young people

Population group rating: Inadequate

Findings

We have rated this population group as requires improvement because the practice have not responded effectively to the low uptake of childhood immunisations in 2018/2019.

- The practice has not met the WHO based target of 95% (the recommended standard for achieving herd immunity) for all of four childhood immunisation uptake indicators. These were substantially lower than the 2017/2018 figures where the practice achieved a minimum of 90% in all four areas. At the time of this inspection the practice was unaware of these figures and had not put an action plan in place in response.
- 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.
- 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	47	78	60.3%	Below 80% uptake

to 31/03/2019) (NHS England)				
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)	62	84	73.8%	Below 80% uptake
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)	54	84	64.3%	Below 80% uptake
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)	58	84	69.0%	Below 80% uptake

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

Any additional evidence or comments

- At the time of the inspection, practice staff were unaware the practice had not met the WHO targets from 2018 to 2019. They had not implemented an action plan but provided unverified data to demonstrate for this year from 1 April to 10 October 2019 they had achieved the vaccination of 86% for children under one year of age and 84% for children up to the age of five years.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement.

Findings

We have rated this population group as require improvement because the practice had not put in place an action plan in response to the 2018/2019 cervical screening results.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period was below the national target and the practice had not implemented plans for improvement.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The healthcare assistant was responsible for carrying out NHS health checks for people aged 40 to 74. On 8 January 2020 the practice had invited 1871 patients and carried out 36% of these health checks.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had signed up for 'E-consult', an online patient consultation service.

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). (31/03/2019 to 30/06/2019) (Public Health England)	62.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	75.5%	75.4%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	48.4%	54.9%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	11.8%	73.8%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	46.7%	61.2%	53.8%	No statistical variation

Any additional evidence or comments

- The practice nurse was solely responsible for carrying out cervical screening.
- The practice nurse held their own failsafe system to follow up abnormal screening, it was suggested at the inspection this was shared with others in case they were unable to follow this up themselves.
- The practice provided unverified data that the cervical screening figures had improved to 67% for ages 25 to 49 and to 86% for ages 50 to 64.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

We have rated this population group as require improvement because the practice did not actively monitor the palliative care register.

- The practice had a palliative care register of patient which included 15 patients. However, a review of five patients demonstrated three patients had reviews in the last 12 months and for two patients there was no evidence of why they were on the list. In addition, there was no evidence of meetings with other agencies. This demonstrated the practice had not reviewed the list.
- The practice manager stated the GP did not attend regular meetings with the palliative care team
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. We found 14 out of 17 had been completed.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

Population group rating: Inadequate

Findings

We have rated this population group as inadequate because we found the practice has not responded to the results of the quality outcomes framework from 2018 to 2019. In addition, the practice has an ineffective system in place to ensure all patients had the correct care plans in place.

- At the previous inspection on the 4 and 13 June 2019 we found the results of the quality outcomes framework demonstrated for 2018/2019 that the practice had not always 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.
- At this inspection on 8 January 2020, the practice had 34 patients with a severe mental illness, 22 of which had received a physical health check.
- We reviewed five patients records with a diagnosis of mental health and found one had a care plan produced by the practice, and one by the hospital.
- We reviewed five records of patients with a learning disability and found two of these patients had a care plan in place.
- 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.

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>	25.0%	91.2%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	3.0% (1)	6.9%	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>	50.0%	91.0%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	3.0% (1)	5.7%	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>	35.3%	82.6%	83.6%	Significant Variation (negative)
Exception rate (number of exceptions).	5.6% (1)	5.5%	6.7%	N/A

Any additional evidence or comments

The provider was responsible for carrying out all mental health, dementia and learning disability reviews.

At the time of the inspection we were provided with unverified data from 1 April 2019 to 8 January 2020.

This demonstrated some improvements for example: -

Out of 34 patients with a diagnosis of mental health

- 22 had the six physical health checks
- 27 had a review of their alcohol consumption.
- 32 had a review of their smoking status.
- 21 had a care plan review.

The practice had commenced a local area incentive scheme for physical health checks for people with severe mental health illnesses in October 2020.

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)	381.6	528.6	539.2
Overall QOF score (as a percentage of maximum)	68.3%	94.6%	96.4%
Overall QOF exception reporting (all domains)	6.8%	5.1%	5.9%

	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.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
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

<p>The practice had taken part in the following audits in 2019: -</p> <ul style="list-style-type: none"> • The local Care Commissioning Group audit for antibiotic prescribing antibiotics. • The health care assistant carried out regular audits of the high-risk medication to ensure correct monitoring. • The provider carried out a weekly audit of the advanced nurse practitioners' notes. • An asthma control audit instigated by the local Care Commissioning Group. Seventeen patients were reviewed. This resulted in: six patients being issued with a spacer, 10 patients being given a comprehensive inhaler technique, two patients were referred to a specialist, and 10 patients were provided with education and information. The practice did not have a date in place for a second cycle of this asthma control audit.

Any additional evidence or comments

- The practice did have a schedule of audits or an overview of the audits that would be applicable to their patient needs.
- Following the inspection of 4 and 13 June 2019, the practice now monitored the results of the quality outcome framework.
- However, they had not considered a specific action plan in response to the low long-term condition reviews, immunisation and cervical smear results. For example: -
 - The practice nurse had recently reduced their hours of work to three days a week (Monday, 9am to 6pm, Wednesday 1pm to 4pm and Friday 9am to 5pm). However, no consideration had been given to the impact of this in relation to accessibility of appointments for working age people.
 - The practice nurse carried out most of the long-term condition reviews, all of the child immunisations and all of the cervical screening, alongside their other duties, such as being the infection control lead, and lead for safety alerts. The management team had not considered whether the practice nurse had enough time to carry out all these duties.
 - The healthcare assistant carried out one part of the patient diabetic reviews that were primarily completed by the nurse. This meant patients had to attend two appointments.
 - As the long-term locum GP and the advanced nurse practitioner did not carry long-term condition reviews, cervical screening or childhood immunisations, this meant that patients were not picked up opportunistically during a routine appointment for a review.

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: <ul style="list-style-type: none"> • At our previous inspection on 4 and 13 June 2019, the practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles. • At this inspection we found staff had completed all the necessary mandatory training and the 	

practice manager maintained an overview of staff training.

- The practice nurse was supported by the surgery to carry out their advanced nurse practitioner course at South Bank University.
- Staff had received an annual appraisal that included training assessment and development.
- The GP carried out three patient notes audits weekly of the advanced nurse practitioners' consultations to ensure they were working within their competencies.

Coordinating care and treatment

Staff sometimes 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) (QOF)	Partial
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.	Partial
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.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice shared premises with other community services and therefore met with them when they wanted to review a patient. However, we did not see any formal notes of meetings. • The clinicians referred patients to secondary care. However, we found no evidence of meetings with the palliative care team. • The practice did not offer online consultations. 	

Helping patients to live healthier lives

Staff sometimes helped 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.	Partial
Patients had access to appropriate health assessments and checks.	Partial
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:

- The practice provided information about a scheme for people who had a BMI of over 42 and therefore could access the physical exercise program.
- The practice clinical staff offered patients advice about reducing weight.
- The practice had the option to refer patients who are high risk diabetes for a nine-month programme that includes education and diet.
- Clinical staff provided advice about monitoring patients' health.
- The percentage of patients with a mental health or long-term condition who had their smoking status recorded in their notes in the past 12 months was 89%, which was below the national average of 95%.

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>	88.7%	95.7%	95.0%	Variation (negative)
Exception rate (number of exceptions).	1.5% (14)	0.6%	0.8%	N/A

Consent to care and treatment

The practice 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.	Partial
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The clinical staff had completed the mental capacity training. • The practice did not carry out minor surgery. • The practice did not fully monitor the process for seeking consent. 	

Caring

Rating: Requires Improvement

At the previous inspection carried out on 4 and 13 June 2019, we rated caring as requires improvement because the practice had not sought patient feedback, and feedback from the patient's GP survey and NHS choices website was mixed about the way staff treated people.

At this inspection we rated caring as **requires improvement** because although we found that the patient feedback from speaking with patients and the CQC comment cards was positive, the management team had not reviewed or responded to the national GP survey prior to the inspection.

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:	
<ul style="list-style-type: none"> The 34 CQC comment cards received demonstrated that staff treated patients with respect. 	

CQC comments cards	
Total comments cards received.	34
Number of CQC comments received which were positive about the service.	34
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	The 34 CQC comment cards received were all positive about the practice, the clinical staff and the reception staff. Patients stated staff had provided the appropriate care and treatment and were kind and caring.
NHS Choices website	The two most recent patient reviews were positive about the service, however asked for the reception staff to have further training.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5247.0	407.0	120.0	29.5%	2.29%

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)	79.0%	84.5%	88.9%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	75.8%	82.0%	87.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	84.3%	92.8%	95.5%	Variation (negative)
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)	71.3%	78.5%	82.9%	No statistical variation

Any additional evidence or comments

- The GP survey taken from 01/01/2019 to 31/03/2019 demonstrates a decline compared to the GP survey from 01/01/2018 to 31/03/2018 in three areas above. However, the practice had an improvement in the percentage of respondents who responded positively to their overall experience of the practice. This was 62% in the 2018 survey and had risen to 71% in the 2019 survey.
- At this inspection, the practice manager stated that they were unaware of the recent GP survey results (published in July 2019) and therefore had not reviewed or responded to it.

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

Any additional evidence

- At the time of the inspection the practice had commissioned an agency to carry out a patient survey on 13 January 2020. The practice offered to make these results available to the commission following the inspection.

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: <ul style="list-style-type: none"> • Easy read and pictorial materials were available. • The practice flagged on the patient record if patients had specific needs and had plans in place for the PPG to engage with specific patient groups. 	

Source	Feedback
Patient interviews	All five patients we spoke with during the inspection were satisfied with the service and told us they were able to get appointments when they required them.

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)	82.0%	91.6%	93.4%	Tending towards variation (negative)

	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.	Partial
Information about support groups was available on the practice website.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff would supply information in other languages on request. • The practice did not have their own website. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 70 carers. At the time of the inspection the practice provided a service for 5430 patients. This was 1.3% of the practice population.
How the practice supported carers (including young carers).	The practice provided longer appointments and offered annual flu vaccines for carers.
How the practice support	The practice manager would send the bereaved a card and offer an

recently bereaved patients.	appointment with the doctor if appropriate.
-----------------------------	---

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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Other patients in reception could hear when the receptionist addressed a patient at the desk.	

Responsive

Rating: Requires Improvement

At the previous inspection carried out on 4 and 13 June 2019, we rated responsive as requires improvement because, the practice patients were not able to access care and treatment in a timely way and the practice had not learnt from complaints.

At this inspection we rated responsive as **Requires Improvement** because although we found that the practice had learnt from complaints. We rated the population groups for long-term conditions and working age people as requires improvement due to the restricted access for patients to the practice nurse.

We have rated all other populations groups in responsive as **Good**.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • North East London Foundation Trust owned the premises. Parking was available on the premises. • The practice did not have a hearing loop. • The practice had a patient population where 71% of patients over the age of 18 were in paid work or full-time education, however the practice had not considered access to practice nurse appointments outside of working hours. 	

Choose one Practice Opening Times	
Day	Time
Opening times reception:	
Monday	8am to 6.30pm.
Tuesday	8am to 6.30pm.
Wednesday	8am to 6.30pm.
Thursday	8am to 6.30pm.
Friday	8am to 6.30pm.
Appointments available Dr Abdullah	
Monday	9am to 1pm and extended hours 4pm to 6pm.
Tuesday	9am to 1pm.

Wednesday	4pm to 7pm extended hours.
Thursday	9am to 1pm.
Friday	9am to 1pm and extended hours 4pm to 7pm.
Appointments available locum ANP	
Wednesday	9am to 7pm.
Friday	9am to 7pm.
Appointments available locum GP	
Tuesday	9 am to 12 pm and 1 pm to 6 30pm.
Appointments with the practice nurse	
Monday	9am to 6pm.
Thursday	1pm to 4pm.
Friday	9am to 5pm.
Appointments available Healthcare Assistant.	
Monday to Thursday	Monday 9am to 4pm, Tue 9am to 7pm, Wed 9am to 6pm and Thursday 9am to 4pm. Some of this time was used for administration..

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5247.0	407.0	120.0	29.5%	2.29%

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 (01/01/2019 to 31/03/2019)	80.7%	92.2%	94.5%	Variation (negative)

Any additional evidence or comments

- We checked appointments on the practice's computer system and saw the next available routine appointment was in two weeks' time, but this was for the advanced nurse practitioner.
- Dr Abdullah carried out home visits.
- Telephone appointments were available between 4pm and 6.30pm.
- The practice offered telephone appointments between 4pm and 6.30pm.
- The practice would prioritise patient in need or urgent care and young children.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent 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 by the local pharmacy.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- We have rated this population group as requires improvement because the practice did not offer a practice nurse service out of normal working hours, despite the practice nurse being responsible for providing long term condition reviews and cervical screening.
- The GP stated that they did not have regular meetings with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues but spoke with them on an ad hoc basis.
- Patients with complex long-term conditions could not be assured they would be reviewed in one appointment. For example, the healthcare assistant carried out one part of the patient diabetic reviews that were fully completed by the nurse, which meant patients had to attend two separate appointments.

Families, children and young people

Population group rating: Good

Findings

- Practice nurse appointments were available after school hours.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had recently commenced opening four days a week until 7pm to offer appointments to working age people. However, the practice nurse only available after 9am and up to 6pm one day a week. This would have restricted access to working women for cervical screening.
- The practice offered telephone appointments.
- Patients could pre-book appointments and prescriptions online.
- The practice offers telephone consultations each day.
- The practice has agreed to commence E consult an online consultation service.
- The practice had 11% of patients who had signed up to on line access. The local Care Commissioning Group target is 30% by April 2020.

People whose circumstances make

Population group rating: Good

them vulnerable

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability and offered longer appointments.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Priority appointments were allocated when necessary to those experiencing poor mental health. The practice also was located next to the hospital's dementia service.
- The training records provided demonstrated that most non-clinical staff had not completed dementia training.
- The staff told us that the GP referred patients to mental health services.

Timely access to the service

People were able to access most 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 necessary.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Reception staff referred patient requests for home visits to the GP who would carry out the home visit. • The CQC patient comment cards did not raise any issues with access to the practice. 	

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 (01/01/2019 to 31/03/2019)	63.6%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	58.1%	62.6%	67.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	60.0%	60.2%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	67.8%	67.7%	73.6%	No statistical variation

Any additional evidence or comments

- The practice had increased the number of telephone lines to four. In addition, the practice had increased the appointments by one GP session and the extended hours for three evenings a week. However, four telephone lines for a practice with over 5,000 patients, for both incoming and outgoing calls, would limit access to the practice by telephone.

Source	Feedback
NHS Choices website	The two most recent NHS choices comments were positive about the service. However, one requested further training for the reception staff.

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.	6
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a notice in reception to inform patients about who to complain to, however this did not include the any other details such as the address to send a written complaint to, and the 	

practice did not have a patient leaflet. During the inspection the practice manager commenced developing a leaflet.

- The practice had discussed complaints with staff at clinical and staff meetings.
- The complaints policy was reviewed in September 2019.
- The practice had not carried out an annual review of complaints.

Example(s) of learning from complaints.

Complaint	Specific action taken
<ul style="list-style-type: none"> • A patient was booked and attended an appointment, for the review of their blood test. The patient complained because this had already been carried out and the appointment was unnecessary. 	<ul style="list-style-type: none"> • The practice apologised to the patient.
<ul style="list-style-type: none"> • A parent asked for an urgent appointment which was refused by a receptionist. 	<ul style="list-style-type: none"> • The practice apologised to the patient and the member of staff received in house training.

Well-led

Rating: Requires Improvement

At our previous rated inspection on 4 and 13 June 2019, we rated well-led as inadequate because the provider had ineffective systems in place at the time of the inspection, which demonstrated that the overall governance arrangements were ineffective, and the practice did not have clear and effective processes for managing risks, issues and performance. The practice submitted an updated action plan prior to the inspection, which included the concerns above and stated they had all been actioned.

At this inspection we found the practice had made improvements to the governance of the practice but some of these areas had not been fully embedded and the practice had not reviewed and fully mitigated the risks to the practice. Therefore, we have rated well-led as **requires improvement**.

Leadership capacity and capability

There was compassionate and inclusive leadership. However, the management team had not fully responded to the challenges that faced the practice.

	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">• Although the lead GP demonstrated they were aware of the overall challenges to GP practices, we found the management team had not recognised or considered the challenges to the practice fully. For example, the low results for the quality outcomes framework, the immunisations and the cervical screening.• The practice had a business continuity plan in place and the provider had considered succession.• The practice was working towards completing a comprehensive action plan which was implemented following the inspection of 4 and 13 June 2019. The main aim of the practice at the time of the inspection was to complete the action plan.	

Vision and strategy

The practice had a vision and strategy to provide sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
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:

- The practice manager describes the main challenge as the lack of premises (because they had three consulting rooms) and the need for more administration staff.
- The practice mission statement was:
 - to welcome people from every background and culture, especially the vulnerable and those at-risk patients who seek medical attention
 - to strive on providing an excellent and professional service to all
 - every person to be treated with respect and dignity and to strive to maintain high level of medical care.
- The practice was working towards completing a comprehensive action plan implemented follow the inspection of 4 and 13 June 2019, where the practice progress was monitored. The main aim of the practice at the time of the inspection was to complete the action plan.

Culture

The practice had a culture which drove sustainable care

	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.	No
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice manager had attended training on the duty of candour and explained how they followed that as part of the significant events and complaints processes. 	

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

Source	Feedback
Staff	Staff we spoke with during the inspection with said they had a supportive management team and felt that improvements had been made. They said the doctor was approachable.

Governance arrangements

The overall governance arrangements were sometimes ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence: Following the inspection on 4 and 13 June 2019, the practice submitted an updated action plan prior to the inspection, which included the concerns found in the inspection and stated that most had been actioned.</p> <p>At this inspection we found: -</p> <ul style="list-style-type: none"> The practice manager had allocated roles and responsibilities to administration staff to ensure all the patient record workflow tasks were carried out. The practice had implemented new or improved systems for: safe recruitment and training of staff, safeguarding adults and children, patient safety alerts, and the management of complaints and significant events. The practice had commenced a system to ensure the recall of patient with long-term conditions and who required blood test. In addition, there was evidence that they monitored the quality outcomes framework results. The practice had implemented a new set of policies commissioned from an independent provider. The practice had implemented a new system for the safe and secure management of patient prescriptions. <p>However, we found some of the systems was not fully embedded. For example: -</p> <ul style="list-style-type: none"> The newly implemented policies did not contain the protocols for the new responsibilities and systems. Therefore, if a member of staff was absent and other staff had to cover their role, there could be an inconsistent approach. In addition, the prescribing policy did not include one of the high-risk medicines that was reviewed on a regular basis. The practice had submitted an overall action plan for the practice, this did include the long-term condition reviews, but this had not fully considered or explored the issues of why the quality outcomes framework results were low. In addition, the practice had not considered or implemented an action plan in response to the low results for cervical screening and childhood immunisations for 2018/2019. At the time of the inspection there was no indication that the practice monitored the uptake of online patient accounts to ensure they met the national targets. A review of clinical, staff and PPG meeting minutes demonstrated the practice did not always have a formal structure or a set agenda to provide a consistent approach. 	

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance, however some had not been fully embedded or fully reviewed.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes

There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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.	Partial
Explanation of any answers and additional evidence:	
<p>Following the previous inspection on 4 and 13 June 2019, the practice submitted an updated action plan prior to the inspection, which included the concerns found in the inspection and stated that most had been actioned.</p> <p>At this inspection we found: -</p> <ul style="list-style-type: none"> • The practice had implemented new and effective systems for the management of high-risk medicines, patient test results and the summarising of patient records. • The CQC team were provided with an example where the provider had managed staff performance issues appropriately. • The premises were owned and managed by North East London Foundation Trust, who were responsible for the fire risk assessment. However, there was a lack of oversight of this from the practice, as when we spoke with the practice manager we found they were unaware of any risks identified or if any actions had been taken as a result of the risk assessment. • The clinicians and the practice manager had carried out internal clinical and management audits, however we were not provided with systematic programme of audits. • The practice had not fully considered the risk of staff absences and the impact on the practice and had failed to put into place plans to mitigate the risk. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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 had not effectively identified and managed all the risks to the practice fully. 	

Engagement with patients, the public, staff and external partners

The practice sometimes involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
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 a patient participation group (PPG). We were provided with the minutes of the most recent PPG meeting on 21 June 2019. • Following the first day of this inspection, the practice had commissioned a survey to take place on 13 January 2020 to seek patient views. • The practice had not taken action following the publication of the national GP survey results, which had been published in July 2019. • The practice was part of a local primary care network. • The practice stated they held both clinical and staff meetings monthly, and we were provided with the minutes of the most recent staff meeting dated 12 November 2019 and the clinical meeting on 2 January 2020. However, the staff and clinical meeting minutes did not include the monitoring of action plans to ensure necessary actions were carried out and followed up. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • We spoke with two members of the PPG who expressed positive feedback about Dr Abdullah and how the staff care for their patients. They described how Dr Abdullah goes out of his way to accommodate patients' needs.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice nurse was supported by the practice to obtain their MSc Advanced Clinical Practice course. • The health care assistant was supported to increase their clinical knowledge and work towards a nursing degree. • The practice was part of a local primary care network. • The practice now carried out internal clinical audits to ensure the quality of the service provided. • The management team and staff described the learning following the previous CQC inspection of 4 and 13 June 2019. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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