

Care Quality Commission

Inspection Evidence Table

Preston Road Surgery (1-550631687)

Inspection date: 3 March 2020

Date of data download: 24 February 2020

Overall rating: Good

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

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes ¹
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 ²
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: 1. At our previous inspection we found that contact details in the adult safeguarding policy differed from those available in the clinical rooms. At this inspection we found the practice had reviewed and updated the policy. We saw that all safeguarding contact details, both in practice policies and on posters in the clinical rooms, were consistent throughout the practice. 2. At our previous inspection we found that children at risk were coded on the clinical system, but the practice did not maintain a risk register of these patients. At this inspection we found the practice had	

Safeguarding	Y/N/Partial
reviewed all vulnerable children and adults coded on the clinical system and created risk registers, which we reviewed on the inspection. The practice provided evidence of clinical meeting minutes that all patients on their risk registers were reviewed and registers updated where appropriate.	

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

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: 19 December 2019	Yes
There was a record of equipment calibration. Date of last calibration: 19 December 2019 and 2 March 2020	Yes ¹
There were risk assessments for any storage of hazardous substances for example, storage of chemicals. Date of completion: 10 February 2020	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 12 August 2019	Yes
There was a record of fire alarm maintenance checks. Date of last check: 3 December 2019 (undertaken six-monthly)	Yes
There was a log of fire drills. Date of last drill: 10 February 2020	Yes
There was a record of fire alarm checks. Date of last check: 2 March 2020 (undertaken weekly)	Yes
There was a record of fire training for staff. Date of last training: Variable as undertaken on e-learning platform (annually)	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 11 February 2019	Yes ²
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: 1. At our previous inspection the practice did not maintain an inventory of equipment requiring medical calibration which had resulted in equipment being missed from the annual calibration schedule. At this inspection we found the practice maintained an inventory and all equipment we reviewed on the day had been calibrated.	

2. At our previous inspection the practice had not undertaken a fire risk assessment following the refurbishment of the practice which had included an extension. At this inspection we found that a formal risk assessment had been undertaken by an external company on 11 February 2019.

Health and safety		Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 11 February 2019 and 2 March 2020		Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11 February 2019 and 2 March 2020		Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At our previous inspection the practice had not undertaken appropriate risk assessments of security and premises and health and safety. At this inspection we found that formal risk assessments had been undertaken by an external company on 11 February 2019, and the practice had addressed the outcomes. The practice had undertaken follow-up risk assessments in March 2020. We reviewed the legionella risk assessment and saw that the practice had acted upon the findings. We saw hot and cold-water temperatures were checked and recorded on a monthly basis. There was evidence of a valid gas safety certificate (24 February 2020) and an electrical installation condition report (14 November 2017), which was valid for five years. 		

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 February 2020		Yes
The practice had acted on any issues identified in infection prevention and control audits.		Yes
There was a system to notify Public Health England of suspected notifiable diseases.		Yes
The arrangements for managing waste and clinical specimens kept people safe.		Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At our previous inspection the arrangements in relation to infection prevention and control (IPC) did not mitigate the risk of spread of infection. In particular, we found there was inadequate storage and segregation of cleaning equipment which posed a risk of cross-contamination. At this inspection we saw that the practice had assigned a dedicated storage area and we observed all equipment was stored in line with guidance. At our previous inspection we saw that the practice had nominated the practice nurse as the Infection Prevention and Control (IPC) lead but had not undertaken any training for the lead role. For example, specific IPC knowledge in line with the Hygiene Code which identified primary care IPC responsibilities for this role, such as how to mitigate the risk of healthcare acquired infection. At this inspection we found that the practice nurse had undertaken additional external IPC training to support them in the role. 		

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Information to deliver safe care and treatment

Staff had 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

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)	0.69	0.59	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	8.1%	10.0%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	7.77	5.89	5.60	Variation (negative)
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) (NHSBSA)	0.51	1.06	2.08	Significant Variation (positive)

Any additional evidence or comments

Since our inspection, additional validated data for the period 1 July 2019 to 31 December 2019 has become available which demonstrated improvement in all prescribing outcomes:

- Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU): Practice 0.68; CCG average 0.58; England average 0.87.
- 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): Practice 6.4%; CCG average 9.7%; England average 8.3%.
- Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection): Practice 7.30; CCG average 5.91; England average 5.58.
- Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU): Practice 0.50; CCG average 1.01; England average 2.06.

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
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice employed their own pharmacist, who provided a total of 25 hours per week and supported medication reviews and reconciliation, and medicine-related searches and audits. The practice also had a pharmacist allocated to the practice four hours per week as part of a Primary Care Network (PCN) initiative. Clinical oversight and supervision were provided by the GP partners. The practice engaged with the Clinical Commissioning Group (CCG) medicine optimisation team and participated in the local prescribing incentive scheme and prescribing audits, which had included antibiotic prescribing. The practice was aware of their prescribing data and benchmarking data with other practices in the CCG. All staff had access to up-to-date antibiotic prescribing guidance. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> At our previous inspection the practice did not have a system in place to regularly review uncollected prescriptions and we found some prescriptions of patients who had deceased and duplicate prescriptions. At this inspection we saw that the practice had put a system in place to review uncollected prescriptions on a monthly basis and inform the GP if prescriptions had not been collected. We spoke with some reception staff who demonstrated the system. 	

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:	11
Number of events that required action:	11
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a nominated lead, an incident policy and form, which was accessible to staff. Staff we spoke with told us that when things went wrong there was a culture of openness and support. The practice told us they encouraged all their staff to report incidents, no matter how small, as part of their quality improvement and learning culture. We saw that significant events were a standing agenda item at practice meetings. We reviewed minutes of meetings and saw outcomes and learning points from incidents were discussed. Staff we spoke with were able to give examples of learning from recent significant events. 	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Delay with urgent two-week wait referral being sent due to delay in task being actioned.	<ul style="list-style-type: none"> The practice discussed and reviewed the system of two-week wait referrals tasked to the secretary by the GPs. It was agreed that an additional member of the administration staff would receive a task in case of absence. In addition, a screen message would be sent to the secretary that a two-week wait referral task had been sent. The practice reviewed their safety-netting systems which, although had picked up the delay, would be reviewed more frequently to ensure referrals had been sent out.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us that alerts were received by the GPs, pharmacist and practice manager and were disseminated to all clinical staff. The lead GP and pharmacist made a decision on their relevance. The practice maintained a register of all alerts received and action taken. We saw that some recent alerts had been acted upon and patient searches and follow-up undertaken. 	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

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) (NHSBSA)	0.41	0.40	0.74	No statistical variation

Any additional evidence or comments

Since our inspection, additional validated data for the period 1 July 2019 to 31 December 2019 has become available which demonstrated some improvement in prescribing outcomes:

- Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) Practice 0.37; CCG average 0.37; England average 0.72.

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, longer appointments for those with enhanced needs and complex medical issues.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice participated in the Whole Systems Integrated Care (WSIC) initiative which enabled more effective management of patients through a linked integrated summary of patient's health and social care which could be used to case manage patients who require more targeted and proactive care. The practice used this data to manage patients and appropriate care planning, specifically those who were at high risk of admission.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice had system and processes in place to followed-up on patients who failed to attend for diabetic eye screening (retinal screening).
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	67.1%	76.4%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.2% (46)	10.8%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	80.4%	78.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.7% (30)	7.6%	9.4%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	80.3%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.3% (34)	7.9%	12.7%	N/A

Any additional evidence or comments

- Data from NHS Digital showed that the practice had a higher than local and national clinical prevalence for diabetes (practice 11.81%; CCG 9.05%; national 6.93%).
- The practice worked in conjunction with a Diabetic Specialist Nurse who held a monthly clinic on site to review complex diabetes patients.
- The practice had focused several patient events on diabetes education and management. For example:
 - The practice had a significant number of Tamil-speaking patients with diabetes who were unable to benefit from the NHS diabetes education programme DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) as this was not available locally in Tamil. The practice had facilitated and funded the delivery of the programme quarterly at its practice with a Tamil interpreter. This was initially for its own registered patients but had recently extended this to all patients registered with a Brent GP. We reviewed feedback from an event held in December 2019 where seven patients attended and four gave feedback through a short survey. All patients responded that the course was useful, and they would recommend it to others.
 - The practice had commenced diabetes educational group sessions for pre-diabetic and diabetic patients. For example, diabetes blood sugar monitoring. One-to-one sessions were also delivered for the over 75-year-olds and housebound patients.

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)	80.1%	78.0%	75.9%	No statistical variation

Exception rate (number of exceptions).	2.9% (9)	2.5%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.0%	92.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	4.8% (1)	6.9%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	80.7%	82.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (21)	3.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.9%	86.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	14.6% (6)	9.1%	5.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had not met the minimum 90% for four of the four childhood immunisation uptake indicators. Uptake for one-year-olds was 81.5% and for two-year-olds ranged from 74.7% to 79.1%.
- The practice demonstrated that they contacted the parents or guardians of children due to have childhood immunisations. The practice had a reminder and recall system and contacted parents or guardians of children who had failed to attend. The practice proactively facilitated access to appointments at local GP hubs which had late evening and weekend appointments.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DtaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	75	92	81.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	68	91	74.7%	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)	72	91	79.1%	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)	71	91	78.0%	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

The practice was aware that childhood immunisation uptake rates were below the minimum 90% target. The practice had identified a decline in their achievement over the last couple of years. For example, data for 2017 showed that uptake for one-year-olds was 92.9% and for two-year-olds ranged from 90.2% to 90.8%. During the same period the practice had identified a shift in their patient demographic with an increase in one demographic group from 6.47% to 20.04% of the practice population. The practice had reviewed their childhood immunisation data and noted that this demographic had been difficult to engage in the childhood immunisation programme. In particular, it was identified that some patients went overseas for family support following a birth and accessed immunisations out of the country. The practice initiated an action plan to address this and encourage childhood immunisation uptake for the wider community. This included:

- Direct engagement with those parents and guardians where there was no record of their babies and infants receiving immunisation in this country. Completion of the immunisation schedule was facilitated upon return to the country or, where appropriate, evidence documented that the appropriate immunisations had been undertaken out of the country.
- GPs writing to patients and/or calling parents and guardians directly to discuss the importance of immunisation.
- A practice funded midwife and health visitor three hours per week to offer additional support and enhancement to the GP-led six-week mother and baby clinic. The practice told us this enabled the practice to support the medical, psychological and lifestyle needs of parents and guardians through one-to-one support, for example on breast feeding and advice on childhood immunisations. This support was in addition to community midwives and health visitors.

- Displaying educational advice on the practice information screen.
- Providing information leaflets in different languages aligned to the patient demographic.
- Sending reminder text messages with links to childhood immunisation information.
- Capturing the immunisation status of new registrations on the patient registration form.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice uptake for the cervical screening was 57.3% which was below the England comparison of 70% and the England target of 80%. We saw that the practice had systems in place to monitor their uptake and demonstrated a recall and reminder system.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. Patient could access telephone and e-consultations and evening appointments were available on Monday and Tuesday until 7.30pm. In addition, patients could access appointments in the evening and at the weekend at several hub GP practices in the area. These were bookable through the GP practice.

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). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	57.3%	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)	65.0%	60.4%	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)	42.4%	43.3%	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)	66.7%	75.0%	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)	44.4%	53.8%	53.8%	No statistical variation

Any additional evidence or comments

- The practice was aware that the cervical screening uptake rate was below the England average and national target. We saw that there had been some improvement since our last inspection when uptake was 51.7% compared with current achievement of 57.3% overall (25 to 49-year-olds 52.9% and 50 to 64-year-olds 71.8%).
- The practice had recently initiated an action plan which included a weekly text reminder from a named GP with a link to cervical screening guidance, clinicians telephoned patients who failed to engage, leaflets were available in languages aligned to the patient demographic and posters were displayed in general and clinical areas. The practice had updated their new patient registration form to include date of last cervical smear and offered an appointment for a cervical smear at the same time as the new patient medical, where required. Patients who had undertaken screening out of the country were encouraged to advise the practice so this could be coded on the clinical system.
- The practice had increased patient access to cervical screening with dedicated appointments available from 8am and in evening extended hours clinics. After the inspection the practice told us they planned to immediately commence a Saturday morning clinic with additional dedicated smear appointments.
- The practice had invited Cancer Research UK to the practice in May 2019 to discuss cervical screening and had supported the Cervical Cancer Prevention Week with the wearing of pink t-shirts. The practice told us they would further engage with Jo's Cervical Cancer Trust with a view to delivering patient educational events and training workshops for clinical and non-clinical staff designed to help staff explore ways to improve the number of women booking appointments.
- The practice had identified a potential coding error since November, which potentially affected their uptake percentage. They had identified that results had been coded as HPV negative but not cervical smear negative. The practice had now rectified this.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- All patients with a learning disability were offered an annual health check which was undertaken by a GP. The practice had 47 patients on their register and at the time of the inspection all patients had received their annual review.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice utilised Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how 13 and there they are treated and cared for.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

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

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	88.7%	90.3%	89.4%	No statistical variation
Exception rate (number of exceptions).	1.6% (1)	6.6%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	93.5%	91.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	1.6% (1)	5.8%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.7%	84.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	10.3% (4)	3.5%	6.7%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	542.8	536.2	539.2
Overall QOF score (as a percentage of maximum)	97.1%	96.0%	96.7%
Overall QOF exception reporting (all domains)	5.9%	5.7%	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.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- The practice had a programme of quality improvement which included audits and searches, both clinical and non-clinical. The practice had completed eight complete two-cycle audits in the past year which included a combination of medicines-related audits initiated by the medicine management team and practice-initiated audits, for example in relation the National Institute for Health and Care Excellence (NICE) guidance and the Medicines and Healthcare products Regulatory Agency (MHRA).

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 and pharmacists.	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"> The practice developed their staff through learning and development. For example, they had supported an administrator to train as a healthcare assistant. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> As part of a Primary Care Network (PCN) initiative the practice had a social prescriber attached to the practice which supported the health and wellbeing of patients by connecting them with local non-clinical services and supported them to take greater control of their own health. The practice funded the delivery of the NHS diabetes education programme DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) on a quarterly basis in Tamil which was accessible to all patients with a Brent GP. The practice engaged with the charitable organisation Hestia, which supported adults and children in times of crisis. For example, domestic abuse and mental health. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions:	96.5%	95.6%	95.0%	No statistical variation

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) (QOF)				
Exception rate (number of exceptions).	0.5% (6)	0.5%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Clinical staff we spoke with demonstrated they were competent in identifying consent issues and understood the general principles of Gillick competencies and Fraser guidelines. We saw evidence that all staff had undertaken Mental Capacity Act (MCA) training. 	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
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"> The GP partners demonstrated a clear commitment, capacity and capability to provide a good quality service and told us there was a drive to continuously improve outcomes for patients. The practice had been responsive to feedback from our previous inspection and had addressed all our findings. 	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us their mission was to improve the effectiveness of clinical care and the patient experience. The mission was underpinned by their ethos to provide the highest quality of care to all its patients regardless of their background, maintain equality, diversity and dignity, treat every patient holistically and be a learning organisation. 	

Culture

The practice had a culture which drove high quality 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.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had duty of candour and whistleblowing policies in place, which were accessible to staff. We saw that being open, duty of candour and whistleblowing training was part of the practice's core training schedule. The practice included health and safety, Display Screen Equipment (DSE), manual handling, Control of Substances Hazardous to Health (COSHH) awareness and conflict resolution training as part of the core training schedule to support staff safety and well-being. 	

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

Source	Feedback
Staff interviews	Staff we spoke with told us the GPs and management were very approachable and the practice worked as a team. Staff were proud and happy to work at the practice. Staff felt supported in the role and were encouraged to upskill.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice demonstrated a meeting structure which included weekly clinical, management and administration meetings, monthly multi-disciplinary team meetings and quarterly whole practice meetings as part of their formal governance framework. The practice also engaged externally in meeting with the Primary Care Network (PCN), local GP forums and educational meetings for the wider GP community. The practice had nominated designated leads, for example safeguarding, information governance, infection prevention and control and complaints. There were practice-specific policies including, child and adult safeguarding, infection and prevention control and significant events. All staff we spoke with knew how to access the policies. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

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.	Yes
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 approached the management of the Quality and Outcomes Framework (QOF) as a team and each clinical indicator had a clinician lead. The practice was aware of performance data and proactively monitored and reviewed the Whole Systems Integrated Care (WSIC) dashboards and the Public Health England Fingertips Tool. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
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"> We did not speak with any patients during the inspection. However, as part of our inspection process, we asked for CQC comments cards to be completed by patients during the two weeks prior to our inspection. Thirty-two comment cards were received, all of which were positive, and described the practice as excellent, caring, friendly, respectful and helpful. Three comment cards included mixed comments regarding accessing appointments. The practice pro-actively sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period September 2019 to February 2020, based on 344 responses, showed that 77% of patients would be extremely likely or likely to recommend the service. We reviewed the National GP Patient Survey for the period 1 January 2019 to 31 March 2019. The outcomes in relation to the practice being caring and responsive were comparable to local and national averages. We found: <ul style="list-style-type: none"> ➤ 88.9% of patients stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (CCG average 84.8%; national average 88.9%). 	

- 87.7% of patients 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 (CCG average 82.7%; national average 87.4%).
- 94.9% of patients stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (CCG average 93%; national average 95.5%).
- 92.9% of patients stated that at their last general practice appointment, their needs were met (CCG average 91.5%; national average 94.5%).
- 66.3% of patients responded positively to the overall experience of making an appointment (CCG average 63.9%; national average 67.4%).
- 64.7% of patients stated that they were very satisfied or fairly satisfied with their GP practice appointment times (CCG average 63.5%; national average 64.7%).

Feedback from Patient Participation Group.

Feedback

The practice had an active Patient Participation Group (PPG). We spoke with two members of the PPG after the inspection. They told us the group met every six months, consisted of approximately 25 members and was representative of the practice population. We reviewed minutes of the last meeting held in December 2019 and saw they were well attended and included doctors and the practice manager.

Any additional evidence or comments

At our last inspection the practice had reviewed and discussed the outcome of the GP national patient survey for 2018 and put some actions in place to address areas where potential improvement had been identified. For example, at that time the percentage of respondents who responded positively to how easy it was to get through to someone at their GP practice on the phone was 58%, which was below the England average 70.3%. The practice had also received similar feedback from patients and the Patient Participation Group (PPG). The practice told us at the last inspection that they planned to install a new telephone system. At this inspection we found that the practice had installed a new telephone system in June 2019 which had improved access to the service and provided a queue system. In addition, the system monitored calls in real-time and highlighted peak times which enabled the management team to deploy more reception staff when needed. The practice undertook regular audits to monitor the efficiency of the system and used performance data outcomes to inform its staffing needs. The practice had recently recruited additional reception staff to enhance its team.

Continuous improvement and innovation

There were 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 engaged with the CCG and neighbouring practices in local current and future initiatives which included the Primary Care Network (an approach to strengthening and redesigning primary care to focus on local population needs and provide care closer to patients' homes) and the Whole Systems Integrated Care (WSIC) programme to improve patient outcomes. 	

- The practice funded additional staff to support services within the community to enhance and improve patient outcomes. For example, a midwife and health visitor.
- The practice had participated in the Productive General Practice quality improvement programme to review processes and systems and develop internal efficiencies.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice encouraged and facilitated upskilling of their staff and we saw that a non-clinical member of staff had been supported to train to become a healthcare assistant.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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