

Care Quality Commission

Inspection Evidence Table

Jai Medical Centre (Brent) (1-545851372)

Inspection date: 13 March 2020

Date of data download: 12 March 2020

Safe

At our previous inspection on 1 October 2019, we found that the practice was not managing safety effectively. In particular, the practices arrangements for managing medicines that required ongoing monitoring and urgent referrals were ineffective. At this inspection, we found that the practice had made the required improvements.

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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection on 1 October 2019, the practice had improved the mechanisms to discuss and share information about safeguarding within the practice team and across the provider's wider group of practices.</p> <ul style="list-style-type: none"> • The practice had reviewed its safeguarding protocols and coding. • The child safeguarding register had been reviewed and was in the process of being updated in liaison with social services teams. • The practice team met monthly. Safeguarding updates were a standard agenda item and the minutes were now being clearly recorded and shared. 	

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection on 1 October 2019, the practice had improved its management of</p>	

information.

For example the practice had introduced a new system to monitor urgent “two-week wait” referrals. These referrals were initiated by the referring GP and then passed electronically to a dedicated team within the practice to monitor. All of these referrals were followed up after one week to check that an appointment had been made and then again after a further two weeks to ensure that the patient had been seen. The administrative team contacted the patient directly if there no specialist clinic letter had been received at the practice. The practice maintained a log showing all completed two-week wait referrals and highlighting those still in progress. The referral records we reviewed included clear details of the reason for referral.

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) (01/01/2019 to 31/12/2019) (NHS Business Service Authority - NHSBSA)	0.65	0.58	0.87	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2019 to 31/12/2019) (NHSBSA)	9.2%	9.7%	8.3%	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 (01/07/2019 to 31/12/2019) (NHSBSA)	6.74	5.91	5.58	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2019 to 31/12/2019) (NHSBSA)	0.87	1.01	2.06	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Medicines management	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection on 1 October 2019, the practice had improved its systems to manage medicines and prescribing safely.</p> <ul style="list-style-type: none"> The practice had improved its systems for prescribing medicines that required ongoing monitoring and produced a flow chart for clinicians to reference. We reviewed the records for all of the patients prescribed these medicines across both surgeries and found prescribing was now in line with guidelines. The practice ran a daily search of patients prescribed medicines requiring ongoing monitoring to check if blood tests were up to date. The practice had identified several cases where the patient's blood test schedule was not well coordinated with the timing of their prescriptions. The GPs were taking steps to synchronise prescribing and monitoring in these cases. The practice had improved its systems for monitoring prescription security. Prescription stationery was stored securely and tracked by serial number. The practice had introduced a new system for following up uncollected prescriptions and ensuring any of concern were passed to a GP. 	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	12
Number of events that required action:	5
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection on 1 October 2019, the practice had improved its systems to record and share learning from safety incidents, significant events and near misses.</p> <ul style="list-style-type: none"> The practice had reviewed and revised its reporting system and staff responsibilities. All the staff we interviewed were clear about the revised process. The practice had repeated its reviews of all incidents over the previous 12 months. These had been documented with further detail and discussed at team meetings. Significant events were added as a standing agenda item to practice meetings. All staff were 	

invited to attend.

- Meeting minutes were shared on a new internal document system which allowed managers to keep an audit trail.
- There were plans for the administrative lead to develop their skills in relation to root cause analysis which is a method to analyse and identify any systemic causes of errors.
- The practice had a low threshold for reporting but did not yet categorise or risk assess incidents by risk. We were told that this was something the practice might introduce.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Unexpected patient death	The responsible GP reviewed the case and their analysis was shared with the practice team for learning. This patient's particular circumstances meant they did not attend the practice regularly for reviews. Following the event, the practice acted to improve the identification and recording of next of kin and to document all attempts to contact patients. The practice also identified better coordination of safety netting alongside specialist teams as an area for further development.
New vaccine stock was delivered to the practice but not immediately moved to cold storage.	The batch of vaccines was compromised and had to be destroyed. The practice team discussed the incident and reviewed the protocol for receiving and checking all deliveries immediately on receipt.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our previous inspection on 1 October 2019, the practice had improved its systems to share learning from safety alerts.</p> <ul style="list-style-type: none"> • Safety alerts were now loaded on the practice document management system and assessed for relevance. Staff members were required to read relevant alerts and this was checked. • The practice kept a log of actions taken. For example, patients prescribed a specific injectable pen had been instructed how to use this safely following an alert. • We saw evidence that the practice responded to national alerts promptly. For example, the practice was responding to daily national guidance on the coronavirus (Covid-19) outbreak. The practice had introduced a 'total triage' system to manage appointments as required. It had also put together a folder with specific guidance and resources relevant to patients with specific needs, for example patients in care homes. The practice had updated the Patient Participation group about the outbreak and sent out a patient newsletter with more information. 	

Well-led

At our previous inspection on 1 October 2019, we found that the practice did not have clear and effective governance arrangements; was not managing all risks safely and did not have effective systems to share learning across the team. At this inspection, we found that the practice had made the required improvements.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had reviewed its organisational structure and line management since the previous inspection. There was greater clarity about the division of responsibility and arrangements for clinical oversight. Managers, staff and clinicians had been involved in these discussions. The clinical lead GP role was more clearly established with regular sessions at both sites.	

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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Since the previous inspection, the practice had reviewed its governance arrangements. The practice held monthly practice meetings. Standard agenda items included safeguarding, complaints and any significant events. All meetings were now clearly documented including multidisciplinary team meetings and the patient participation group meetings.There were now clear arrangements for clinical oversight, supervision and appraisal. Staff we spoke with told us they were well supported professionally with dedicated time for professional development and learning. The clinical leads had dedicated time for their management roles.	

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.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: At our previous inspection of 1 October 2019, we identified several safety risks including the practice's management of medicines which required monitoring; prescription security; and its monitoring of urgent referrals. At this inspection, we found that the practice had fully addressed these concerns. New systems had been put in place, tested and evaluated to address these risks.	

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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had mechanisms in place to share learning both within the practice and across the wider provider group. The practice partnership ran two other practices in North London.	

Examples of continuous learning and improvement

- The practice had strengthened its cervical screening monitoring system to ensure that all patients who had undergone screening had received a result and appropriate action had been taken for abnormal results. The practice had proactively identified two cases which would otherwise have been missed using the new process.
- The practice was developing a clinical audit programme. We were shown evidence of a recent two-cycle audit looking at how well the practice documented preferred place of death for patients recognised as being in their last year of life which showed a marked improvement. The results were discussed with the clinical team to embed learning and encourage further improvement.

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.