

Care Quality Commission

Inspection Evidence Table

Dr Paramjit Wasu (1-526774472)

Inspection date: 7 July 2020

Date of data download: 14 July 2020

We carried out this announced focused inspection on 7 July 2020 to check whether the practice had addressed the issues we identified at our previous inspection on 10 February 2020. This report covers our findings in relation to those specific areas and does not change the current ratings held by the practice.

Safe

Safety systems and processes

The practice had made improvements to their 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.	Not inspected
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: At the previous inspection we found practice staff did not know to access safeguarding policies and procedures, the child protection register was not up to date, and some staff had not completed up to date safeguarding training.	

Safeguarding	Y/N/Partial
At this inspection we found the practice had made improvements in relation to safeguarding. Safeguarding policies had been updated and were accessible to staff. The child protection and vulnerable adults registers had been reviewed in conjunction with the Royal College of General Practitioners ('RCGP'), who have been supporting the practice. The child protection list had been significantly reduced (as previously there were patients on this list who were over 18 years) and we saw a clear rationale for actions taken for each patient included. Staff had completed up to date safeguarding training at an appropriate level for their role. During the Covid-19 pandemic, the practice had contacted patients who were shielding. There was no evidence of any recent multidisciplinary meetings, but we did see correspondence with other health and social care professionals by email.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: At the previous inspection we found gaps in recruitment processes and staff vaccination records. We checked a sample of staff files, including for a new member of staff who had only commenced employment at the practice a few weeks before our inspection; we found that appropriate recruitment checks had been completed and the practice had copies of necessary documents, including references, signed employment contracts, and Disclosure and Barring Service (DBS) checks. There was a record of staff vaccination as per requirements in the 'Green Book'.	

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.	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:	

At the previous inspection we found there was no cleaning schedule for the spirometer and nebulizer, clinical waste bins were not labelled and there was no sharps injury policy displayed at the practice.

At this inspection, we saw cleaning schedules in place for medical equipment, including the spirometer and nebulizer.

Clinical waste bins were available and appropriately labelled.

The practice had introduced a sharps injury policy and posters regarding sharps injuries were displayed in clinical rooms. Staff we spoke to knew what to do in the event of a sharps injury.

There was a pandemic management policy in place, which set out systems for cleaning in relation to patients with possible Covid-19.

There was adequate personal protective equipment ('PPE') available for staff to use and staff we spoke to knew how to use PPE, although there were no signs up regarding donning/doffing of PPE. We saw handwashing posters were displayed throughout the practice.

Risks to patients

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

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

Explanation of any answers and additional evidence:

At the previous inspection we found that a practice nurse who started working at the practice did not complete an effective induction. At this inspection we found the practice's induction process for staff was clear. We checked a sample of staff files and found induction checklists were complete or were in the process of being completed for one staff member who had only commenced employment a few weeks before the inspection date.

The practice had been registered as a Yellow Fever Centre with the National Travel Health Network and Centre (NaTHNaC) and at our last inspection in February 2020 we found there was no evidence of risk assessments carried out for patients receiving a yellow fever vaccine. Since the previous inspection the practice had cancelled their registration as a Yellow Fever Centre, and we saw evidence from NaTHNaC confirming this.

Staff had completed sepsis awareness training, and staff members we spoke to were aware of symptoms indicating sepsis or a deteriorating patient. We saw sepsis posters were displayed in the practice, along with a sepsis identification chart in the reception area.

Information to deliver safe care and treatment

Record keeping standards had improved and 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

Explanation of any answers and additional evidence:

At the previous inspection we identified gaps in patient records and examples of poor record keeping. At this inspection we reviewed a sample of patient records, including for patients prescribed high-risk medicines, older patients in nursing homes, patients with long-term and chronic conditions, children and patients diagnosed with dementia; we found there were no concerns around the quality of record keeping. The RCGP had been supporting the lead GP to maintain clear patient records and our review of records demonstrated improvement in this area since the last inspection.

A member of staff was responsible for summarising patient notes and results and entering this information into the practice's clinical system.

At the previous inspection we found the system to monitor urgent two-week wait referrals was ineffective (a two-week wait referral is a referral to hospital for suspected cancer). At this inspection we saw the practice had a spreadsheet to record and track urgent referrals. We checked the system and found it was being used effectively to monitor urgent referrals; we saw evidence where the patients had been contacted by the practice to follow-up the referral and where clinical letters from secondary care received had been received. The staff member responsible for maintaining this spreadsheet told us they had recently noticed increased delays in referrals to specific departments at one local hospital; this had been discussed with the GPs and to mitigate this the clinicians were referring patients to other local hospitals for those specialities.

At the previous inspection we found monitoring of cervical screening results was ineffective, in that the practice did not have a failsafe system to ensure a result was received for every cervical screening sample sent to the laboratory. At this inspection we did not identify any concerns in relation to the

failsafe system for cervical screening. We saw there were no outstanding cervical screening results and all cervical screening samples had been followed up. The practice was carrying out audits of any abnormal results and these were shared with the nurse and discussed at a clinical meeting.

At our inspection in February 2020 we found instances where test results had not been matched to the patient. When we checked the test results inbox at this inspection we did not see any outstanding results and found test results were managed and actioned appropriately.

There was no evidence of any recent multidisciplinary meetings, but we did see correspondence with other health and social care professionals by email.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2019 to 31/03/2020) (NHS Business Service Authority - NHSBSA)	0.94	0.69	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). (01/04/2019 to 31/03/2020) (NHSBSA)	10.0%	10.2%	8.2%	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 (01/10/2019 to 31/03/2020) (NHSBSA)	4.98	6.08	5.46	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2019 to 31/03/2020) (NHSBSA)	0.86	0.89	2.01	Variation (positive)

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about 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 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
Explanation of any answers and additional evidence: At the previous inspection we found Patient Group Directions ('PGDs') were not being signed correctly (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). At this inspection we found all PGDs were appropriately signed and in date. When we reviewed a sample of patients records during this inspection we did not identify any issues around repeat prescribing or changed to patients' medicines made by other services. We saw instances where the GP had reviewed repeat prescriptions when altering or adding medications, and all prescriptions issued matched the working clinical diagnosis. At the previous inspection we identified instances where required monitoring had not been carried out when GPs prescribed high-risk medicines. We checked a sample of patients prescribed high-risk medicines during this inspection (including methotrexate, azathioprine, warfarin and direct oral anticoagulants) and did not identify any significant concerns around monitoring or prescribing. Our review of patient records did not identify any concerns around antimicrobial prescribing and the practice's prescribing data was in line with local and national averages. At the previous inspection we found that certain medicines for use in an emergency were stored in the incorrect emergency packs (for example, adrenaline was stored in the diabetes pack instead of the anaphylaxis pack). At this inspection we found the practice had appropriate medicines for use in an emergency, all of which were in date and suitably stored. There was a record of expiry dates of emergency medicines being checked weekly. Adrenaline was kept in the room in which vaccines are administered. There was medical oxygen and a defibrillator on site and a record of regular checks to ensure they were in good working order.	

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	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
Explanation of any answers and additional evidence: At the previous inspection we found instances where some staff were not aware of some significant events that had taken place and did not know how to report an incident. At this inspection the staff we spoke to knew how to report a significant event. Learning from complaints and incidents was a standing agenda item at practice meetings. There had not been any significant events since our last inspection in February 2020.	

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: We saw evidence the practice had received safety alerts, logged them and disseminated them to staff. The practice had run searches upon receipt of recent safety alerts to identify any affected patients.	

Effective

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.

	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
Explanation of any answers and additional evidence: Staff told us they use NICE guidelines when delivering care and treatment. The practice nurse advised they attend nursing meetings through the Ealing Clinical Commissioning Group where practice and updates are discussed. During the inspection we reviewed a sample of patient records, including for patients prescribed high-risk medicines, older patients in nursing homes, patients with long-term and chronic conditions, children and patients diagnosed with dementia; we found there were no concerns around the quality of record keeping. The RCGP had been supporting the lead GP to maintain clear patient records and our review of records demonstrated improvement in this area since the last inspection. Our review of patient records did not identify concerns around the clinical care being provided and we saw evidence of appropriate referrals, prescribing and safety-netting by the lead GP. The clinical records review identified patients with possible dementia were being read coded as having dementia before an official diagnosis was made by the dementia specialist teams.	

Effective staffing

Most staff had the skills, knowledge and experience to carry out their roles, although there were still some gaps in relation to training and supervision.

	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.	Not inspected
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.	Partial
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: At the previous inspection we found gaps in clinicians' role-specific training. At this inspection we found the nurse was up to date with role-specific training. We checked a sample of training records for staff and found that most mandatory training was up to date, although we found two staff members' information governance training had expired. At the time of our inspection, the practice was in the process of creating a training matrix in order to more effectively monitor completion of all staff training. The practice had implemented a process for supervising clinical staff, such as the practice nurses, however this was not yet fully embedded at the time of our inspection. The supervision process, whereby the lead GP would sit in on nurse appointments and observe clinical sessions, only started in late May/early June 2020; the first observed session with the practice nurse was scheduled to take place on 10 July 2020. We saw there were appropriate medical indemnity arrangements in place for clinical staff.	

Well-led

Leadership capacity and governance arrangements

The overall governance arrangements had improved since the last inspection, although systems and processes were not fully embedded.

	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
There were governance structures and systems which were regularly reviewed.	Partial
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: Following our previous inspection in February 2020, the practice was being supported to make improvements by the Royal College of General Practitioners ('RCGP'). There was evidence of improvement, particularly in relation to the lead GPs standard of record keeping, and systems to monitor urgent referrals and cervical screening. There was also a new deputy practice manager in post who had joined to assist the management of the practice. The practice had succession plans in place in relation to both clinical and practice management. A new deputy practice manager had recently joined to assist the practice manager, with the intention that the deputy would eventually take over the practice manager role. The practice advised they were in the process of taking on two long-term locums as salaried GPs, with the intention for them to then become GP partners. Under direction from the RCGP, the practice had reviewed and updated practice policies and procedures. Practice policies and procedures were available in hard copy and electronically and staff we spoke to knew how to access them. Policies we checked during the inspection were up to date and contained the necessary information. The practice had also reviewed its child protection and vulnerable adults registers in conjunction with the RCGP. Management staff told us they had introduced spot checks and had established open communication with staff in order to monitor risks and review practice performance. We saw improvements around the standard of record keeping, availability and checks of emergency medicines and equipment, failsafe systems for urgent two-week wait referrals and cervical screening results; however, there were still some gaps, for example in relation to staff training and clinical supervision. Many of the changes to the practice's systems and processes had been made recently and with significant input and direction from the RCGP, so there was limited evidence at the time of our inspection that this improvement would be sustained over a significant period of time and that the improvement was being driven by practice leaders.	

Managing risks, issues and performance

The practice, with external support, had introduced new processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
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.	Yes
Explanation of any answers and additional evidence: The practice had a business continuity plan, which had been updated to include information and plans in relation to the Covid-19 pandemic. A copy of the plan was kept in the staff room. The practice had 'buddy' practice arrangements in place with another local practice and was also being supported by their primary care network. The practice had systems in place to manage risks relating to premises and equipment. We saw completed risk assessments for health and safety, fire safety and disability access. Medical and other equipment had been calibrated and portable appliance testing had been carried out. At the previous inspection we found there was a lack of oversight of systems to prevent cross infection and systems relating to emergency medicines. At this inspection we found infection control arrangements had improved and emergency medicines and equipment were appropriately stored and checked on a regular basis. We saw that the practice had completed audits in relation to premises safety and accessibility, abnormal cervical screening results, and a clinical audit reviewing whether patients prescribed a specific high-risk medicine were being monitored appropriately. Management staff told us they had introduced spot checks and had established open communication with staff in order to monitor risks and review practice performance. However, many of the changes to the practice's systems and processes had been made recently and with significant input and direction from the RCGP, so there was limited evidence at the time of our inspection that this improvement would be sustained over a significant period of time and that the improvement was being driven by practice leaders.	

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.