Care Quality Commission

Inspection Evidence Table

Dr Raphael Rasooly (1-538841289)

Inspection date: 07/12/2020

Date of data download: 04 December 2020

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Requires Improvement

Following the inspection in March 2020 we rated the practice as inadequate for providing safe services because:

- The provider did not have clear systems and processes to keep patients safe.
- Receptionists had not been given sufficient guidance on identifying deteriorating or acutely unwell patients. They were not aware of actions to take in respect of such patients.
- The provider did not have appropriate systems in place for the safe management of medicines.
- The provider did not learn and make improvements when things went wrong.

At this inspection we found a marked improvement in relation to overall safety systems and processes however we identified further risks with medicine management. In particular, we found continuing concerns with medicine reviews for patients on repeat medicines, monitoring of patients on high-risk medicines and controlled drugs, and compliance with safety alerts. Because of these concerns the practice is rated as requires improvement for providing safe services.

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

Safeguarding	Y/N/Partial
Policies took account of patients accessing any online services.	No
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.	No
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 inspection in March 2020 the provider did not have clear systems, practices and processes to keep people safe and safeguarded from abuse because safeguarding policies did not provide information and guidance for staff on female genital mutilation (FGM), the provider could not demonstrate safeguarding training had been completed by all staff, DBS checks had not been undertaken for all relevant staff and some staff members did not know the process for escalating safeguarding concerns within the practice.

At this inspection we found the provider had made a number of improvements. Staff we spoke to understood how to escalate safeguarding concerns within the practice and knew who the safeguarding lead GPs were across both locations. The provider could demonstrate training for all staff on safeguarding children and vulnerable adults to the appropriate level for their role, and DBS checks had been appropriately undertaken. We saw from meeting minutes where safeguarding cases had been discussed.

Safeguarding policies did not take account of patients accessing online services and it was not clear how the Out of Hours service was informed of relevant safeguarding information.

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 inspection in March 2020 the provider could not demonstrate that recruitment checks had been conducted in line with Schedule 3 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At a follow-up inspection in August 2020 we reviewed staff files and found the provider had improved recruitment processes, appropriate recruitment checks had been undertaken, however there was no formal recruitment policy in place to govern the staff recruitment process.

At this inspection we reviewed ten staff files including a number of recently recruited staff. The staff files included four locum GPs, two pharmacists, a nurse, the HCA and two non-clinical staff. Our review demonstrated that the appropriate recruitment checks had been undertaken and a recruitment policy had been implemented.

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: Greenhill Park; 15/05/20, Neasden Medical Centre; 11/05/20	Yes
There was a record of equipment calibration. Date of last calibration: Greenhill Park; 21/09/20, Neasden Medical Centre; 21/09/20	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: Greenhill Park; 05/05/20, Neasden Medical Centre; 01/12/20	Yes
There was a log of fire drills. Date of last drill: Greenhill Park; 24/11/20, Neasden Medical Centre; 17/09/20	Yes
There was a record of fire alarm checks. Date of last check: Greenhill Park; 24/11/20, Neasden Medical Centre; 10/11/20	Yes
There was a record of fire training for staff.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: Greenhill Park; 28/06/20, Neasden Medical Centre; 29/06/20	Yes
Actions from fire risk assessment were identified and completed. Greenhill Park; 28/06/20 Neasden Medical Centre; 29/06/20	Yes

Explanation of any answers and additional evidence:

At the inspection in March 2020 the provider had not undertaken Control Of Substances Hazardous to Health (COSHH) risk assessments, fire marshals were not appointed to provide adequate cover over both locations, there was no up to date fire risk assessment or fire safety training for staff.

At a follow-up inspection in August 2020 we saw a fire risk assessment dated April 2019 however it did not include COSHH. We found the provider had addressed the shortfalls in fire marshal provision across both locations.

At this inspection we found the provider had addressed all outstanding shortfalls in fire safety provision. They also provided an up to date gas safety record and evidence of electrical installation checks for both locations.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: September 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2020	Yes
Explanation of any answers and additional evidence: (Premises/security had been undertaken as a section in the health and safety risk assessment).	

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: 31/07/20	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 inspection in March 2020 the provider could not evidence infection prevention and control training for a number of staff and the provider could not demonstrate that regular temperature checks were carried out for the hot and cold water outlets at both locations in order to mitigate risks associated with legionella bacteria.

At a follow-up inspection in August 2020 we found the provider had rectified the shortfalls in training and had introduced a system to monitor water temperatures.

Since the last inspections we saw evidence that legionella risk assessments were carried out by a professional company at both locations and water temperature logs had been completed. We found infection prevention and control measures were implemented in line with Covid-19 guidance.

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

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 inspection in March 2020 the provider could not evidence basic life support and sepsis training for all staff and there was no induction system for locum staff.

At this inspection we found that all staff had undertaken basic life support and sepsis training. The provider had also introduced a formal induction process for locum staff. We saw examples of completed induction records for newly appointment locum staff.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, we identified shortfalls in the recording of information in the patient notes.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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 inspection in March 2020 we reviewed a selection of individual care records on the EMIS clinical system and found that care records were not comprehensive particularly in relation to medicine and long-term condition reviews. We found examples of where pathology results had not been filed on the clinical system due to actions that had not been followed up by a GP.

At a follow-up inspection in August 2020 we found improvements in the management of pathology results and new protocols were in place for staff to follow.

At this inspection we found that the details of patient consultations were not always comprehensive, and this was particularly evident with medicine and long-term condition reviews. In some cases, there was minimal or no information to show what had been discussed at the reviews.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, we identified shortfalls in a number of areas.

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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.42	0.55	0.82	Significant 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). (01/10/2019 to 30/09/2020) (NHSBSA)	12.5%	10.3%	8.8%	Tending towards variation (negative)
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 (01/04/2020 to 30/09/2020) (NHSBSA)	4.65	5.76	5.34	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	33.7‰	47.7‰	124.1‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.59	0.33	0.68	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

At the inspection in March 2020 we found minimal evidence of structured medicine reviews for patients on repeat medicines.

At this inspection we found further concerns with medicine reviews. Following searches carried out on the providers EMIS clinical system we found examples of where no medicine review had been undertaken within the appropriate timeframe and where medicine reviews had been undertaken, it was not documented in the patient notes what had been discussed.

We reviewed five patients on a Schedule 4 controlled drug with ten or more prescriptions in the last 12 months and found two had not had a clinically appropriate medicine review.

We reviewed five patients on a Schedule 3 controlled drug with ten or more prescriptions in the last 12 months and found one had no documented medicine review in the notes, one patient had their medicine stopped however there was no rationale recorded in the notes, and for another patient we found the indication for the medicine was not recorded in the notes.

Medicines management	Y/N/Partial
We reviewed four patients on a combination of medicines that require blood tests every six months (a medicine that is primarily used to treat fluid buildup and medicines to treat hypertension) and found two patients had not received blood tests in the previous year. At the inspection in March 2020 we reviewed patients on direct oral anticoagulants (DOACs are medicines that required ongoing monitoring) and found some instances where up to date blood tests were not recorded in the clinical system. At a follow-up inspection in August 2020 we reviewed all patients on DOACs and found they were being managed appropriately. At this inspection we randomly selected three patients on DOACs and found that blood tests for kidney function had been checked and recorded in the patient notes. However, the creatinine clearance had not been calculated and documented in the notes which demonstrated that the doses of DOACs were not being determined based on appropriate monitoring in line with licensing and national guidance. At the inspection in March 2020 the provider could not demonstrate that they were taking action to optimise antimicrobial prescribing to bring in line with local and national targets. At the follow-up inspection in August 2020 we found the provider had reviewed their antibiotic prescribing data and created an antibiotic prescribing audit to review in-house practices. The audit was set for quarterly searches to be carried out by the pharmacist. We found the provider had reduced the practice's prescribing of antibiotics. At this inspection we found the data showed that the provider had further reduced antibiotic prescribing to the values detailed in the indicator table at the beginning of this section. At the March 2020 inspection we found no documented checks of emergency equipment to ensure it were fit for use, emergency medicine provisions had not been risk assessed and there were no anaphylaxis kit in the treatment room. At the follow-up inspection in August 2020 we found the provider had put in place documented checks of the medical oxygen and defibrillator at both locations, an anaphylaxis kit was in the treatment room and all emergency medicines in place which was reconfirmed at this inspection. In response to the medicine management concerns identified at this inspection, the provider told us they accepted the findings and they would take immediate action to rectify the issues. The provider told us that the improvements they had made since the last inspection to medicine management were a work in progress and the employment of two full-time pharmacists had already made a positive impact on medicine management. Following the inspection visit the provider sent us an action plan with timeframes for completion of the concerns identified. One of the pharmacists told us they were working with the primary care network pharmacist on medicine optimisation. The current focus was reviewing patients on steroid inhalers and there was a plan to start monitoring the prescribing of high dose opiods (a medicine primarily used for pain relief) following this.	

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. (Since the March 2020 inspection).	five
Number of events that required action:	five

Explanation of any answers and additional evidence:

At the inspection in March 2020 we found staff were not clear on the procedure for reporting incidents. Staff provided us with examples of incidents which had not been reported and gone through a significant event analysis to ensure action was taken to prevent recurrence and share learning. The provider could not demonstrate sharing and learning from incidents by the whole practice team.

At a follow-up inspection in August 2020 we found the provider had introduced a significant events policy and added significant events as a standing agenda item at weekly staff meetings. Staff understood significant event reporting procedures.

At this inspection we reviewed a selection of staff meeting minutes that demonstrated shared learning across the practice team. Meeting minutes were also available on the shared drive to update staff who could not attend.

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

Event	Specific action taken
Incorrect coding	A staff member accidentally coded a patient with learning disabilities as pregnant as part of a project to review sodium valproate patients. Error spotted as part of the review, corrected with no harm done.
Possible safeguarding concern	The respiratory nurse flagged a patient as a possible safeguarding concern after a review due to living circumstances and patient exaggerating their problems. The patient was followed up where it was established that there was no safeguarding concern at all.
Hospital Prescribing Error	A hospital discharge letter gave the wrong drug strength which was questioned by the pharmacist and upon follow-up was corrected.

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:

At the inspection in March 2020 the provider demonstrated a system to capture, monitor and act upon safety alerts. However, the system had been introduced in October 2019 and therefore we could not be assured that the practice had run searches and acted upon safety alerts prior to this date.

At a follow-up inspection in August 2020 we found the provider had formalised their approach by creating a safety alert policy. They had employed a pharmacist, who had taken over the process, had carried out searches on previous safety alerts, and we saw that safety alerts were discussed at clinical team meetings.

At this inspection we saw examples of actions taken on recent alerts for example, regarding sodium valproate in pregnancy and an MHRA alert relating to EpiPen's. We also saw evidence from clinical meeting minutes details of safety alerts that had been discussed and acted upon by the pharmacist.

However, we found evidence of non-compliance with an MHRA alert from February 2019 with a medicine used to treat type 2 diabetes and a rare but serious potentially life-threatening side effect called 'Fournier's gangrene'. We selected five random patient records from 114 patients prescribed the medicine in the last six months and found no documentation of advice been given in line with the MHRA alert recorded in the notes. We also found evidence of non-compliance with an MHRA alert from November 2018 with a diuretic medicine and the risk of non-melanoma skin cancer. We selected two from five patients prescribed the medicine and found that no documentation of advice been given in line with the MHRA alert.

In response to the concerns with safety alerts identified at this inspection, the provider told us they accepted the findings and they would take immediate action to rectify the issues. The provider told us that the improvements they had made since the last inspection to comply with safety alerts were a work in progress and the employment of two full-time pharmacists had already made a positive impact on compliance with safety alerts. Following the inspection visit the provider sent us an action plan with timeframes for completion of the concerns identified.

Effective Rating: Requires Improvement

Following the inspection in March 2020 we rated the practice as inadequate for providing effective services because:

- There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to show that staff had the skills, knowledge and experience to carry out their roles.
- The practice was unable to show that care and treatment was always delivered in line with evidence-based guidance.
- Some performance data was significantly below local and national averages.

At this inspection we found improvement in respect of monitoring of the outcomes of care and treatment and the supervision and training of staff to carry out their roles effectively. We found some improvement in performance data such as cervical smear and childhood immunisation uptake although performance remained below target. Further improvements were needed particularly in relation to the oversight of clinical practice and structured reviews for patients with long-term conditions. Because of these concerns we have rated the practice as requires improvement for providing effective services.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment 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.	Partial
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.	No
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.	N/A
Explanation of any answers and additional evidence: At the inspection in March 2020 the provider could not demonstrate that GPs were providing clinical care using the same evidence-based guidance, for example, NICE guidelines. The standards of clinical care provided was not monitored. The provider told us that GPs kept up to date on an individual basis	

and there was no system to monitor clinical effectiveness. There were no protocols to support the HCA including specific circumstances where patients should be referred to a GP for further assessment.

At a follow-up inspection in August 2020 the provider had introduced a policy on the supervision of locum staff which included undertaking regular checks of locums' consultation notes but could not provide any specific evidence to demonstrate improvement in clinical oversight.

At this inspection we found evidence in clinical meeting minutes of topics being discussed in particular updates in NICE guidance. For example, minutes from a clinical meeting on 11/11/2020 recorded a discussion around a NICE recommended medicine for the treatment of leukemia and minutes from a clinical meeting on 28/10/2020 recorded NICE updates in the management of Rheumatoid Arthritis. The provider had also introduced a number of protocols to support the role of the HCA. However, no progress had been made in relation to the monitoring of GPs consultation notes to ensure high standards of clinical care.

At the inspection in March 2020 we found little evidence of structured reviews for patients with long-term conditions including reviews of their conditions and medicines.

At a follow-up inspection in August 2020 we identified further concerns particularly in relation to asthma reviews not taking place within the recommended timeframe. Following this inspection, because of the findings, we issued a Requirement notice for Regulation 12 Safe care and treatment.

At this inspection we reviewed six patients prescribed 12 or more medicines for asthma in the last 12 months (12 or more indicates poor control of asthma) and found four did not have a review of their condition in the recommended timeframe and therefore the provider was in continuing breach of Regulation 12 Safe care and treatment.

We also found instances where the indication for prescribing a medicine was not documented in the patient notes and medicine reviews were not comprehensively documented, and therefore we did not have reassurance that patients ongoing needs were always fully assessed.

In response to these concerns identified at the inspection, the provider told us they accepted the findings and they would take immediate action to rectify the issues. The provider told us that the improvements they had made since the last inspection to patients' medicine and long-term condition reviews were a work in progress and the employment of two full-time pharmacists had already made a positive impact on patient reviews. Following the inspection visit the provider sent us an action plan with timeframes for completion of the concerns identified.

Older people

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to older people because of the overarching concerns identified in the delivery of effective care.

- 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 followed up on older patients discharged from hospital.
- We found that annual medication reviews for older patients were not comprehensive, as it was not always documented in the patient notes what had been discussed.
- 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: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to people with long-term conditions because of continuing concerns we identified in relation to structured reviews.

- We reviewed six patients prescribed 12 or more medicines for asthma in the last 12 months (12 or more indicates poor control of asthma) and found four did not have a review of their condition in the recommended timeframe.
- 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.
- We found that care records for medication reviews for patients with long-term conditions were not comprehensive.
- We found examples of where patients with asthma did not have an asthma management plan documented in the notes.

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. (01/04/2019 to 31/03/2020) (QOF)	75.1%	77.1%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.9% (6)	6.9%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	95.2%	89.5%	89.4%	No statistical variation
PCA rate (number of PCAs).	13.7% (10)	6.5%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	85.1%	83.5%	82.0%	No statistical variation
PCA rate (number of PCAs).	3.9% (6.0)	3.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	77.4%	65.5%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	19.3% (126.0)	13.3%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.7%	72.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	16.9% (188.0)	5.6%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	96.8%	90.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	6.1% (4)	9.0%	4.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to families, children and young people because the childhood immunisation uptake remained below the national target.

- The practice has not met the minimum 90% for the five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for the five childhood immunisation uptake indicators. However, performance had improved since the last inspection for four of the indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	108	125	86.4%	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) (01/04/2019 to 31/03/2020) (NHS England)	102	131	77.9%	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) (01/04/2019 to 31/03/2020) (NHS England)	102	131	77.9%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	102	131	77.9%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	62	117	53.0%	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 latest published figures for childhood immunisations show the provider has not met the WHO targets however there has been improvement since the previous year with four out of five indicators. Performance for the first listed indicator above has improved on the previous year from 80.6% to 86.4%, the second from 67% to 77.9%, the third from 66% to 77.9%, the fourth from 69.1% to 77.9%, however, the fifth indicator has declined from 60.3% to 53%. The practice manager discussed with us additional efforts the provider was making to improve uptake. These included information in different languages, access to early/late immunisation appointments through the local Hub service. The provider also ran regular searches on the clinical system to identify non-attenders and a designated staff member contacted patients to encourage them to attend. We were told that the provider liaised with the health visitor when appropriate and we also saw evidence from meeting minutes where immunisations had been discussed.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings
The practice is rated as requires improvement for the care provided to working age people because cervical smear uptake was below the national target. • Public Health England figures for cervical cancer screening showed a slight improvement since the last inspection (52.6% to 56.9%). However, they remained way below the England average. • 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.

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: 30/06/2020) (Public Health England)	56.9%	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)	56.1%	60.9%	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)	42.9%	43.5%	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 (01/04/2019 to 31/03/2020) (QoF)	90.9%	91.6%	92.7%	N/A

(to) (PHE)		-		-

Any additional evidence or comments
At the inspection in March 2020 the Snapshot data from Public Health England for cervical screening uptake showed a performance of 52.6% (Snapshot date: 30/09/2019). At this inspection the Snapshot data (Snapshot date: 30/06/2020) showed an improvement in uptake to 56.9%. Since May 2020 inspection the provider had increased nurse hours to 16 hours per week to provide more capacity for cervical screening in addition appointments were available at the local Hub service which ran 8am to 8pm, Monday to Sunday and a primary care network Saturday clinic was available for cervical smears. The practice manager discussed with us additional efforts the provider was making to encourage eligible patients to attend for smears. These included flags on the EMIS clinical system of non-attenders for opportunistic discussion, invites translated into languages appropriate to the local population including Polish, Bulgarian, Italian and Romanian and liaising with the primary care network and extended hours Hub to arrange access to out of hours smear sessions. We also saw evidence from clinical meeting minutes of discussions around smear coverage.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings
The practice is rated as requires improvement for the care provided to people whose circumstances make them vulnerable because of the overarching concerns identified in the delivery of effective care. • Same day appointments and longer appointments were offered when required. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings
The practice is rated as requires improvement for the care provided to people experiencing poor mental health because of the overarching concerns identified in the delivery of effective care. • 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. • 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 (01/04/2019 to 31/03/2020) (QOF)	98.9%	87.8%	85.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	11.5% (12)	7.9%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	89.3%	77.8%	81.4%	No statistical variation
PCA rate (number of PCAs).	3.4% (1)	4.3%	8.0%	N/A

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity. However, the provider had improved its quality improvement activity since the March 2020 inspection.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559	Not Available	533.9
Overall QOF score (as a percentage of maximum)	100%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	13.5%	Not Available	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.	No
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

At the inspection in March 2020 we found little evidence of quality improvement, including clinical audit, being undertaken by the provider and no comprehensive program of audit.

At this inspection we found the provider had increased the remit of quality improvement activities although work was required to develop it into a comprehensive program.

Quality improvement initiatives undertaken included:
Participation in a pharmacist-led, IT-based intervention to reduce clinically important medication errors in primary care (PINCER).
Participation in a quality improvement tool developed by the Department of Health (QIPP)
Searches to ensure compliance with MHRA alert regarding Sodium Valproate in pregnancy.
Audits to ensure monitoring of Lithium treatment is in line with NICE guidance.
Audits to identify inadequate cervical smears and recall patients as appropriate.
High risk medicine / DOAC / warfarin monitoring.
Antibiotic audits to monitor compliance with NICE and local guidance.
Patient death audits to monitor patient deaths on an annual basis, broken down into expected vs unexpected deaths.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

At the inspection in March 2020 the provider could not evidence role-specific training for nursing staff. There was no paperwork to demonstrate that the nurses and HCA had the necessary competency checks to perform their roles effectively and no clinical protocols to support the HCA with their role. Job

descriptions and contracts of employment were vague and did not include role specific information. The provider could not evidence a structured induction programme for newly appointed staff and appraisals lacked detail of learning and development needs.

At a follow-up inspection in August 2020 we found the provider had reviewed their approach to staff induction, job descriptions and contracts and role-specific training needs. We found mandatory training modules had been completed by staff and the provider had reviewed the staff appraisal policy and completed a new appraisal for each member of staff. However, we found that appraisals continued to have little information on the learning and development needs of staff.

At this inspection we found that the provider had employed a number of new staff since the March 2020 inspection. We reviewed induction training records, mandatory and role-specific training for these staff and found the necessary documentation was in place. Staff we interviewed told us that their appraisal supported their development.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	No
Explanation of any answers and additional evidence: The provider could not evidence that the process for seeking consent was monitored.	

Caring Rating: Requires Improvement

Following the inspection in March 2020 we rated the practice as requires improvement for providing caring and services because:

- The practice had not acted on feedback from the National GP Patient Survey.
- The practice needed to improve on the identification and support of patients with carer responsibilities.

At this inspection we found some improvement. The provider had reviewed policy on identifying and supporting patients with carer responsibilities. The provider had undertaken an analysis of the National GP Patient Survey, results showed an improvement on the previous years performance and an action plan had been drawn-up to make further improvements although performance remained below local and national averages. In addition, since the March 2020 inspection, feedback received from patients directly to the CQC was predominantly negative in relation to kindness, respect and privacy. Because of these concerns the practice remains rated as requires improvement for providing caring services.

Kindness, respect and compassion

Staff did not always treat patients with kindness, respect and compassion. Feedback from patients was mainly negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Partial
Staff displayed understanding and a non-judgemental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: Since the inspection in March 2020 we received 27 ‘share your experience’ feedback forms directly through our website or by phone from patients who used the service. Twenty-four of these reported a negative experience, two reported a positive experience and one was mixed. The main themes relating to the caring aspects of the service were poor staff attitude, lack of empathy, staff rude and abrupt to patients and not supportive of the needs of older people.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	79.5%	85.8%	88.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time	72.6%	83.5%	87.0%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	93.2%	93.2%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	67.0%	75.7%	81.8%	Tending towards variation (negative)

Any additional evidence or comments
At the inspection in March 2020 the provider could not demonstrate that they were monitoring patient feedback and taking action to improve the service provided accordingly. At this inspection the provider demonstrated that they had carried out an analysis of the national GP survey performance and put in place actions to improve specific indicators. The provider had compared performance to the previous year which showed a marked overall improvement in performance. However, further improvement was necessary as some indicators were showing as variation (negative) or tending towards variation (negative).

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

Any additional evidence
The provider gathered feedback through the friends and family test (a single question survey created by the NHS which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care).

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Staff spoke several different languages appropriate for the local population.	

Source	Feedback
Interviews with patients.	We were unable to speak to patients at the inspection because of Covid restrictions.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	96.2%	89.8%	93.0%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: In addition to interpreter services staff spoke a variety of languages that aligned with the local populations needs. Information was written in a variety of languages including Polish, Bulgarian, Romanian and Arabic.	

Carers	Narrative
Percentage and number of carers identified.	The provider had 82 patients with carer responsibilities on the Neasden and Greenhill patient list and 23 patients with carer responsibilities on the St. Andrews list. This equated to approximately 0.9% and 1.2% of the number of registered patients respectively.
How the practice supported carers (including young carers).	The provider had created policy to improve identifying carers. There was a carers support leaflet available through the provider website and links to online resources. Carers were signposted to local support organisations.
How the practice supported recently bereaved patients.	The provider sent us an example of emotional support provided to a bereaved patient and the patients response.

Privacy and dignity

The practice did not always respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	No

Explanation of any answers and additional evidence:

From 'share your experience feedback' received from patients directly to the CQC we noted a common theme around privacy. People reported that there was no consideration for privacy at the reception area. They said that conversations with patients could be overheard and patients' medical history discussed openly in the reception area.

Responsive Rating: Requires Improvement

Following the inspection in March 2020 we rated the practice as requires improvement for providing responsive services because:

- The practice had not acted on feedback from the National GP Patient Survey.
- There was insufficient nursing capacity which aligned with low child immunisation and cervical screening achievement rates.

At this inspection we found some improvement. The provider had undertaken an analysis of the National GP Patient Survey, results showed an improvement on the previous years performance and an action plan had been drawn-up to make further improvements. The provider had increased nursing capacity to 16 hours per week and strengthened the clinical team. However, cervical screening and child immunisation uptake remained below national targets. In addition, since the March 2020 inspection feedback received from patients directly to the CQC was predominantly negative in relation to access to the service. Because of these concerns the practice remains rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

At the inspection in March 2020 we found insufficient nursing capacity to meet the needs of people requiring cervical screening and immunisation appointments. At this inspection we found the provider had increased nurse hours to 16 hours per week to help improve cervical smear, childhood immunisation and flu vaccination uptake.

At this inspection we noted the facilities and premises needed a refurbishment. We visited the Neasden location on the day of inspection and found the decor was in need of a refreshment and some equipment for example the examination couch in the doctors consultation room was not in a good state of repair.

The provider had improved the gender mix of staff. Patients could access both male and female GPs at both locations.

Practice Opening Times

Day	Time
Opening times:	
Monday	08:00-18:30
Tuesday	08:00-18:30
Wednesday	08:00-18:30
Thursday	08:00-18:30
Friday	08:00-18:30
Appointments available:	
Monday	08:00-18:30
Tuesday	08:00-18:30
Wednesday	08:00-18:30
Thursday	08:00-18:30
Friday	08:00-18:30

Older people

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to older people because of the overarching concerns identified in the delivery of responsive care.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to people with long-term conditions because of the overarching concerns identified in the delivery of responsive care.

- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to families, children and young people because of the overarching concerns identified in the delivery of responsive care.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to working age people because of the overarching concerns identified in the delivery of responsive care.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice closed at 6.30pm Monday to Friday and therefore few appointment slots out of working hours. However, pre-bookable appointments were available to all patients 8am until 8pm Monday to Sunday through an extended hours hub service. GP appointments were available Sunday 10am until 3pm at the branch site.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to people whose circumstances make them vulnerable because of the overarching concerns identified in the delivery of responsive care.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- Two primary care network social prescribers worked with the practice who were proactive in contacting vulnerable patients to ensure access to food and medicine particularly during the Covid-19 lockdown period.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

The practice is rated as requires improvement for the care provided to people experiencing poor mental health because of the overarching concerns identified in the delivery of responsive care.

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when necessary.	Yes

The provider had changed the way people accessed the service in line with Covid-19 guidance. There was a telephone triage system in place whereby the GPs triaged patients for a telephone consultation, physical appointment or referral to a designated Covid-19 'hot hub'. The practice manager told us that most appointments were telephone consultations and patients were only seen face to face when necessary. For example, when an examination was required, immunisation or cervical smear. E-consults were available (allows patients to submit their symptoms to a GP electronically). However, the practice manager told us that there was limited demand for these from patients.

Since the inspection in March 2020 we received 27 'share your experience' feedback forms directly through our website or by phone from patients who used the service. Twenty-four of these reported a negative experience, two reported a positive experience and one was mixed. A general theme emerging from the feedback was a lack of access to appointments and not enough clinical staff for the number of registered patients. Since the last inspection the provider had strengthened the clinical team. This included three new sessional GPs, a practice nurse and two clinical pharmacists. At the time of the inspection sessional GPs were providing per week 15 sessions, the salaried GP 12 sessions, practice nurses 16 hours and the two clinical pharmacists were full-time. We can assess the impact of the staff changes on patient satisfaction with access at the next inspection of the practice.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	77.8%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	66.0%	59.4%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	66.3%	59.1%	63.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	71.8%	64.3%	72.7%	No statistical variation

Any additional evidence or comments
At the inspection in March 2020 the provider could not demonstrate that they were monitoring patient feedback and acting to improve the service provided accordingly. At this inspection the provider demonstrated that they had carried out an analysis of the national GP survey performance and put in place actions to improve specific indicators. The providers analysis showed an overall improvement in performance compared to the previous year.

Source	Feedback
For example, NHS Choices	Two out of 5 stars based on five reviews. Comments included bad customer service, excellent care and support, not very helpful and don't care.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received since the last inspection.	19
Number of complaints we examined.	five
Number of complaints we examined that were satisfactorily handled in a timely way.	five
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: At the inspection in March 2019 there was no evidence of learning from complaints to drive continuous improvement.	

At this inspection we found the provider had reviewed the complaints policy, provided training to staff on handling complaints, and we saw evidence from meeting minutes that complaints were a standing agenda item at meetings where they were discussed and learning shared.

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint about a Drs attitude.	Patient received an apology and the provider spoke to the Dr regarding this.
A relative complaint about patient's treatment.	The provider contacted the relative where it was discovered that the complaint was against the hospital rather than the GP practice.
A relative queried about patient's referral.	This was due to hospital referral issues. The provider continued to monitor the referral status and updated the relative.

Well-led Rating: Requires Improvement

Following the inspection in March 2020 we rated the practice as inadequate for providing well-led services because:

- Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- While the provider had a clear vision, that vision was not supported by a credible strategy.
- The overall governance arrangements were ineffective.
- The provider did not have clear and effective processes for managing risks, issues and performance.
- The provider did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation.

At this inspection we found some improvement in leadership and governance. However, concerns about governance arrangements, particularly clinical governance and the sustainability of the improvements remained. Because of these concerns the practice is rated as requires improvement for providing well-led services.

Leadership capacity and capability

Leaders demonstrated some improvement in the capacity and skills to deliver high quality sustainable care although we could not be assured of the sustainability of the improvements.

	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.	Partial

Explanation of any answers and additional evidence:

At the inspection in March 2020 we found ineffective leadership and oversight. Leaders could not demonstrate an effective approach to maintaining and improving the quality of care provided.

At this inspection we found some improvement. Leaders had identified the challenges of providing high quality care and had made some progress in addressing these. The provider told us the main challenges were a high turnover of clinical staff and a patient demographic with a higher than average degree of social deprivation. To address these challenges a new period of recruitment had been initiated. The provider had recruited three sessional GPs, a practice nurse and two full-time clinical pharmacists. To help reduce the health inequalities and improve the support of vulnerable patients, the provider had utilised the services of two social prescribers sourced through the primary care network. To improve cancer screening, child immunisation and flu vaccination uptake the provider had increased nursing capacity and strengthened call/recall systems.

In relation to leadership development, we were told at the inspection that consideration was underway to the formation of a partnership within the practice to strengthen leadership.

Vision and strategy

The practice had a clear vision and 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	No

Explanation of any answers and additional evidence:

At the inspection in March 2020 we found no strategy or business plan to realise the practice vision. Staff did not understand the vision, values and strategy and their role in achieving them.

At this inspection we found the provider had formulated the practice's vision and values. These had been developed in collaboration with staff and staff we engaged with understood their role in achieving them. The vision and values were displayed in the practice's reception area and available on the shared drive. The provider had implemented a mission statement which included a statement on the practice's commitment to equality, diversity and human rights. The mission statement talked about improving the health and quality of life for all individuals in the communities they serve, delivering an invaluable service to patients and providing a positive and safe experience for all their patient care. The provider had drawn up a five-year business plan with an aim to becoming part of a community-led, multidisciplinary, flexible, integrated team with an appropriate mix of skills and roles. We found no evidence of patient or external partner involvement in the formulation of the vision, values and strategy and there was no indication of how progress would be monitored.

Culture

The practice had improved its culture to drive 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.	Partial
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:

Since the inspection in March 2020 the provider had implemented a duty of candour policy and there was evidence from the staff training log that staff had completed duty of candour training. We reviewed one example from the complaints log where it was recorded that the patient received an apology. However, there were no further examples and therefore we could not ascertain if a duty of candour was consistently applied.

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

Source	Feedback
Staff interviews	We spoke to a mix of staff as part of the inspection including a pharmacist, nurse, HCA, receptionist and administrator. All the staff interviewed reported a positive experience of working at the practice. They said the culture was one of team work. Leaders were approachable and they felt supported by them.

Governance arrangements

There were some improvements in responsibilities, roles and systems of accountability to support good governance and management. However, concerns remained in relation to clinical governance.

	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:

At the inspection in March 2020 we found inadequate governance arrangements. The provider could not demonstrate effective governance systems for key areas such as complying with safety alerts, induction, recruitment, training, supervision, staff competence and development. The provider could not demonstrate effective governance systems to ensure care and treatment was delivered in line with national guidance. The provider could not demonstrate a systematic and formal approach to staff meetings and evidence of shared learning to improve quality. There was no effective system for reviewing and updating practice policy and procedures and clinical protocols were not in place to support the HCA. There was ineffective clinical governance and oversight.

At this inspection we found some improvement in governance. For example, oversight of key areas such as induction, recruitment, training and staff development had markedly improved. There was evidence of regular discussions amongst clinicians to discuss trends and updates in NICE guidance from clinical meeting minutes and the provider could demonstrate a marked improvement in meeting arrangements.

We saw evidence that staff meetings had been carried out consistently since the last inspection, minutes were documented with standing agenda items including significant events, complaints and safety alerts with evidence of shared learning. For those staff who could not attend, meeting minutes were made available via email or the shared drive. Practice policy and procedures had been reviewed and updated, a variety of new policies had been implemented and staff knew how to access them and understood their roles and responsibilities. The provider had changed policy on reviewing hospital letters and clinical correspondence which was now undertaken collaboratively by the pharmacist and lead GP. Shared care agreements were evidenced between the provider and secondary care to manage patients on high risk medicines and governance procedures for managing and monitoring service-level agreements with third parties.

Clinical governance showed some improvement, but concerns remained. The provider had drawn-up a clinical governance policy, however the policy did not specify who the provider had delegated as clinical lead. Clinical protocols had been implemented to support the HCA to undertake their role safely and effectively. A system to improve clinical effectiveness through weekly clinical meetings to discuss trends and updates in NICE guidance was in place. The provider had broadened their scope of audits and quality improvement activity and implemented policy to govern the process of reviewing GP consultation notes to ensure effective care and treatment. However, there was no evidence that the process of reviewing GP consultations was underway. Results from our searches on the EMIS clinical system identified a number of continuing issues with medicine management, complying with safety alerts, medicine and long-term condition reviews. Although the provider submitted an action plan with timeframes for completion to address these issues the concern remained that the provider made clinical improvements reactively rather than taking a proactive approach. Whilst the provider had made progress in governance arrangements we still had concerns about their effectiveness and sustainability.

Managing risks, issues and performance

There were some improvements in the 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.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

At the March 2020 inspection we found that the provider could not demonstrate effective assurance systems and they were not regularly reviewed and improved. At the inspection we found some improvement however assurance systems were not comprehensive. For example, the provider did not monitor the clinical practice of locum staff.

At the March 2020 inspection we found minimal evidence of processes to manage performance. At this inspection we found some improvement. For example, we found improvement in the oversight of performance regarding antimicrobial prescribing and stewardship. We found a markedly improved approach to staff meetings with evidence of routine discussions around performance.

At the March 2020 inspection we found few examples of quality improvement, including clinical audit, being undertaken by the provider. At a follow-up inspection in August 2020 we found the provider had broadened their remit for clinical audit and we found this had been developed further at this inspection. We found that internal audit had been reviewed and with the employment of two full-time clinical pharmacists, audit was becoming more routine and targeted on areas of concern. However, further progress was required to develop it into a comprehensive program.

At the March 2020 inspection we found the business continuity plan had not been reviewed to include current risks. At this inspection we found the provider had updated the plan to include all eventualities.

Although we identified some improvement in risk management since the March 2020 inspection. At this inspection we found continuing concerns with medicine reviews for patients on repeat medicines, monitoring of patients on high-risk medicines and controlled drugs, and compliance with safety alerts.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	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
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:
At the inspection in March 2020 we found the provider did not use performance data from the National GP Patient Survey to improve patient satisfaction with the service. At a follow-up inspection in August 2020 and this inspection we saw an action plan designed to address areas of low performance in the National GP Patient Survey. The provider had undertaken a comparison of the results with local and national figures which showed they had improved their performance in 12 out of 18 indicators.

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice involved patients and staff 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.	Partial
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: The practice manager told us that there were 12 members in the PPG. The provider showed us the meeting minutes from a PPG meeting in July 2020. There had not been a meeting held since July due to Covid-19 restrictions and therefore the PPG had become less active. The minutes showed that the provider had engaged with patients and involved them in discussions relating to the service. There was evidence that patients' views had been gathered and discussed. The provider told us that there were plans to start a PPG at the level of the primary care network soon.	

Feedback from Patient Participation Group.

Feedback
We were unable to arrange interviews with the PPG as no members were available to be interviewed.

Continuous improvement and innovation

There was some improvement in 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:	

At the inspection in March 2020 the provider could not demonstrate a strong focus on continuous learning and development. They could not demonstrate how learning was shared effectively and used to improve the service provided. There was no examples of innovative practice by the provider.

At this inspection we found a marked improvement in this respect. A structured program of meetings had been implemented including weekly clinical meetings and fortnightly whole practice meetings. It was evident from meeting minutes that a number of standing agenda items were routinely discussed and learning shared. For example, from incidents, safeguarding cases and complaints. We saw training and development opportunities were routinely discussed in staff meetings and NICE guidelines discussed to improve clinical effectiveness. We found that the practice had made some progress in mitigating risk including clinical risk however further improvement was necessary to ensure risk management was comprehensive and sufficiently embedded to ensure high quality sustainable care.

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.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.