Care Quality Commission

Inspection Evidence Table

Park Royal Medical Practice (1-5373877841)

Inspection date: 30 April 2019

Overall rating: Requires improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe — Rating: Requires improvement

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	N
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	N
Explanation of any answers and additional evidence: • Staff gave us conflicting information as to which GPs had lead roles for safeguarding adults and children.	

Safeguarding	Y/N/Partial
• The safeguarding adults' policy contained a short narrative regarding female genital mutilation (FGM) and stated that it is a criminal offence but did not state that it is a legal requirement to report FGM to the appropriate authorities. The safeguarding policies for both adults and children did not reference the most recent intercollegiate safeguarding guidance published in January 2019. • Staff told us that safeguarding registers for children and vulnerable adults were not maintained and we were unable to review evidence that systematic reviews of children and vulnerable adults had been conducted. • Although non-clinical staff had been trained to act as a chaperone for patients, the practice policy did not provide clear guidance on the procedure involved, for example, where the member of staff should stand when providing this role. • Staff told us they did not have meetings with health visitors, midwives or school nurses.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: • We reviewed evidence that information in staff recruitment records was incomplete. For example, two locum GPs records were unavailable, one GP's record was missing a full employment history and three transcripts of interviews were missing for two GPs and one admin staff. • The practice did not demonstrate that staff had completed required blood tests to provide certificated immunity and had undertaken immunisations in line with PHE guidance. • Although systems were in place to ensure clinical staff had the appropriate registration at the time of recruitment, there was no system in place to regularly monitor this to ensure it remained up to date.	

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: 23/05/2018	Partial
There was a record of equipment calibration. Date of last calibration: 23/05/2018	Partial
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 04/01/2019	Partial
There was a log of fire drills. Date of last drill: unknown	N
There was a record of fire alarm checks. Date of last check: 07/08/2018	Y
There was a record of fire training for staff. Date of last training: different dates.	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Not completed	N
Actions from fire risk assessment were identified and completed.	N

Explanation of any answers and additional evidence:

- We reviewed information to demonstrate that portable appliance testing and calibration for some medical devices had been undertaken, but this did not include all items of equipment, for example, the hearing loop, ECG machine and ear irrigation equipment.
- The practice was situated within a purpose-built private finance initiative (PFI) NHS property building and its facilities management was undertaken by the same property company. The practice did not maintain oversight of risk assessments, including control of substances hazardous to health (COSHH), legionella and fire safety, undertaken by the facilities management company.
- During the inspection the provider could not demonstrate these risk assessments were in place. Following the inspection and during the factual accuracy process the provider submitted risk assessments related to health and safety and COSHH. In addition, the provider has commissioned external fire safety and legionella risk assessments.
- The practice did not maintain a copy of fire extinguishers checks, fire drill checks and fire alarm checks and this information was supplied to us by the hospital facilities management company.
- We reviewed evidence that five out of fifteen staff had not completed annual fire safety training.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 1 May 2018	Y

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 May 2018	Y
Explanation of any answers and additional evidence: • Staff told us that the property management company had conducted appropriate premises and security and health and safety risk assessments', but the practice did not hold a copy which they could show us during the inspection. • During the inspection the provider could not demonstrate this risk assessment was in place. Following the inspection and during the factual accuracy process the provider submitted evidence to demonstrate that a health and safety risk assessment has been carried out and action points have been completed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: 18 May 2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: • We reviewed evidence that five out of 15 staff had not undertaken annual infection prevention and control (IPC) training and that the clinical lead for infection prevention and control had not undertaken enhanced training to support them in this role. • Prior to the inspection, the provider employed an Advanced Nurse Practitioner (ANP) who had been the IPC lead and had undertaken enhanced IPC training. However, during and following the inspection, the provider could not demonstrate interim infection and prevention controls whilst waiting to recruit a new member of staff.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

- Staff told us they were under pressure due to an increased workload and were actively recruiting additional clinical and administration personnel to support them and increase capacity.
- Staff told us that temporary staff undergo an induction but were unable to demonstrate evidence of this and the practice did not have a locum pack in place.
- There was limited evidence that comprehensive risk assessments, for patients with long term conditions, were embedded into practice systems. However, clinical staff have submitted evidence of a plan to address areas for improvement, identified as part of their quality and outcome framework (QOF) review.
- Practice staff told us how they would screen patients for potential medical emergencies, but we observed that patients who called or attended the practice to request a GP appointment, were not screened for red flag signs.

Information to deliver safe care and treatment

Staff had limited systems to ensure they had information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

- Clinical staff told us they followed a consistent approach in relation to evidence-based practice. However, we reviewed minutes of clinical meetings and National Institute of Clinical Excellence (NICE) guidance was not a standing agenda item and we were unable to review evidence this had been discussed as minutes from clinical meetings were limited in content.
- The practice did not have a system or process to manage and safety net urgent two-week wait (2WW) referrals. We reviewed evidence of a number of 2WW referrals that had not been followed up by the practice. Following the inspection, the practice submitted evidence they had reviewed and followed up all referrals.
- The practice did not have a system or process to safely manage test results in line with best practice guidance. We found some examples of test results that dated back to January 2019 which had not been reviewed and actioned by a GP. Following the inspection, the practice submitted evidence they had reviewed, actioned and filed all results appropriately.
- During the inspection three unmatched patients were identified relating to incoming test results. Following the inspection and during the factual accuracy process the practice has addressed this issue within the clinical system and implemented a new process for the monitoring and management of incoming test results.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.72	0.60	0.91	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). (01/01/2018 to 31/12/2018) (NHSBSA)	8.7%	10.5%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pimeclone 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA)	5.45	5.87	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	0.95	1.13	2.13	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Y
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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- The practice did not keep a record of serial numbers for those prescriptions kept in doctors bags.
- The practice did not have a system or process in place to safely manage patients health who had been prescribed high-risk medicines and we reviewed evidence that in some cases information contained in clinical records regarding appropriate blood monitoring for patients, had not been updated regularly.
- Staff submitted evidence to us of planned protocols, which were undated, regarding safe prescribing of high-risk medicines, for example, lithium, azathioprine, methotrexate and warfarin. However, the methotrexate protocol did not include the latest recommended monitoring guidance, for example, how frequently blood monitoring must be undertaken for patients who are prescribed this medicine.

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y

There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	5
Explanation of any answers and additional evidence: • The practice had a system and policy in place to record SEAs however, staff did not complete the required form and evidence reviewed indicated that the practice had been slow to analyse SEAs and share learning.	

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

Event	Specific action taken
Vaccines not delivered	Supplier was unaware of the new practice address. Practice submitted a priority order for new vaccines. In future, staff will check all suppliers have current practice address.
Smear test incorrectly labelled.	Staff will ensure all specimens are labelled as soon as they are taken.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Effective Rating: Requires improvement

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

Explanation of any answers and additional evidence:

- The provider could demonstrate evidence of comprehensive care plans for patients who had received ante and postnatal care; end of life care; children and those patients who had a disability.
- We reviewed some patients' records and the provider could demonstrate evidence of appropriate post-hospital discharge consultations and consultations for dementia screening.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHSBSA)	0.75	0.42	0.79	No statistical variation

Older people Population group rating: Good

Findings

- Older patients with complex needs are care planned and referred to the Complex Patient Management Group (CPMG) for additional support and integrated care.
- There is a monthly multi-disciplinary (MDT) meeting to include district nurses, palliative care nurse and community staff to review cases and agree joint management of patients' care.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Staff who were responsible for reviews of patients with long-term conditions had not received initial core specific training for roles they had performed, for example, long term conditions review, ear irrigation and travel medicine.
- The practice could not demonstrate that it was systematically providing patients with long-term conditions with a structured annual review to check their health and medicines needs were being met. Clinical staff submitted an action plan on the day of inspection which has highlighted this as an area for improvement.
- Although the practice told us they were working to support patients who were pre-diabetic to prevent them from developing Type 2 diabetes, staff told us they did not have embedded risk assessment processes in place to identify patients who may be at risk of other long-term conditions.
- The practice told us they worked closely with the local diabetic pathway team to improve care but for patients who had been diagnosed with diabetes, the practice quality and outcomes framework (QOF) achievement rates for appropriate blood glucose monitoring (64.6%) was identified as a negative variation compared to local (77.0%) and national (78.8%) levels.
- For patients who had been diagnosed with diabetes, the practice achievement rate for appropriate blood cholesterol monitoring was identified as trending towards a negative variation (69.4%) compared to local (78.7%) and national (80.1%) levels.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	64.6%	77.0%	78.8%	Variation (negative)
Exception rate (number of exceptions).	4.3% (22)	11.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.1%	79.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	4.7% (24)	8.1%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	69.4%	78.7%	80.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	6.2% (32)	8.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	84.2%	78.9%	76.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.7% (4)	2.6%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	88.9%	93.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.7% (1)	9.5%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	77.5%	82.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.2% (21)	3.7%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	80.8%	85.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.3% (3)	10.6%	6.7%	N/A

Families, children and young people

Population group rating: requires improvement

Findings

- For two out of three indicators, childhood immunisation uptake rates for children aged 2 years were below World Health Organisation (WHO) targets.
- During the inspection staff we interviewed told us that consultation times were between 9am and 5pm. Following the inspection and during the factual accuracy process the provider told us they have a policy of always accommodating appointments children who can be seen between 8.30 am and 6.30pm week days and from 9am to 1pm on Saturdays.
- Administration staff followed up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Staff told us they did not hold meetings with health visitors, school nurses or midwives.
- Clinicians told us they referred young people to a dedicated sexual health and contraception service within the hospital building.
- The provider could not demonstrate how the practice was proactive in identifying support strategies for this patient group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	105	113	92.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	62	67	92.5%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	59	67	88.1%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	56	67	83.6%	Below 90% minimum (variation negative)

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice offered appointments on Saturday mornings for working age people but did not offer extended hours appointments Monday to Friday.
- The practice did not have a cytology policy in place and did not audit cervical smears.
- Staff told us they did not have a failsafe system in place regarding cervical smears.
- Clinical staff who undertook cervical smears were unable to tell us what the inadequate rate of smears was, as the audit undertaken regarding inadequate smears did not include how many patients had been included in the sample.
- The provider could not demonstrate how the practice was proactive in identifying support strategies for this patient group.

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	65.8%	63.7%	71.7%	No statistical variation

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) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	53.6%	61.8%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %)(01/04/2017 to 31/03/2018) **(PHE)**	38.2%	42.0%	54.5%	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. (01/04/2017 to 31/03/2018) **(PHE)**	75.0%	79.2%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	50.0%	55.2%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Staff told us they had an agreement with the urgent care centre (UCC) within Central Middlesex Hospital, that they would accommodate those patients, with a same day appointment, who are regarded as living in vulnerable circumstances, and who wished to register with a GP.
- The provider could not demonstrate they held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The provider could not demonstrate how the practice was proactive in identifying support strategies for this patient group.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- Patients are encouraged to refer to improving access to psychological therapies (IAPT) where appropriate.
- The practice achievement rate for patients with a serious mental illness who had a documented care plan in their records was recorded as a negative variation, (72.3%), compared to local (88.6%)and national (89.5%) levels.
- The practice provides care for approximately 120 Care Home patients, 25 residential home patients and patients living in Extra Care facilities. The practice team contains GPs' with a special interest in older patients, including dementia, who attend regular multi-disciplinary team meetings with specialist clinical staff, consultants and colleagues within the PCN.

- The provider could not demonstrate how the practice was proactive in identifying support strategies for this patient group.

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 (01/04/2017 to 31/03/2018) (QOF)	72.3%	88.6%	89.5%	Variation (negative)
Exception rate (number of exceptions).	3.3% (4)	7.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.2%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.6% (2)	5.8%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	80.3%	84.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (3)	4.1%	6.6%	N/A

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	488.8	536.7	537.5
Overall QOF exception reporting (all domains)	3.7%	5.9%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years	Partial

- Patient outcomes were hard to identify as limited clinical audits had been carried out to improve the quality of care and there was limited evidence that the practice was comparing its performance to others; either locally or nationally. For example, we reviewed evidence of two

completed-cycle audits. One related to care plans for patients in the care homes the practice provided medical services to and the second related to a national medical safety alert. The first audit demonstrated an increase that care plans were in place for patients, from 75% to 93.75% and will be re-audited every four months. The second demonstrated that all female patients who had been prescribed a particular medicine, valproate, had had their records reviewed. The practice did not demonstrate they had a pregnancy prevention plan in place regarding this medicine and that they had planned to re-audit this.

- GPs had conducted a one-cycle audit of under 16-year olds to ensure that patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma had been followed up. Fifty percent of patients had been reviewed within 48 hours. The practice had planned to re-audit this in three months-time.

Effective staffing

The practice was unable 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.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The practice could not demonstrate how they assured themselves of the competence of clinical staff who carried out long term condition reviews, ear irrigation, vaccinations and travel medicine advice and immunisations. Following the inspection and during the factual accuracy process the provider submitted evidence of the practice nurse's cervical smear training.
- Staff told us they had undertaken an orientation programme when they had commenced employment at the practice, but the practice could not demonstrate evidence of this.
- Although some staff had received annual appraisals, the practice nurses had not.
- Staff told us there was no overarching policy and protocols for the roles the HCA performed. Following the inspection and during the factual accuracy process the provider told us HCA is currently only providing limited clinical support in phlebotomy and health checks and not the full range of HCA competencies. However, the practice has not demonstrated how they have trained the HCA for these specific aspects of their role and assessed their competence.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018)	Yes

(QOF)	
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
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 not 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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	N
Explanation of any answers and additional evidence: • The provider could not demonstrate how the practice supported and signposted patients with long-term conditions to appropriate services. • The practice has smoking cessation services advertised on their website. • The practice did not demonstrate how they supported patients to engage with national priorities and initiatives to improve their health.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	97.6%	95.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.1% (2)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	28
Number of CQC comments received which were positive about the service.	28
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comments cards	Patients consistently stated that staff listened and were kind and helpful.
CQC comments cards	Patients were consistently complimentary about the professionalism of the clinical staff at the practice.
Staff	Staff told us that a consistent theme regarding feedback they received from patients related to availability of appointments at the practice.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7066	413	97	23.5%	1.37%

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 (01/01/2018 to 31/03/2018)	92.2%	85.6%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	83.7%	82.8%	87.4%	No statistical variation
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 (01/01/2018 to 31/03/2018)	93.5%	93.1%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	82.7%	78.2%	83.8%	No statistical variation

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

Any additional evidence
• The practice had undertaken Friends and Family feedback exercises and 96% of patients who had completed this were extremely likely or likely to recommend the practice to others.

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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: • The practice refers carers to the care navigator who is based at the practice and supports and sign post patients to a range of local services such as the Brent Carers Centre, debt support services and providing information on benefits and assistance with completing forms.	

Source	Feedback
Interviews with patients.	Patients consistently reflected their satisfaction with the practice, in particular, how they had been treated with kindness and had received sufficient time in consultations.

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 (01/01/2018 to 31/03/2018)	96.1%	89.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Partial
Patient information leaflets and notices were available in the patient waiting area which	N

told patients how to access support groups and organisations.	
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	N
Explanation of any answers and additional evidence: • Staff told us that interpreter services were available for patients whose language is not English but the practice had not displayed information for patients regarding this. Following the inspection and during the factual accuracy process the practice told us staff speak a number of languages and are able to support patients outside of consultations and the practice website is readable in 63 languages. • During the inspection we did not see evidence of patient information leaflets in the patient waiting area and information regarding support groups and networks for patients was unavailable on the practice premises and website. Following the inspection and during the factual accuracy process the practice told us they provide access to the Silent Sounds interpreting service for patients who are heard of hearing and have commissioned information posters which will be displayed in the waiting room.	

Carers	Narrative
Percentage and number of carers identified.	The practice has 89 (1.26%) carers highlighted on the clinical system.
How the practice supported carers.	The care navigators provide information on the Brent Carers Centre and will refer if the patient consents. The care navigators will also visit the patient/ carer at home.
How the practice supported recently bereaved patients.	GPs' work with the families of patients who are approaching the end of their life to ensure the appropriate documentation is in place to reflect the wishes of the patient and will support the patient to die in the place of their choice. In addition GPs' will speak to bereaved families after the death to offer condolences and support.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.00am-6.30pm.
Tuesday	8.00am-6.30pm.
Wednesday	8.00am-6.30pm.
Thursday	8.00am-6.30pm.
Friday	8.00am-6.30pm.
Saturday	9.00am-1.00pm
Appointments available:	
Monday	9.00am-5.00pm.
Tuesday	9.00am-5.00pm.
Wednesday	9.00am-5.00pm.
Thursday	9.00am-5.00pm.
Friday	9.00am-5.00pm.
Saturday	9.00am-1.00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7066	413	97	23.5%	1.37%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	93.7%	91.3%	94.8%	No statistical variation

Older people — Population group rating: Good

Findings

- The practice offered services for patients including automatic blood pressure monitoring (ABPM), warfarin monitoring, COPD and asthma management.
- The practice offered a range of primary care services targeting older patients, for example the flu, shingles and pneumococcal vaccinations.

People with long-term conditions — Population group rating: Good

Findings

- The practice offered services for patients including automatic blood pressure monitoring (ABPM), warfarin monitoring, COPD and asthma management.
- 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.

Families, children and young people — Population group rating: Good

Findings
• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students) — Population group rating: Good

Findings
• Appointments were available for Saturday morning for patients who found it difficult to access care during Monday-Friday opening hours. However, patients' did have access to a GP hub service located on the practice premises between 4.00-8.00pm on weekdays including public holidays and 10.00am to 2.00pm on Saturdays.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• We found that staff were aware of and committed to meeting the needs of this population group. • Staff had completed equality and diversity training.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• We found that staff were aware of and committed to meeting the needs of this population group. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • Staff had completed dementia awareness training.

Timely access to the service

People were 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.	Partial
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Explanation of any answers and additional evidence:

- Although staff told us they had received guidance regarding screening patients for sepsis and red flag signs, we found evidence that patients who attended to make an appointment were not screened appropriately.
- Staff told us there was a consistent theme with complaints at reception regarding lack of availability of appointments but this was not reflected in the GP Patient Survey results.
- The practice had been undertaking a pilot project with Brent CCG regarding e-consultations to enable greater access to medical advice and patients for patients.

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 (01/01/2018 to 31/03/2018)	96.1%	N/A	70.3%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	79.7%	63.3%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	81.0%	65.0%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	82.5%	67.4%	74.4%	No statistical variation

Any additional evidence or comments

- We have reviewed evidence of the Friends and Family Test conducted by the practice. 96% of patients were likely or extremely likely to recommend the practice to other people.

Source	Feedback
For example, NHS Choices	4/5 rating based on 10 reviews. There were consistent themes throughout reviews that patients were happy with their GPs' and care. Three patients stated they had experienced rudeness from staff.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	4 Plus one carried over
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	N
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

- The practice had not provided clear information for patients on their complaints procedure. For example, they had not displayed posters or provided leaflets for patients on how to make a complaint in the waiting room or on the practice website. Following the inspection and during the factual accuracy process the provider submitted a poster which has been displayed in the patients waiting room and a complaints leaflet. However the complaints leaflet did not contain appropriate information regarding time scales within which a complaint may be made, in what form a complaint may be made and did not contain information regarding consent in relation to a deceased person, someone who lacks the capacity to make their own decision and a non-Gillick competent child.
- We reviewed one complaint. The letter sent to the found that dates did not correspond with the practice complaints policy and staff told us they were awaiting a response from the patient.
- We reviewed evidence that the practice did use complaints to drive improvements in patient care. For example, information regarding the types of appointments offered is now made available to patients so those people who require an extended consultation time with a clinician are able to book this time.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient awaiting procedure but the practice is not registered with CQC for this regulated activity.	Letter of apology sent to patient, who had been offered a referral to another practice for this procedure. Practice are working to correctly register this particular registered activity.
Patient who had accessed a same-day appointment complained they had been unable to discuss one issue only with GP.	Letter sent to patient with explanation of same day service.

Well-led Rating: Requires improvement

Leadership capacity and capability

There was limited evidence that leaders could demonstrate they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N

Explanation of any answers and additional evidence:

- The lead GP was clear about the challenges they faced and were developing plans and priorities to improve. For example, on the day of the inspection, the provider submitted an action plan but this related only to reaching QOF targets.
- A senior clinical member of staff told us of informal plans they had in relation to retirement but these had not been formally discussed and no formal plans had been put in place.

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

- Clinical staff were clear about the challenges they faced and were developing plans and priorities to improve.
- We found that staff were committed to providing a good service to all patients but the practice had not systemically planned care for some patient population groups. On the day of inspection, clinical staff submitted evidence of an action plan to us to address this.
- However, arrangements as to how they will specifically measure and monitor the progress of the action plan were not recorded.

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

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

Source	Feedback
Non-clinical member of staff	I really enjoy working here and would like to would like to advance my career here.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	N

Explanation of any answers and additional evidence:

- Information we reviewed during the inspection process did not reassure us that governance structures and systems in the practice were regularly reviewed, for example, there was no system or policy in place regarding the assurance of safe management of test results.
- Staff told us of potential retirement plans for a senior member of staff but formal succession plans had not been undertaken.
- Staff gave us conflicting information as to which clinician was practice lead in various areas, for example, they referred to the lead clinician for safeguarding children and adults.
- There was no overarching policy and protocols related to the scope and role of the HCAs.
- We reviewed evidence that actions from practice meetings were not followed up on and not actioned.
- The practice is situated within a managed hospital building. When we had asked to see copies of fire safety, premises and security and health and safety risk assessments, and cleaning audits, staff told us they were unable to access them and had not undertaken their own risk assessments of its premises area. Arrangements with the property management company regarding sharing relevant information with the practice are insufficient.
- During the inspection the provider could not demonstrate these risk assessments were in place. Following the inspection and during the factual accuracy process the provider submitted risk assessment related to health and safety; premises and security and COSHH. In addition, the

practice submitted further information regarding an overarching fire safety risk assessment and they have commissioned external fire risk and legionella risk assessments of its own practice premises which will be completed shortly.

Managing risks, issues and performance

The practice had limited 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.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

Explanation of any answers and additional evidence:

- The practice had some systems and processes in place to manage risk but did not have oversight of risk assessments for its own premises.
- During the inspection the provider could not demonstrate these risk assessments were in place. Following the inspection and during the factual accuracy process the provider submitted evidence to demonstrate that an infection prevention and control and a health and safety risk assessment has been carried out and action points have been completed. In addition, the provider has commissioned external fire risk and legionella risk assessments of its own practice premises.
- Some systems were in place were in place to manage quality assurance, but we were concerned the practice had a reactive rather than a proactive approach. For example, the practice had submitted evidence on the day of the inspection, of an action plan which detailed planning and systematic risk assessments for patients with long term conditions.
- Staff were open with us and acknowledged the challenges they faced regarding quality and outcomes framework (QOF) achievement rates, following the merger of the two practices, and have developed an action plan to address this.
- The practice's risk management processes are insufficient. During the inspection, it has not been possible to fully review information regarding this.
- We saw evidence that the provider had responded to external drivers of change, for example, following the inspection, some issues raised during our visits were acted upon. However, they could not produce evidence that it proactively identified and responded to risks and assessed the impact on safety and quality.

Appropriate and accurate information

The practice had limited systems to act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N

Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- The practice did not have a system or process to assure that test results and clinical correspondence were safely managed. We reviewed evidence that some test results were outstanding and some patients had not undertaken appropriate blood monitoring at the required intervals when prescribed high-risk medicines. Immediately after the inspection, the practice undertook appropriate follow-up of patients to mitigate the risks found.
- The practice is situated within a managed hospital building. When we had asked to see copies of fire safety, premises and security and health and safety risk assessments, and cleaning audits, staff told us they were unable to access them and had not undertaken its own risk assessments of its premises area.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
• Very happy with the doctors and staff who are responsive to the Patient Participation Group (PPG). They told us they communicate with practice staff between meetings if required.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial

Examples of continuous learning and improvement
• The practice had demonstrated minimal evidence of innovation or service development. For example, a clinical pharmacist had recently been employed, who when they have been appropriately trained as an independent prescriber, will be able to conduct patients medicines reviews. • Following the inspection and during the factual accuracy process the provider told us they were proud of their achievements during their first year in that the practice has successfully managed the transition and merger of two practices and maintained a caring and response service to patients. They told us the senior management team are committed to ensuring their second year will be used to innovate and remodel the delivery of care. • The practice is part of the Harness E-consultation pilot providing 24 hour a day access to patients and assuring a response within 24 hours. The pilot is the first in London covering 21 practices linked by an E-hub and is the basis of the award of digital accelerator status by the NHS Digital to Brent CCG. The practice advertises the service on its website. E-consultations are being promoted to patients to reduce the time pressures on the practice appointments system.

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.
- 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.

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

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.