Care Quality Commission

Inspection Evidence Table

Dr Madhukar C Patel (1-510267969)

Inspection date: 20 January 2020

Date of data download: 17 January 2020

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
The practice kept registers of vulnerable adults and children at risk. Cases were discussed and reviewed at clinical meetings and multidisciplinary team meetings. The GPs did not usually attend safeguarding case conferences. However, they provided safeguarding reports and shared information with other relevant professionals and agencies promptly when required. The practice assessed all requests for information to ensure it was only shared when appropriate and necessary. The GPs followed up children at risk who had failed to attend appointments (for example, following referral) by telephoning the parents. Safeguarding policies did not directly reference the practice's online services but the practice had systems in place, for example, in relation to online access of records to protect patients at risk of abuse.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	

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: 20/03/2019	Y
There was a record of equipment calibration. Date of last calibration: 20/03/2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 04/09/19	Y
There was a log of fire drills. Date of last drill: 10/01/2020 (six monthly)	Y
There was a record of fire alarm checks. Date of last check	N/A
There was a record of fire training for staff. Date of last training: Staff had completed online fire training within the last 12 months on various dates. Fire marshals had attended a training session in person.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 07/08/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The practice had not identified any substances on site that it considered to be sufficiently hazardous to require a separate risk assessment. The practice displayed a sign outside the door to the nurse's room to alert people that emergency oxygen was located inside. Cleaning materials were located in a locked cupboard. The fire risk assessment included a recommendation that a fire alarm system be fitted. The practice had booked a contractor to carry out this the work in March 2020.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 29/08/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 29/08/2019	Y
Explanation of any answers and additional evidence: The practice carried out a full health and safety risk assessment annually which covered premises and security. All identified issues from the assessment had been addressed, for example new chairs	

had been purchased for the waiting area. A separate Legionella risk assessment had been completed by a specialist consultancy in July 2019 and the practice employed a local plumber whose responsibilities included carrying out and logging the recommended water temperature checks.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 25/06/2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

The practice had allocated a clinician as the practice infection prevention and control lead. The practice provided annual in-house training for staff on infection prevention and control. Online training modules were also accessible. The practice had not yet provided ‘enhanced’ training for the infection prevention and control lead but was aware that relevant local training resources were under development.

All the actions identified in the infection prevention and control audit had been or were being addressed within the agreed timeline. For example, the practice had checked and recorded that all staff had been immunised in line with current guidelines after the audit highlighted gaps in the practice records.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
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:

- The practice planned staff absence in advance to ensure cover was available.
- Staff, including administrative staff, were trained on how to recognise the signs of sepsis and information about this was displayed around the practice. Staff we spoke with were confident of the protocol to alert the clinicians immediately if patients presented with symptoms or appeared to be acutely unwell or deteriorating. The clinicians had access to a sepsis template on the clinical records system which was based on current guidelines.
- The practice had experienced a medical emergency in 2019. Staff had responded and the patient had been treated and transferred to hospital successfully. The event was recorded as a significant event and the learning discussed. As a result, the practice protocol was amended to reduce the risk of delayed communication of the emergency within the practice.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.36	0.59	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	6.3%	10.0%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	5.26	5.89	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	0.71	1.06	2.08	Significant Variation (positive)

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

Medicines management	Y/N/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.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- The practice had a clear repeat prescription policy and protocols. It did not however have a process to identify cases where repeat prescriptions should be ceased, for example, in the hypothetical case of a patient prescribed controlled drugs who was then sentenced to time in prison.
- The practice had created its own template on the clinical records system for certain medicines that require ongoing monitoring to ensure that the clinicians were carrying out all appropriate checks before issuing prescriptions.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	11
Number of events that required action:	11
Explanation of any answers and additional evidence: The practice shared information within the team including the clinical and administrative staff. It did not routinely share learning with other practices for example within its primary care network. It had not yet reported any incidents to the NHS National Reporting and Learning System (NRLS).	

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

Event	Specific action taken
The practice mistakenly booked an interpreter who did not speak the patient's first language. Consultation had to be rebooked. Patient inconvenienced.	Reception staff now documented both the fact that the patient needed an interpreter and the specific language required in the patient record.
Unexpected and sudden death of a young adult patient diagnosed with diabetes mellitus.	The clinical team reviewed the criteria for multidisciplinary input and broadened these to include younger patients with a history of poor engagement with services.

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
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts. For example, the practice had taken action to ensure that women prescribed sodium valproate were aware of the risks in relation to pregnancy and were advised on contraception.	

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	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 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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.15	0.40	0.74	Significant Variation (positive)

Older people Population group rating: Good

Findings
• The practice used clinical tools, such as the local 'whole systems integrated care dashboard' and frailty templates within the clinical records system, to identify older patients who were living with frailty. Patients identified as at risk, received a full assessment of their physical, mental and social needs. The practice telephoned these patients every two weeks to check on their health and wellbeing.

- The practice followed up on older patients discharged from hospital with a telephone call or home visit. The practice ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. The lead GP had been involved in developing local referral and treatment 'pathways', for example a falls and frailty pathway.
- Health checks were offered to patients over 75 years of age. The practice had developed its own health check template to ensure that the checks were consistently completed in line with guidelines.
- Flu, shingles and pneumonia vaccinations were offered to eligible patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured review (at least annually) to check their health and medicines needs were being met.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The local prevalence of diabetes was high at over 12%. The lead GP had an additional qualification in diabetes management and patients could access a diabetes nurse specialist at the practice. The practice provided initiation of insulin treatment on the premises avoiding the need for patients to attend hospital for this treatment.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice carried out active case finding exercises, for example it had recently participated in a project to identify patients with undiagnosed atrial fibrillation.
- 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.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	82.6%	76.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	15.0% (75)	10.8%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	85.2%	78.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.4% (22)	7.6%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	81.9%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	7.6% (38)	7.9%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	83.7%	78.0%	75.9%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.9% (2)	2.5%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.9%	92.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	3.4% (1)	6.9%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	84.9%	82.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.4% (24)	3.9%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	85.0%	86.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	20.0% (5)	9.1%	5.9%	N/A

Any additional evidence or comments

The practice exception reporting rate for the indicator measuring the percentage of patients diagnosed with atrial fibrillation who were being treated with anti-coagulation drug therapy was higher than average at 20%.

This might plausibly be a random variation due to the small numbers of patients diagnosed with the condition at the time (25 in total). The practice had recently participated in a project to identify patients with the condition who had not yet been diagnosed. Several cases had been identified as a result. The practice expected the exception reporting rate for this indicator to come down in the next reporting year.

Families, children and young people Population group rating: Good

Findings

- The practice had not met the minimum 90% target for four of four childhood immunisation uptake indicators. The practice had almost achieved the target for the one-year old cohort (89%). It had achieved around 80% for the three booster immunisations given to the two-year old cohort. The practice reported this was due to several factors. For example, some families who had recently arrived to the country reported that their children had already had their vaccinations overseas. The practice only included this information on the child's records when parents could provide evidence of which immunisations had been completed. The practice also reported a steady increase in the number of parents refusing childhood vaccinations over recent years.
- The practice had taken some action to try and increase immunisation uptake. All newly registered children were invited for a health check with the practice nurse which included discussing, and if possible, administering any outstanding immunisations.The practice contacted the parents or guardians of children due to have childhood immunisations. Where parents refused to allow their baby or toddler to be immunised, the practice offered catch up immunisations when the child was older.

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and liaised with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with ante-natal advice and post-natal support as required and relevant immunisations.
- Young people could access the practice for sexual health advice and contraception including free condoms. The practice did not offer all contraceptive methods but signposted patients to dedicated sexual health clinics for under 25s locally.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice offered chlamydia screening kits to patients aged between 16 and 24.
- The clinicians opportunistically provided advice on testicular self-examination to young men over the age of 15.
- The lead GP was involved in local projects looking at tackling childhood obesity and knife crime.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	71	80	88.8%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	59	75	78.7%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	60	75	80.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	59	75	78.7%	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

Working age people (including those recently retired and students)

Population group rating: Requires improvement

This population group was rated as requires improvement because the practice's cervical screening rate was markedly below the national target of 80%.

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice followed up any abnormalities or risk factors promptly.
- The practice was not meeting the national cervical cancer screening target of 80%. The nurses telephoned patients who did not attend following their invitation and had resources available to explain the procedure and its benefits. The practice had recently extended its nurse sessions so women could attend outside working hours for cervical screening.
- The practice participated in the MMR catch up programme and had systems to inform eligible patients to have the meningitis vaccine, for example, when starting university.
- The practice had offered Saturday registration sessions for students living in nearby university accommodation.
- Patients could book or cancel appointments online and order repeat medicines online. The practice was part of an online consultation pilot scheme.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	65.0%	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)	62.7%	60.4%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	41.8%	43.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months,	88.9%	75.0%	68.1%	N/A

who have a patient review within 6 months of diagnosis. (01/04/2018 to 31/03/2019) (PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	50.0%	53.8%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice maintained a register of patients who were housebound or otherwise assessed as vulnerable. The register was regularly reviewed by the clinical team.
- The practice had a track record in meeting the health needs of refugees and asylum seekers. The practice catchment area for this group covered the whole of Brent.
- The practice facilitated homeless patients to register at the practice and to use the surgery address for correspondence.
- The practice maintained a register of patients with a learning disability. These patients 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 and their carers.
- The practice had identified the recently bereaved as a high-risk group and offered health checks to these patients.
- The practice used structured templates to carry our reviews and health checks that included prompts for substance misuse issues.
- Staff had received training in relation to issues such as domestic abuse, female genital mutilation and modern slavery. The practice took action to safeguard vulnerable patients against the risk of abuse.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice maintained a register of patients with serious mental health problems and reviewed it monthly alongside any changes or updates from the community mental health teams. The practice carried out annual blood tests and other forms of monitoring in line with guidelines.

- Patients assessed to be experiencing mild to moderate depression were offered talking therapies and signposted to local resources.
- The practice screened patients at risk for depression, for example postnatally or following diagnosis of a long-term condition.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The lead GP was part of a team developing a standard physical health check template for patients with severe mental illness. This was about to be made available to all general practices in Brent to improve the health and life expectancy of this group of patients.
- Patients at risk of dementia were identified and offered an assessment with their family members or carers if appropriate. When dementia was suspected there was an appropriate referral for diagnosis.

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Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	90.3%	89.4%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	6.6%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	96.8%	91.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.8%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	84.6%	83.6%	Variation (positive)
Exception rate (number of exceptions).	0.0% (0)	3.5%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	557.2	536.2	539.2
Overall QOF score (as a percentage of maximum)	99.7%	96.0%	96.7%
Overall QOF exception reporting (all domains)	5.2%	5.7%	5.9%

	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.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The practice had carried out at least eight clinical audits in 2019. These included a mix of regular audits, first cycle and second cycle audits (where the audit is repeated to check that improvements have been sustained).
- The practice carried out regular audits of polypharmacy. Polypharmacy is the prescribing of multiple medicines to an individual patient. Polypharmacy puts patients at increased risk of harmful drug interactions and associated side effects. The audit had identified several cases where some medicines could be safely stopped following review and discussion with the patient.
- The practice had also audited its prescribing of protein pump inhibitors (a type of medicine) alongside anti-platelet therapies. The results for both cycles showed that the practice was providing care in line with current guidelines in all identified cases.

Any additional evidence or comments
The lead GP was also the current Chair of the local clinical commissioning group and had aligned practice priorities for improvement with locally agreed priorities and identified areas of health need. The practice nurse we spoke with (who was an independent prescriber) confirmed they were involved in clinical audit and research at the practice. For example, they had worked on prescribing audits and research into high usage of certain asthma medicines. Both nurses carried out audits of their inadequate cervical smear rate as required.

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.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
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 kept records of staff training and professional development and reviewed competencies following induction. Staff were encouraged to attend locally available training that was relevant to their roles or development.
- The practice participated in discussions at primary care network level in relation to skills and workforce development.
- Clinical staff we spoke with described the practice as very good in relation to clinical supervision with formal and informal opportunities for reflection and review.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
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.	Y
Explanation of any answers and additional evidence:	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	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.	Y
Explanation of any answers and additional evidence: • The practice provided an in-house smoking cessation service. • Practice patients had access to a social prescriber who attended the practice once a week and could support patients with social issues such as housing problems and access to food banks.	

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 (01/04/2018 to 31/03/2019) (QOF)	98.1%	95.6%	95.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.4% (4)	0.5%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence:	

Well-led Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: • The practice had identified a GP to potentially join the practice as a partner to ensure a stable transition period and leadership development as part of its succession planning.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
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.	Y
Explanation of any answers and additional evidence: • The practice vision focused on providing personalised care to patients that met their individual needs. • The practice's immediate priorities were to find and move to larger premises and make best use of the extended skills of the expanding local primary care workforce and resources in partnership with the other practices in the primary care network. • The practice was preparing to become a GP training practice within the next 12 months.	

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
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff interviews	Both the administrative and clinical staff we spoke with were positive about the working culture within the practice. The practice team was described as supportive with a collaborative ethos. We were told that the senior management team were always open to ideas and suggestions.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	

- The practice held regular staff, clinical and multidisciplinary meetings. There was effective oversight, supervision and communication. For example, the practice nurses who both worked part-time had handover sessions.
- Clinical staff had administrative time built into their sessions, for example to enable the nurses to follow-up patients who had not attended for childhood immunisations.

Managing risks, issues and performance

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

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

Explanation of any answers and additional evidence:

- Staff told us that the practice was responsive to their ideas to mitigate risks. For example, the length of time of appointments for childhood immunisations had been extended by five minutes following a change to the immunisation schedule.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- The practice had acted on recommendations from the previous inspection; the results of audits and comparative data analysis, for example, to reduce antibiotic prescribing.

If the practice offered online services:

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

Explanation of any answers and additional evidence:

- The practice was participating in a pilot online consultation scheme which was being led by the clinical commissioning group. This had been implemented in line with national NHS digital security requirements.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	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

Explanation of any answers and additional evidence:

- The Patient Participation Group met twice a year. The previous meeting had been held in October 2019. Topics discussed included the practice's own patient survey results which had been largely positive; new local NHS guidance on prescribing medicines which could be obtained over the counter and the Brent online consultation pilot.

Any additional evidence

- Forty-four patients completed comment cards about the service in the days leading up to the inspection.

- All but five of these comments were wholly positive. Patients described the service as welcoming, friendly and helpful. The staff team were frequently described as going out of their way to support patients with more complex problems and disabilities. Several people commented positively about their experiences of the way the team had treated older or younger family members. Most people commenting reported that the service was accessible when they needed an appointment.

- Five comments included some criticism. Three of these mentioned the length of time it could take to book an appointment and one person said that a GP had been insensitive but this was not the norm for the practice.

- One person said they had reported a potential environmental hazard to the reception staff and this had been quickly removed.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

- The practice participated in pilot schemes and research it considered had the potential to benefit patients.
- The practice was planning to offer eligible patients the opportunity to participate in a restricted calorie diet intervention for patients diagnosed with type II diabetes.
- The practice had recruited patients to trial a mobile 'app' to support self-management of diabetes. Twenty-five patients had been recruited to date. Their progress was being monitored with monthly blood tests.
- The practice was a pilot site for offering online consultations. The pilot had proved popular with patients.

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.