

Care Quality Commission

Inspection Evidence Table

Lisson Grove Health Centre (1-549237033)

Inspection date: 05 June 2019

Date of data download: 02 June 2019

Overall rating: Good

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

Safe

Rating: Good

- *At our last inspection not all risks to patient safety were managed well. At this inspection we found arrangements for identifying, monitoring and managing risks to patient safety, had improved. The practice had systems to ensure safe prescribing. Staff used the clinical record system effectively to control and monitor medicine reviews and re-authorisation dates for individual items on the repeat medicine list.*
- *At our last inspection there was an ineffective system of medicines reviews for patients with long term conditions. We found medicine reviews were not well coded or documented. At this inspection there was an effective system of structured medicine reviews for patients with long term conditions. Medical records we looked at contained sufficiently consistent information to support the care of the patient and to enable the reviewing clinician to carry out a consultation.*

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.	Y ²
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y ¹
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

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y ³
Staff who acted as chaperones were trained for their role.	Y ³
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 – We looked at the policies and procedures and saw the practice had reviewed their policy framework. The practice had begun a programme of review and audit reviewing the quality of coding to improve consistency across the practice. In March 2019 staff reviewed and updated the Read-coding policy to ensure that clinicians and Read-coders had a standardised approach to coding in line with practice policy. (Read codes are a national standard coding system used in general practice for recording clinical information).</p> <p>2 – We saw policies covering adult and child safeguarding procedure and safeguarding contact details on the back of doors throughout the practice. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.</p> <p>The practice had a system to alert staff to patients known to be at risk of abuse. The practice showed us a separate register of these patients to facilitate regular review.</p> <p>3 – All staff including those who acted as chaperones had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The provider had a record of which staff had completed chaperone training.</p>	

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 and 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
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment processes ensured that appropriate background checks had been completed for all staff.</p> <p>The practice infection control policy included reference to vaccination/immunity to Hepatitis B for all staff who might come into contact with body fluids, clinical waste and sharps in the course of their duties. Records we checked showed staff had been screened and completed a Hepatitis B immunisation course.</p>	

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: 18/06/2018	Y
There was a record of equipment calibration. Date of last calibration: 18/06/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. Date of COSHH assessment: 01/08/2018	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 24/04/2019	Y
There was a log of fire drills. Date of last drill: 29/01/2019	Y
There was a record of fire alarm checks. Date of last check: 03/04/2019	Y
There was a record of fire training for staff. Date of last training: 07/03/2019	Y
There were fire marshals.	
A fire risk assessment had been completed. Date of completion: 25/10/2018	Y
Actions from fire risk assessment were identified and completed.	Y ¹
<p>Explanation of any answers and additional evidence:</p> <p>The practice is located in a building which is owned and maintained by Central London Community Healthcare NHS Trust (CLCH). The building maintenance is carried out by a facilities management company engaged by the landlord CLCH.</p> <p>1 – Fire safety checks were the responsibility of the landlord CLCH. The practice had obtained a copy of the latest fire risk assessment from the landlord which we were shown. The managers provided evidence that the practice had responded to all of the assessor's recommendations. The practice had a system in place to check the working status of the fire alarms. Staff were clear about the fire evacuation procedure and the assembly points at the site.</p> <p>.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Y

Date of last assessment: 15/08/2018	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 15/08/2018	P ¹
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us the facilities management company had conducted appropriate premises and security risk assessments. The practice had obtained copies which they showed to us during the inspection. We saw documented actions that had been taken in relation to health and safety and those in progress, and this was monitored.</p> <p>The practice had their own safety officer responsible for conducting regular checks of the workplace and reporting on any accidents at work. Staff at the practice told us they reported health and safety issues to the facilities management service. If there was an urgent issue or hazard identified the facilities company will come out the same day.</p> <p>The practice had a training matrix to record the dates staff had completed safety training and the renewal dates for annual training.</p> <p>1 – The practice had obtained a copy of the legionella risk assessment report for the building carried out by a risk assessor for the facilities management service, in March 2018. It was not clear how the practice monitored legionella control. We were told that the facilities management company employed by the landlord was responsible for implementing the recommendations. There was no record that the practice had responded to all of the assessor's recommendations. There was no log book of recommended checks to manage the risk of legionella within the water system. Staff told us the practice had arranged a number of meetings to discuss health and safety matters which have been cancelled or not attended by the landlords. The practice told us they shared their safety risk assessments with the landlord.</p>	

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
Date of last infection prevention and control audit:11/11/2018	
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
<p>Explanation of any answers and additional evidence:</p> <p>Responsibility for infection control at the practice was allocated to a member of the nursing team. The practice used a checklist template to ensure any actions identified in the latest infection control audit would be actioned and monitored.</p> <p>The cleaning of the premises was done by the facilities management company. There was a general cleaning schedule which cleaners had to sign. The practice had oversight to make sure cleaning was carried out appropriately. The IPC lead maintained the medical equipment cleaning log. We saw a cleaning log for the ear irrigator.</p> <p>The practice had carried out their own risk assessment in relation to infection prevention and control</p>	

and we saw evidence of actions completed.

Risks to patients

There were gaps in 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 ¹
Risk management plans for patients were developed in line with national guidance.	Y ²
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 other 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:

1 – At our last inspection, the practice had not adequately assessed risks to staff and patient safety. For example, there was an ineffective system of medicines reviews for patients with long term conditions. We found medicine reviews were not well coded or documented which meant we were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions. At this inspection we found the practice had improved consistency in the way that medicine reviews were coded and documented; there was an effective system of structured medicine reviews for patients with long term conditions. Medical records we looked at contained sufficiently consistent information to support the care of the patient and to enable the reviewing clinician to carry out a consultation.

We asked the practice about the actions taken to improve the system of medicine review. Staff told us they had engaged with the CCG and the primary care network and were working towards developing a consistent approach across the practice to repeat prescribing and development of templates and standard protocols. At this inspection we saw the practice had an updated Read coding protocol which included specific guidance on Read coding principles. The practice had developed a repeat prescribing protocol, dated May 2019 and in April 2019 staff undertook an audit to review the quality of coding across the practice.

2–There were processes to review rates of polypharmacy (that is, where patients may be at risk of adverse effects associated with taking multiple medicines). We saw evidence that a polypharmacy review was undertaken in March 2018. This was a shared project with a pharmacist from the CCG medicines management team. The pharmacist searched for patients on 14 or more medicines and

clinics were set up to carry out a review of those patient identified at a face to face medicine review. Staff told us during the inspection that findings were tasked to the patient's GP to action.

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 ¹
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.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	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:

At this inspection we reviewed processes relating to review of patients' medicines and clinical conditions and the documenting of those activities.

1 –At this inspection staff told us the practice undertook periodic reviews of staff consultations and prescribing to ensure that they were delivering care and treatment in accordance with legislation and guidance. Following our inspection, the practice provided evidence of records of staff peer review where auditing of their consultations occurred.

At this inspection we saw the practice had an updated Read coding protocol which included specific guidance on Read coding principles. Staff had carried out a coding audit carried out between 23 and 26 April 2019. The aim of the audit was to check for coding accuracy of patients with major medical conditions and who were considered medically complex as they were on 10 or more medicines. The practice coder did a search against these criteria and identified 306 patients. The practice coder reviewed 47 patients' notes out of 306 to see if the coding was correct. All forty-seven patients had their major health conditions correctly coded in the patient record. None were missing coding; however, the practice told us four had duplicate coding entries in their notes. These were corrected to ensure that the date of diagnosis and the correct code were visible and any duplicate entries removed.

2 –We reviewed 14 patient records and looked at examples of hospital letters and discharge summaries. Each clinician had an electronic inbox for incoming correspondence or urgent medicine requests. Incoming correspondence was examined for diagnoses and new diagnostic codes were forwarded to a coder. There was a process where third party requests were actioned where the clinicians agreed they

were reasonable requests and that patient consent had already been established. The workflow system had a shared community tab to enable patients records to be shared with external clinicians with the patient's consent. We found actions to amend a patient's medicine were logged in the patient record system and had been actioned in a timely way.

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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.64	0.52	0.88	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	10.5%	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, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.25	5.90	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.13	1.30	2.07	No statistical variation

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,	Y ¹

Medicines management	Y/N/Partial
and there was regular review of their prescribing practice supported by clinical supervision or peer review.	
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 ²
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 ³
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 ⁵
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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 ⁴
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
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection we reviewed processes relating to review of patients' medicines and clinical conditions and the documenting of those activities.</p> <p>At our last inspection not all risks to patient safety were managed well. At this inspection we found arrangements for identifying, monitoring and managing risks to patient safety, had improved, but had not yet had sufficient time to demonstrate they were embedded. Staff had developed prescribing policies and quality improvement activities to ensure safe prescribing across the practice. For example, in March 2019 the practice had updated its Repeat Prescription and Medicine Review protocol</p> <p>1 –The nurse prescriber at the practice received adequate peer review. The nurse prescriber had a diabetes specialism and told us they met once a week with the lead GP to review their caseload.</p> <p>2 – At our last inspection the process of scheduling and recording medicine reviews was not being managed in line with current guidelines. We found medicine reviews were not well coded or documented which meant we were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions. At this inspection we found the practice had reviewed their systems of medicine reviews and had started to implement changes to ensure adequate documentation and recording of medicine reviews was undertaken across the practice.</p>	

Medicines management	Y/N/Partial
<p>3 – The practice had a process to monitor third party workflow requests. We reviewed patient records and looked at examples of hospital letters and discharge summaries. We found that patient records were updated with information from the hospital including changes to medicine. The practice acted effectively on tasks and requests raised on the patient record system. The practice was able to clearly outline the process for reviewing discharge summaries.</p>	
<p>4 – We saw evidence that emergency medicines were being checked regularly and all medicine checked was in date. The practice did not hold a complete stock of nationally recommended emergency medicines at the time of inspection. We saw the practice had carried out satisfactory risk assessments for the medicines not stocked. Staff told us that in the event of a severe medical emergency they would call 999.</p>	
<p>5 –The practice told us they had reviewed processes for identifying medicines which may interact to the detriment of the patient thus putting patients at risk. For example, the practice had started audits on amitriptyline, pregabalin and gabapentin and showed us the searches that had been done. We saw in the amitriptyline audit they had decided on an action plan. Clinicians were reminded regarding the risk profiles of amitriptyline and interactions. We saw that a drug interaction checking facility was available on the clinical records system and clinicians were reminded to use this.</p>	

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 ¹
Number of events recorded in last 12 months:	11
Number of events that required action:	11
<p>Explanation of any answers and additional evidence:</p> <p>1 – There was a comprehensive system for recording and acting on significant events. Staff kept an electronic record of safety incidents and significant events. We saw the significant event policy and report template. We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Staff we spoke with knew how to identify and report concerns and significant events.</p>	

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

Event	Specific action taken
Patient took overdose of prescribed sleeping tablets.	Discussed in team meeting. The team considered circumstances of the event and it appeared that it was an impulsive act from the patient. SEA taken to MDT to make team aware of recent incident. Action was agreed to ensure patient had information for Mental Health crisis team and explain how/when to access the crisis service.
2WW referral delay from secondary care communication. LGHC received a letter from secondary care provider indicating that a patient should be referred via 2WW pathway. The clinic letter was not typed until 2 weeks after the clinic date so the time had lapsed before the letter reached the practice	This was reported back to the service provider who said they would undertake their own investigation and the CCG were made aware. Learning from the event was discussed at team meeting. The meeting gave staff a good opportunity to discuss the importance of clearing workflow in a timely fashion and if there are delays to let the practice manager know so that they can monitor workflow.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y ¹
Staff understood how to deal with alerts.	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>1 –The practice had a process for managing safety alerts and we saw information was communicated and actions were followed up. We saw evidence that staff were able to perform searches.</p> <p>2 – At this inspection, staff told us about the recent safety alert about the increased numbers of measles cases, the practice carried out a search on the patient record system and used SMS messages to contact families of applicable patients. The practice held a team meeting to discuss the alert because measles is a contagious infectious disease. Staff were reminded that if a patient presents they need to be isolated to prevent risk of affecting other patients and staff.</p>	

Effective

Rating: Requires improvement

- *Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in three of the four areas where childhood immunisations are measured.*
- *The practice indicators for Cervical screening were low. Although the practice had taken action we had yet to see what impact this had on improving uptake.*

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 ¹
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
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection we reviewed processes relating to review of patients' medicines and clinical conditions and the documenting of those activities.</p> <p>1 – At this inspection we found arrangements for identifying, monitoring and managing risks to patient safety, had improved. The practice had reviewed systems to ensure safe prescribing.</p> <p>Staff were aware of the inconsistency and lack of detail in medicine reviews and told us this had been discussed at a recent practice team meeting and we saw evidence of this. Staff told us they had approached the CCG to help them develop a medicine review template for clinicians to use. Following our inspection, the practice contacted the CCG IT technicians to request that an additional computer alert was added to the patient care record. The practice told us the alert now appears when any patient notes with un-reviewed medicine are opened.</p> <p>We saw evidence of positive action to address issues in the form of a review of records and asthma management. The practice had carried out a CCG audit to identify patients diagnosed with asthma who</p>	

had been prescribed more than eight issues of a short acting beta2 agonist inhaler (salbutamol or terbutaline) in the previous 12 months The National Review of Asthma Deaths (NRAD's) report recommended that prescription of more than 12 Short-Acting Bronchodilator Inhalers (SABA) inhalers a year should prompt a review of a patient's asthma management. We saw a record of actions resulting from the asthma review with each patient.

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) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	1.31	0.95	0.77	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice had a dedicated health visitor for the elderly. An outreach clinic for the elderly was held locally once a week. The practice took part in an integrated care team pilot with another local practice. Caseloads were discussed, with consent from patients, via a web call three times a week.
- The practice routinely offered annual health checks to patients over 75 years of age. Patients aged 75 or older had care plans and patients with long term conditions received a medicine review at least annually. There were processes to review rates of polypharmacy (that is, where patients may be at risk of adverse effects associated with taking multiple medicines).

People with long-term conditions

Population group rating: **Good**

Findings

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Following our inspection, the practice shared performance indicators which demonstrated 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.
- Despite being in one of the most deprived areas of London and having a high prevalence of diabetes we saw evidence of effective performance achievement in the care and management of patients with diabetes. The diabetes services team at the practice included the lead GP and nurse prescriber who were trained in injectable therapies. The practice had audited the service at year 1 and year 4 (September 2018) and this showed the diabetes service was safe and effective.
- For patients with the most complex needs, we were told that the GPs worked with other health and care professionals to deliver a coordinated package of care. GPs attended weekly multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice had a protocol for the call and recall of patients on the asthma register. However, this recall process would not have picked up patients not coded for asthma which we found on our review of patient records.

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) <small>(QOF)</small>	84.2%	78.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	16.0% (84)	10.6%	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) <small>(QOF)</small>	80.9%	75.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	6.7% (35)	9.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
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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) <small>(QOF)</small>	83.1%	78.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	5.5% (29)	10.3%	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) <small>(QOF)</small>	74.7%	77.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.3% (9)	7.6%	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) <small>(QOF)</small>	93.3%	88.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	3.7% (4)	12.5%	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)	81.9%	79.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.1% (16)	3.8%	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)	97.7%	87.9%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	2.2% (2)	6.7%	6.7%	N/A

Any additional evidence or comments

Families, children and young people

Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates in 2017/2018 for the vaccines given were below the WHO target of 95% in three of the four areas where childhood immunisations are measured. Staff told us that they were aware of these results and all delayed and childhood immunisation decliners were contacted by letter or telephone in a bid to improve uptake of childhood immunisations.
- The practice provided us with Open Exeter data showing higher immunisation performance in 2018/19. However, this was not comparable data. The comparable 2018/19 CHIS data was published in July 2019 and showed Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets in three areas: PCV booster 71.8%, Hib/MenC booster 76.9% and MMR 74.4%. The 2018/19 CHIS data showed a decline in uptake rates from 2017/2018. Staff told us the practice was starting to implement a more effective recall system. This would include meeting with the linked Health Visitor to work together on engaging more parents and guardians in the immunisation programme. Following our inspection, the practice shared CCG performance data for 2018/19 which showed the practice was one of the highest achieving practices in Central London CCG for immunisations of 12-month olds and the practice was still in the top 50% for achievement across practices in CLCCG area for 24 month immunisations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health

visitors when necessary.

- The practice is one of six Child Health GP Hubs operating as part of the Connecting Care for Children (CC4C). (CC4C is a paediatric integrated care model to address the disproportionately high rates of paediatric A&E and paediatric outpatient attendance across the region). A paediatric consultant visited the child health GP hub at LGHC every four to six weeks to take part in a child health focused, multidisciplinary team meeting.
- Young people could access services for sexual health and contraception.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and the clinicians would liaise with health visitors when necessary.
- The practice worked closely with young mothers, some of whom acted as 'Patient health champions' who supported other patients through education, signposting and peer support.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.

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) <small>(NHS England)</small>	67	74	90.5%	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) <small>(NHS England)</small>	65	88	73.9%	Below 80% (Significant variation negative)
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) <small>(NHS England)</small>	70	88	79.5%	Below 80% (Significant 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) <small>(NHS England)</small>	68	88	77.3%	Below 80% (Significant variation negative)

Any additional evidence or comments

We asked the practice what they had done to improve uptake of childhood immunisations. The practice provided data showing an improvement but the nationally comparable CHIS data published in July 2019 showed Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets in three areas: PCV booster 71.8%, Hib/MenC booster 76.9% and MMR 74.4%. The 2018/19 CHIS data showed a decline in uptake rates from 2017/2018.

Staff told us the practice was starting to implement a more effective recall system. This will include meeting with the linked Health Visitor to work together on engaging more parents and guardians in the immunisation programme.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicine without the need to attend the surgery.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice rates for cervical screening were low. The practice had recognised this and told us they had taken action to address low uptake but there was not yet evidence of improvement.
- The practice had high exception reporting rates for cervical screening. The staff told us this was due to cultural factors. There was a failsafe system to check that results were received for all tests taken and that any abnormal results were followed up.
- Patients could book or cancel appointments online and order repeat medicine without the need to attend the surgery. The practice had extended hours opening on Saturday between 8.30am and 12.30pm.

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	57.2%	52.2%	71.7%	Variation (negative)

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)	55.6%	54.1%	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)	37.8%	37.8%	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)	71.9%	59.7%	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)	42.9%	53.5%	51.9%	No statistical variation

Any additional evidence or comments

As shown above, in 2017/18 the practice was below the 80% coverage target for the national cervical screening programme (as measured by Public Health England). We asked the practice what they had done about low uptake to encourage greater coverage. Staff showed us the Call and Recall protocol for cervical screening. Cervical screening appointments were available at different times during the week. Non-attenders were flagged on the woman's record so that the screening test could be discussed opportunistically.

To improve cervical screening uptake, leaders had organised training for two practice nurses and the Health Care Assistant to become Community Connectors. The community Connectors are people who help to share cervical health messages to communities of interest, for example minority groups to overcome barriers to awareness and screening.

There was a Cervical Cytology failsafe policy for following up women with an abnormal or inadequate cervical cytology sample result. The sample taker audited their inadequate cytology rates and had a system of follow up to recall patients for a second test.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless

people, travellers and those with a learning disability.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- We saw evidence of effective provision of services for people whose circumstances make them vulnerable. The Substance Misuse reduction counselling service worked closely with North West London drug and alcohol dependency team to provide a specialist in-house service which was integrated with the practice team. During our inspection, we spoke to patients in recovery, who made wholly positive comments about their experience of using this service. There was daily counselling provision at the practice from drugs and alcohol dependency counsellors based at the practice.
- The practice had a part time dedicated alcohol and drug addiction nurse who was available to discuss any issues. The nurse was supported by a GP with a Special Interest in Drug Addiction.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medicine.
- 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.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- The practice had more than double the national prevalence of mental health in its patient population. The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

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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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	79.8%	81.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	11.4% (14)	9.7%	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) <small>(QOF)</small>	90.5%	87.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.7% (7)	7.6%	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) <small>(QOF)</small>	79.2%	84.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.0% (4)	7.5%	6.6%	N/A

Any additional evidence or comments
<p>There were 30 patients on the Learning Disability register. 90% of patients registered with a learning disability had a comprehensive care plan in place.</p> <p>There were 164 homeless patients registered at the practice.</p>

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)	551.3	520.2	537.5
Overall QOF exception reporting (all domains)	6.0%	6.7%	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.	Y ¹

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

1 –The practice had carried out regular medicine audits, and worked with the local CCG medicines management team, to ensure prescribing was in line with best practice guidelines. The practice had a programme of quality improvement activities in place to improve prescribing safety. For example, the practice showed us the Reduction of Medicines Related Harm audit which had run over the last three years (2017 to 2019). This comprehensive audit looked at 50 medicine combinations that were considered by North West London CCG medicines management pharmacists to pose the highest risk to patients.

The practice had taken part in a clinical commissioning group (CCG) audit to identify patients diagnosed with asthma who had been prescribed more than 8 symptom reliever inhalers in the previous 12 months. The practice told us they had run searches of patient records and reviewed patients found to have been prescribed more than 12 SABA inhalers a year. We saw a record of an external warfarin INR review in January 2019. Blood coagulation results were within acceptable range.

At this inspection, staff told us the practice had started a review of patients on amitriptyline, pregabalin and gabapentin and showed us the searches that had been done. We saw in the amitriptyline review they had decided on an action plan. Clinicians were reminded regarding the risk profiles of amitriptyline and interactions. A drug interaction checking facility was available on clinical system and clinicians were reminded to use this.

The practice had carried out an audit of four years of Initiation of Injectable Therapy on people initiated on a combination of medicines for diabetes. The aim of this audit was to monitor the safety and effectiveness of the service. We saw evidence from a retrospective review of the patients treated which showed the initiation of injectable therapy service at Lisson Grove Health Centre was both safe and effective.

We saw evidence of an audit of Long Acting Reversible Contraception (LARC). Results showed the practice provided a safe and effective service for their patients, and the numbers of patients opting for LARC methods in the practice was increasing.

The senior GP partner had an interest in dermatology and treatment of scarring alopecia. In March 2018, the GP performed an audit following changes to Royal College of Ophthalmology guidelines. Results of the audit identified 15 patients who had not had screening performed by a hospital department. The GP wrote to patients explaining he would be making an eye referral.

Effective staffing

The practice was able to demonstrate 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 ³
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 ¹
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 ²
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included support for revalidating GPs and nurses.</p> <p>1 – At our last inspection, staff told us that the nurse prescriber’s medicine reviews were always seen by a GP for the more complex patients they reviewed. The nurse prescriber at the practice received adequate peer review of their caseload and prescribing decisions. The nurse prescriber had a diabetes specialism and told us they meet once a week with a GP to review their caseload. However, there was no record or minutes of peer review meetings. At this inspection we saw completed templates of peer review meetings between the lead GP and the nurse prescriber.</p> <p>2 – At our last inspection, the pharmacist did not work on Fridays when the GP partners had their clinical meetings. It was not clear how the practice ensured continuity of care for patients whose medicine was reviewed by the pharmacist. We raised this with the GP partner who showed us evidence in minutes of a clinical team meeting in March 2019, that the practice had made arrangements for the pharmacist to attend LGHC on Fridays when there was a clinically relevant need. At this inspection, we were told a new pharmacist had recently been recruited but was not available for us to speak with on the day we visited. The GP partner told us staff were working with the new pharmacist to complete their induction and training and provide supervision and audit of their work.</p> <p>3 – The practice was a teaching practice. The GP partners provided teaching and supervision for medical students. This included time spent in both observation of and review of the learner’s consultations and</p>	

prescribing.

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) (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 ¹
<p>Explanation of any answers and additional evidence:</p> <p>1– Information was shared between services, with patients' consent, using a shared care record. MDT meetings took place monthly with other healthcare professionals when care plans were routinely reviewed and updated for patients with complex needs. Staff told us minutes of MDT meetings were not taken and patients' records were updated directly from notes following the MDT meetings.</p>	

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 ¹
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.	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>1 – The practice had organised a local carer's event in March 2019 to help give support to carers and promote The Carers Network.</p> <p>2– Staff told us all patients who smoke had been offered smoking cessation advice and the practice provided a room for the advisor to use at the weekly smoking cessation clinic. The practice shared data with us from the CCG dashboard which showed the practice had a high success rate of working with</p>	

their patients to deliver smoking cessation in a proactive way.

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) <small>(QOF)</small>	100.0%	95.6%	95.1%	Significant Variation (positive)
Exception rate (number of exceptions).	0.5% (8)	1.2%	0.8%	N/A

Any additional evidence or comments

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
Explanation of any answers and additional evidence:	

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
Explanation of any answers and additional evidence: The practice provided care to a diverse population of patients. Staff were committed to providing care that respected patients' rights, beliefs, preferences and individual autonomy and were able to provide examples.	

CQC comments cards	
Total comments cards received.	34
Number of CQC comments received which were positive about the service.	25
Number of comments cards received which were mixed about the service.	8
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Comment cards	<p>Patients consistently described the staff as kind and helpful. We saw examples of the practice providing individualised care to support vulnerable patients. Patients told us that they felt the practice cared about their health and gave them support to improve their wellbeing. They described examples where staff provided them with information and contact details of local services that can offer additional support to patients.</p> <p>There were eight comment cards which were mixed about the service and one negative. Patients commented that it was sometimes difficult to get an appointment.</p>
Staff interviews	When asked what they thought the practice did well, staff singled out the regular GPs for providing patient-centred care.

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
7427	424	101	23.8%	1.36%

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)	77.4%	83.5%	89.0%	Tending towards variation (negative)
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)	75.9%	82.7%	87.4%	Tending towards variation (negative)
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)	89.9%	93.8%	95.6%	Tending towards variation (negative)
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)	70.7%	77.1%	83.8%	No statistical variation

Any additional evidence or comments

After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed the practice had improved but still scored below the national average in the National GP Patient Survey in relation to satisfaction with patients who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them: Practice 84% Local (CCG) average: 86% National average: 89%.

After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed the practice still scored below the national average in the National GP Patient Survey in relation to satisfaction with patients 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: Practice 80% Local (CCG) average: 82% National average: 87%.

After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed the practice scored above the national average in the National GP Patient Survey in relation to satisfaction with patients who stated that that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to: Practice 97% Local (CCG) average: 92% National average: 95%.

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

Any additional evidence

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 website contained information about local support groups and included information about common health conditions and the services provided by the practice. The website included a translation facility.	

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)	76.6%	90.2%	93.5%	Significant Variation (negative)

Any additional evidence or comments

The practice still scored below the national average in the National GP Patient Survey in relation to satisfaction with patients being involved as much as they wanted to be in decisions about their care and treatment. After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed an improved score of 86% for this indicator.

The practice provided evidence of actions to address areas from the practice survey which were lower than the national average. For example, the practice arranged for Ipsos Mori to carry out a review of patient feedback and the practice manager had implemented a weekly surgery where patients could come and talk about a wide range of matters. Patients could book to attend this surgery through reception. The practice also did an audit of waiting times for GP appointments but were not able to identify a problem for pre-booked appointments.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice proactively identified patients who were carers. The practice had identified 57 patients as carers (0.8% of the practice list). Staff told us they identified carers opportunistically. The practice had organised a local carer's event in March 2019 to help give support to carers and promote The Carers Network.
How the practice supported carers.	We were told that carers were advised about local carers services. The practice offered carers flexible appointment times and invited them for annual influenza vaccinations.
How the practice supported recently bereaved patients.	Responsible GP provided support and signposting to specialist bereavement services.

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
Explanation of any answers and additional evidence:	

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 ¹
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
<p>Explanation of any answers and additional evidence:</p> <p>1 - Booked appointments were available two to four weeks in advance. There was a walk-in clinic (Monday to Thursday) and telephone triage by a duty doctor on Friday mornings. Daily telephone consultations with a GP were available for patients. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.</p> <p>The practice offered evening appointments and extended hour appointments on Saturday mornings. Patients could book appointments online and make cancellations.</p> <p>The practice used two regular long-term locum GPs to fill the staff rota and this increased the practice's ability to provide continuity of care to patients who valued this.</p> <p>The practice manager had implemented a weekly surgery where patients can come and talk about a wide range of matters. Patients could book to attend this surgery through reception.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Saturday	8.30am to 12.30pm
Appointments available:	
Monday	8.30 am to 12.30pm and 2.30pm to 7pm
Tuesday	8.30 am to 12.30pm and 3pm to 7pm
Wednesday	8.30 am to 12.30pm and 3pm to 7pm
Thursday	8.30 am to 12.30pm and 3pm to 7pm

Friday	8.30 am to 12.30pm and 3pm to 6.30pm
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National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7427	424	101	23.8%	1.36%

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)	86.8%	92.2%	94.8%	Variation (negative)

Any additional evidence or comments

After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed the practice score had improved from 86.8% to 95% (Local (CCG) average: 91% National average: 94%) for the percentage of patients who stated that at their last general practice appointment, their needs were met.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. Housebound patients were visited at home by District Nurses, the community matron and GPs.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Good

Findings

- The practice was working towards improving the consistency in the way that medicine reviews are coded and documented.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people

Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice worked with the local Family Lives team to give early support to local families identified as needing extra help.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Appointments for GPs and nurses were available in the evenings and there was extended hours opening on Saturdays.
- Joint working was undertaken with the health visiting team and other agencies where families and children required extra support to keep them safe.
- The practice held a GP baby clinic weekly on Tuesdays between 3:00pm – 4:00pm with a doctor and Practice Nurses available. GP appointments were available during baby clinic and the practice had an “open door” policy between Health Visitors and practice clinicians.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, evening and Saturday appointments.
- Pre-bookable appointments were available to all patients at other practices within the area during the evening and at weekends. Patients could access a range of services at other sites locally, for example, Improving Access to Psychological Therapies (IAPT) and smoking cessation services.
- Walk in appointments were available every morning. Nursing appointments were available in the evening and there was extended hours opening on Saturdays for cervical screening and healthy living advice.
- Patients had electronic access to making appointments and could access their own records and order medicine online.
- The practice used the electronic prescription service, so that people could collect their medicines directly from their community pharmacy without having to visit the practice.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Staff told us patients with a visual impairment were added to the register of patients living in vulnerable circumstances. Patients were offered a meeting with the Practice Manager to establish their preferences of communication.
- The practice had set up a GP-led community alcohol de-toxification service which was the only one in Westminster. The service was run by a GP, clinical nurse specialist and a counsellor who assessed and supported alcoholics through detox and offered aftercare with group and individual counselling. Between April 2018 and March 2019 there were 75 referrals into the alcohol service of which 43 patients required community alcohol detoxification. All 43 patients completed detoxification and 36 remained abstinent at six months and seven patients had reached one year of abstinence.
- The practice had a part time dedicated alcohol and drug addict nurse who was available to discuss any issues. The nurse was supported by a GP with a Special Interest in Drug Addiction.
- Vulnerable patients were identified and offered appointments without triage, for example those with hearing difficulties.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Patients who failed to attend their appointments were proactively followed up by a phone call from a GP.
- The Primary Care Plus mental health practitioner held a weekly clinic at the practice and a CBT/IAPT practitioner provided a weekly clinic at the practice.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were 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.	Y
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:	

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)	63.8%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	46.3%	65.7%	68.6%	Tending towards variation (negative)
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)	58.7%	62.1%	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)	55.2%	69.2%	74.4%	Tending towards variation (negative)

Any additional evidence or comments
<p>After our visit, the 2019 National GP Patient Survey data (collected between January and March 2019) was published which showed the practice score had improved from 63.8% to 79% (Local (CCG) average: 81% National average: 68%) for the percentage of patients who responded positively to how easy it was to get through to someone at their GP practice on the phone</p> <p>The practice score had improved from 46.3% to 72% (Local (CCG) average: 65% National average: 67%) for the percentage of patients who responded positively to the overall experience of making an appointment</p> <p>The practice score had improved from 58.7% to 70% (Local (CCG) average: 61% National average: 65%) for the percentage of patients who were very satisfied or fairly satisfied with their GP practice appointment times.</p>

The practice score had improved from 55.2% to 65% (Local (CCG) average: 64% National average: 74%) for the percentage of patients who were satisfied with the type of appointment (or appointments) they were offered.

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.	11
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: At this inspection staff were able to outline the system for handling complaints including verbal complaints. Complaint leaflets were available to patients who wished to make a complaint. We saw evidence of discussion of complaints in minutes from team meetings.	

Well-led

Rating: Good

- *The provider had systems to ensure oversight of safe prescribing.*
- *Practice leaders had developed policies and quality improvement activities to ensure safety and assure themselves they were operating as intended.*
- *There were effective arrangements for identifying, managing and mitigating risks.*

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels; the leadership had identified areas for improvement.

	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 ¹
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1– The leadership were driving improvements effectively. The practice had made an improvement to their prescribing protocol since our last inspection, leaders had addressed concerns in relation to the recording of medicine reviews. The practice had a programme of quality improvement activities in place to improve prescribing safety.</p> <p>Leaders were working with a number of organisations to improve the stability and sustainability of their current operating model.</p> <p>There was a designated lead for each clinical and non-clinical area.</p> <p>Leaders were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.</p>	

Vision and strategy

The practice had a clear vision to provide high quality sustainable care, and there was an effective supporting strategy

	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 ¹
The vision, values and strategy were developed in collaboration with staff, patients and	Y

external partners.	
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 ²
<p>Explanation of any answers and additional evidence:</p> <p>There was a clear vision and set of values to provide patients with high quality, personalised and holistic care. All staff were aware of the vision and we saw that this translated into the action of the practice. The practice had a mission statement to “provide the safest, most sensitive care we can, with the resources available, in a challenging but vibrant environment.”</p> <p>1 – The provider had a comprehensive, coordinated strategy to ensure the service operated safely and as intended, for example in relation to medicine review and prescribing.</p> <p>2 –We saw minutes from the annual whole team meeting which reviewed the achievements and learning from the previous year. At this annual whole team meeting the practice agreed a plan for the year ahead. Staff told us the practice team meet regularly to ensure the plan is delivered and the partners meet monthly often with other staff, so the plan can be updated to meet changing need.</p>	

Culture

The practice culture effectively supported 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
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that all practice staff worked together as a team. Staff told us that the GPs and managers were very approachable. There were frequent staff meetings. Leaders encouraged staff to raise concerns. Staff said they felt confident that managers would address their concerns and issues raised.</p>	

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

Source	Feedback
Staff	Staff were committed to providing a high-quality service to patients. They consistently told us the quality of clinical care provided was excellent and something they were proud of.

Governance arrangements

The practice had made improvements since our last inspection, we found the leadership structure had undertaken actions to ensure patient safety.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y ¹
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:	
<p>1 – At our last inspection, we found the overall governance arrangements were ineffective. Issues that could threaten the delivery of safe and effective care were not identified and managed. Not all policies and procedures were reviewed regularly to ensure they were in line with best practice. For example, there was a prescribing and medicine review policy, but it did not contain sufficient guidance on recording medicine reviews and Read Codes.</p> <p>Following our last inspection, the practice told us the partners had reviewed the organisational structure of the practice and a manager had been allocated to governance who worked alongside the Practice Manager to ensure that oversight of the practice was not affected by operational demands.</p> <p>At this inspection, the leadership team had taken action to address most of the concerns raised. The leadership team had ensured improvements to prescribing protocols and updates to recording medicine reviews were communicated effectively to all staff.</p> <p>medicine</p> <p>There was an effective system of structured medicine reviews for patients with long term conditions. Medical records we looked at contained sufficiently consistent information to support the care of the patient and to enable the reviewing clinician to carry out a consultation.</p>	

Managing risks, issues and performance

The practice had clear and effective processes for managing all risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y ¹
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.	P ²
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:

1 – The leadership team were driving improvements effectively. There were effective governance arrangements in place to ensure priority areas of improvement were highlighted, risks identified, and actions planned.

Leaders had addressed concerns in relation to recording and documentation of medicine reviews. At this inspection we found arrangements for identifying, monitoring and managing risks to patient safety, had improved. The leaders had carried out audits to review the quality of read coding at the practice and updated their prescribing protocols to ensure oversight of safe prescribing.

Appropriate and accurate information

The practice acted 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.	Y ¹
There were effective arrangements for identifying, managing and mitigating risks.	Y ²
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. We saw evidence that the practice used the results of clinical audits to improve performance.

1 – We saw evidence the practice had audited prescribing in line with current clinical guidance. Staff had carried out a polypharmacy review audit in May 2018. This was a shared project with the CCG Medicines Management team. Staff told us the CCG pharmacist did a search of patients on 14 or more medicines. We asked to review the findings but were not able to open the files sent to us. From the files we looked at, 22 out of 50 patients who met this criteria were invited in to a face to face polypharmacy review with the North West London CCG pharmacist at their clinic. However, we were not able to tell when the practice planned to re-audit and there was no clear analysis of results or follow up of agreed actions. We were told the findings were tasked to the usual GP to action.

medicine

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
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:	

Feedback from Patient Participation Group.

Feedback
<p>We spoke to three members of the patient participation group (PPG). They reported that the practice involved them and considered their suggestions. Patient feedback on difficulties for working age people to get an appointment system had resulted in effective action. The practice added extended hours appointments which offered working age patients access to extended appointments twice a week – one weekday night and Saturday mornings.</p> <p>The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the PPG gave feedback to the practice about an increasing problem of isolation in the community and suggested coffee mornings should be held quarterly at the practice for local people. LGHC has hosted three events for the over 60's with the aim being to reduce social isolation.</p>

Any additional evidence
<p>Staff said suggestions are encouraged and discussed in the team. Staff identify opportunities for further training to develop their roles. The practice engages effectively with the CCG and local services to get involved in audits and pilots and to assist learning and development and improve quality.</p>

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y ¹
Explanation of any answers and additional evidence:	
<p>1 – Leaders had started to implement the lessons learned following the concerns raised in relation to ensuring consistency in recording and documenting medicine reviews.</p> <p>The practice team was actively involved in local pilot schemes to improve outcomes for patients in the area. For example, the practice had joined a new LGBT Foundation pilot called Pride in Practice (PiP). (Pride in Practice (PiP) is a social prescribing programme to help practices develop their relationships with LGBT patients).</p>	

To improve cervical screening uptake, leaders had organised training for two practice nurses and the Health Care Assistant to become Community Connectors. The community Connectors are people who help to share cervical health messages to communities of interest, for example minority groups to overcome barriers to awareness and screening.

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.