

Care Quality Commission

Inspection Evidence Table

Lilyville @ Parsons Green (1-6226776993)

Inspection date: 19 December 2019

Date of data download: 17 December 2019

Overall rating: Requires improvement

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

Safe

Rating: Good

Safety systems and processes

The practice had systems, practices and processes in place to keep people safe and safeguarded from abuse. However, we identified some gaps in these processes.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial 1
Partners and staff were trained to appropriate levels for their role.	Partial 2
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Partial 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 4
1. Following the inspection, the provider submitted evidence they had updated their safeguarding policy, which included reference to intercollegiate guidance for safeguarding training, for vulnerable adults and different staff groups at the practice.	
2. We asked the practice to submit evidence regarding staff training for safeguarding children and	

Safeguarding	Y/N/Partial
<p>vulnerable adults. Following the inspection, they submitted evidence of safeguarding training for all staff. However, they could not demonstrate evidence that all clinical staff had completed safeguarding training at the appropriate level. For example, we saw evidence that one out of eight GPs' had undertaken adult safeguarding training at the appropriate level. Following the inspection, the provider submitted evidence that the practice manager had completed level two for both children and vulnerable adults. The practice nurse had undertaken level two training for both adults and children. The practice provided evidence that the practice nurse had been booked to undertake level three training for children in January 2020. However, they have not submitted evidence this had since been completed. All administration staff had completed appropriate level training.</p> <p>3. The provider could not demonstrate that all non-clinical staff, who may be asked to chaperone, had undertaken chaperone training. For example, we reviewed nine non-clinical staff records and saw that only two members of staff had completed training regarding this. Staff told us they had been asked to chaperone when not trained to do so. Following the inspection, the provider submitted evidence that one additional member of staff had previously completed chaperone training. In addition, they had updated their chaperone policy to reflect the required training requirements.</p> <p>4. The provider shared the same premises with health visiting staff and could demonstrate they worked collaboratively to support children and vulnerable adults at risk of harm.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial 1
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N 2
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
1. We reviewed five staff records and saw that recruitment checks had been undertaken. The provider could not demonstrate evidence they had induction checklists and interview summaries for any staff member. Following the inspection, the provider submitted evidence of one partially completed spreadsheet regarding an induction record summary.	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 18/12/2019</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 04/10/2019</p>	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y

There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 11 April 2019	Y
There was a log of fire drills. Date of last drill: 17 December 2019	Y
There was a record of fire alarm checks. Date of last check: 23 December 2019	Y
There was a record of fire training for staff. Date of last training: various	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 25 September 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: September 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2019	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial 1
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
1. The provider had highlighted staff immunisations and certified immunity as an issue that required attention in their infection prevention and control audit. They could not demonstrate, when asked, that all staff had undertaken the required immunisations or had certified immunity in line with national guidance.	

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.	N ¹
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial ²
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	
<ol style="list-style-type: none"> 1. The provider could not demonstrate that there was an effective induction system for staff. We reviewed five staff records and did not see evidence of an induction for any member of staff. 2. The provider could demonstrate they effectively managed their system for medical emergencies, including suspected sepsis. All clinical staff were trained in basic life support (BLS) and had undertaken sepsis training. However, we saw that three out of nine non-clinical staff had not completed BLS training. This was either out of date or no evidence had been submitted. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, we identified some gaps regarding fail-safe systems.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y

Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial 1 2
There was a documented approach to the management of test results and this was managed in a timely manner.	N 3
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial 4 5
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
<ol style="list-style-type: none"> 1. The practice had a process in place to monitor and manage two-week wait urgent referrals. However, this was not a fail-safe system to check whether patients had been seen at secondary care and had been followed up. We reviewed practice records and saw that 606 patients had been referred via this pathway in the previous 12 months and reviewed a sample of 16 records to check that patients had been seen by the appropriate secondary care team. There was no evidence that any patients had come to harm. 2. The practice had a process in place to monitor and manage cervical screening. However, this was not a fail-safe system to check whether patients had been seen at secondary care and had been followed up. Following the inspection, the provider submitted evidence of a safety netting system they planned to use going forward. We will review the effectiveness of this at the next inspection. 3. The provider could not demonstrate they had a policy in place regarding the management of test results. For example, blood test results received by the practice on a daily basis. 4. We saw evidence the provider had not reviewed 136 test results, 28 of which were abnormal, within 72 hours. Following the inspection, they submitted evidence that all patients' blood tests had been reviewed by a GP, that any patients who required follow-up had been contacted and any required actions had been undertaken. The provider told us they would improve their system in relation to this to ensure abnormal results are reviewed on the same day by the duty doctor. Non-clinical staff are not responsible for the management and review of any test results. 5. Following the inspection, the provider submitted evidence regarding a pathology results processing protocol and workflow guidance. We will review compliance with this at the next inspection. 	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.62	0.56	0.87	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and	14.4%	9.4%	8.5%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	4.74	5.49	5.60	Tending towards variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	0.60	0.82	2.08	Significant Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y

Medicines management	Y/N/Partial
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial 1
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
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
1. The practice had attained good achievement rates in two out of three antibacterial indicators we reviewed. In addition, the practice regularly undertook benchmarking of their prescribing with other providers in the local area. They were aware of the outlier regarding prescribing of a group of antibiotics and had begun work to address this. We will review the effectiveness of the practice's strategy to improve this at the next inspection.	

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:	18
Number of events that required action:	18
1. The provider submitted comprehensive information regarding their significant events analysis (SEA). We saw evidence the practice shared their learning at local and national levels. They had submitted eight SEA's to the National Reporting and Learning System (NRLS). In addition, the provider shared all SEAs with Hammersmith and Fulham GP Federation.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
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A phone call was received directly to a clinical room. This turned out to be a scam caller.	Staff have been briefed regarding actions to take if this recurs. The practice contacted the telephone provider and actions were agreed to stop any repetition.
A sharps bin from a different provider had been placed in the practice's external clinical waste bin.	Discussed with relevant stakeholders and remedial actions were undertaken.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<ul style="list-style-type: none"> The provider could demonstrate they had a system in place regarding patient safety alerts. For example, we saw evidence of actions taken for an alert for a medicine that is contraindicated in pregnancy. This included a pregnancy prevention programme for female patients of reproductive age who were prescribed this medicine. However, the search for this medicine had not been undertaken since June 2018. Following the inspection, the provider submitted information to demonstrate they had undertaken an audit regarding this and planned to continue this on a monthly basis. 	

Effective

Rating: Requires improvement

The practice was rated as requires improvement for providing effective services because:

- The provider could not demonstrate they had achieved World Health Organisation (WHO) target rates for four out of four childhood immunisations indicators.
- Cervical screening achievement rates were low.
- The provider could not demonstrate they had undertaken appropriate clinical supervision with the practice nurse.
- The provider could not demonstrate they had undertaken appropriate clinical supervision with the healthcare assistant.
- The provider could not demonstrate that all staff had completed regular training.

Effective needs assessment, care and treatment

Clinical practice was supported by clear pathways and tools. Patients' needs were assessed and care and treatment were delivered in line with current legislation, standards, and evidence-based guidance. However, some patient outcomes were below local and national averages.

	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	Y

needs and their mental and physical wellbeing.	
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial 1
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial 2
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
<p>1. The provider had a system in place to monitor and manage patients presenting with symptoms which could indicate serious illness. However, this was not a fail-safe system to check whether patients had been seen at secondary care and had been followed up. Following the inspection, the provider submitted evidence they have initiated a system to follow-up patients who been referred to secondary care by the fast track referral pathway. We will review the effectiveness of this at the next inspection.</p> <p>2. The provider could not demonstrate they had a policy in place regarding the management of test results. For example, blood test results received by the practice on a daily basis. We saw evidence the provider had not reviewed 136 test results, 28 of which were abnormal, within 72 hours. Following the inspection, they submitted evidence that all patients' blood tests had been reviewed by a GP, that any patients who required follow-up had been contacted and any required actions had been undertaken. The provider told us they will improve their system in relation to this to ensure abnormal results are reviewed on the same day by the duty doctor.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.55	0.71	0.74	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The provider could demonstrate they had identified, assessed and addressed the needs of patients with moderate and severe frailty use the e-Frailty Index. In the previous 12 months, they had carried out a frailty project which included a proactive GP visit and holistic assessment. The provider linked these patients with community resources, identified unmet health and social care needs, and support patients in increased ownership of their own healthcare. The practice believed the project has been contributed to their improved hospital admission rates. The practice provided care for a local Care Home. GPs proactively planned visits to manage the care of these patients and liaised with the visiting Consultant Geriatrician to improve the health and wellbeing of the patients.

- The practice is an active member of the South Fulham primary care network (PCN). The network has recently employed a link worker who will work part-time in the practice. The link worker engages with older patients to help address social isolation concerns.
- 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.
- Where necessary patients could book double appointments with a named GP who knew them well.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- We reviewed evidence the practice nurse, who was responsible for reviews of patients with long-term conditions, had received core specific training. However, they could not demonstrate evidence of appropriate updates regarding this.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had recently undertaken a review of all patients who have type two diabetes. Following this review, individual changes were initiated for patients. In addition, an Endocrine Consultant attended the practice on a quarterly basis to hold a virtual clinic review of complex diabetic patients.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that includes an assessment of asthma control was 84.8%. This was tending towards a positive variation and was compared to 72.9% locally and 75.9% nationally.
- 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.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.3%	77.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	8.7% (22)	12.0%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12	80.6%	74.9%	78.1%	No statistical variation

months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) ^(QOF)				
Exception rate (number of exceptions).	9.9% (25)	11.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) ^(QOF)	87.2%	78.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	13.1% (33)	10.9%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) ^(QOF)	84.8%	72.9%	75.9%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.2% (11)	5.8%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) ^(QOF)	94.3%	86.5%	89.6%	No statistical variation
Exception rate (number of exceptions).	10.2% (10)	11.0%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) ^(QOF)	82.7%	80.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.2% (34)	7.4%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) ^(QOF)	95.7%	89.2%	91.1%	No statistical variation

Exception rate (number of exceptions).	5.7% (7)	4.9%	5.9%	N/A
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Families, children and young people

Population group rating: Requires improvement

Findings

- The practice had not met the minimum 90% target for three of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators. The provider submitted information regarding achievement rates from the NHS Open Exeter portal. However, the patient data we review to ensure accuracy and consistency regarding childhood immunisations is provided by Public Health England (PHE). This is collected on a year by year basis.
- In addition, the provider told us they had written an action plan regarding this to improve uptake rates. The action plan included the practice nurse and child safeguarding GP lead holding monthly meetings to review the rate of immunisation of children in the practice. Parents/guardians are actively contacted to bring children in for immunisations. We will review the effectiveness of the action plan at the next inspection.
- The practice safeguarding GP lead met monthly with the practice nurse and health visitor to review those children who had not had their immunisations and discuss any safeguarding concerns. The practice maintained a register of children and young people for whom there were safeguarding concerns. There was a process in place for when children were not brought to their immunisations' appointments.
- The practice offered a meningitis ACWY vaccination to those children who may have missed this in school.
- Young people could access services for sexual health and contraception with GPs.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	76	84	90.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	95	116	81.9%	Below 90% minimum
The percentage of children aged 2 who	97	116	83.6%	Below 90% minimum

have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	97	116	83.6%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) for the period 01/04/2018-31/03/2019, was 57%. This is compared to an achievement rate of 58% for the time period 01/04/2017-31/03/2018.
- The provider told us they send reminder texts and letters to female patients regarding their cervical smear test. In addition, patients were offered the option of evening and weekend smear appointments at a local GP hub. We will review the effectiveness of this approach at the next inspection.
- The provider offered telephone consultations on a daily basis to increase access to GPs to patients who may find it difficult to attend within core hours.
- Patients may access GP appointments after hours and at weekends in GP hubs in the borough of Hammersmith and Fulham.
- A clinical pharmacist performed routine medication reviews for patients on a Sunday. Staff told us they will be continuing to develop this element of this service.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health	57.0%	N/A	80% Target	Below 70% uptake

England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	65.8%	60.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	50.4%	41.7%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	64.4%	50.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	35.7%	52.7%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice maintained a register of patients with a learning disability. These patients are invited to have an annual health check.
- The provider has signed up to provide Out of Hospital care for homeless patients. They offered those patients a double appointment to identify and manage their complex needs. This included screening for alcohol mis-use and its impact, infectious diseases and substance abuse issues. Patients were signposted to appropriate specialist services with consent. For example, to homeless health and housing services.
- Same day appointments and longer appointments were offered to patients when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

Population group rating: Good

Findings

- A primary care mental health worker supported patients with their mental health needs.
- The practice works collaboratively with a Consultant Psychiatrist from the local community mental health team.
- The practice performed annual reviews, including physical health checks for this patient group and anticipatory care plans were made. Information included in care plans included early signs of deterioration and sources of support for patients who were in crisis are pro-actively

identified.

- Same day and longer appointments were offered to patients when required.
- There was a system for following up patients who failed to collect prescriptions for mental health medicines.
- 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.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.3%	87.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	6.3% (4)	12.2%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.7%	89.5%	90.2%	No statistical variation
Exception rate (number of exceptions).	4.7% (3)	9.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.7%	82.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.1% (4)	7.6%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	535.6	516.9	539.2
Overall QOF score (as a percentage of maximum)	95.8%	92.5%	96.4%

Overall QOF exception reporting (all domains)	4.7%	7.4%	5.9%
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	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y ₁
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y ₂
<p>1. The provider engaged in comprehensive programme of quality improvement and clinical audit. We reviewed evidence the provider had undertaken quality improvements including in clinical and non-clinical areas. For example, an antibiotic audit reviewing its prescribing which was above local and national rates. Following the inspection, the provider submitted evidence that they had identified why prescribing rates were above average; the second audit cycle demonstrated improvement regarding this. We will review compliance with this at the next inspection. In addition, they participated in Hammersmith and Fulham GP Federation clinical audits. For example, spirometry, which is a way of testing lung function, wound care and near patient monitoring regarding high risk medicines.</p> <p>2. We reviewed evidence the practice reviewed non-elective admissions and readmissions and benchmarked themselves with the GP providers within the borough of Hammersmith and Fulham.</p>	

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

<ol style="list-style-type: none"> 1. A near patient monitoring (NPM) audit was initially conducted in 2017-2018. A second cycle NPM audit was undertaken in 2018-2019 and we reviewed evidence of quality improvement regarding the management of high risk medicines. 2. High dose opiates study. The provider had undertaken a one-cycle audit of patients who had been prescribed opioids medicines who had pain caused by cancer and non-cancer causes. The audit did not detail when a second-cycle would be completed. 3. A disability access audit. A recommended implemented action from this audit was increased signage for people who have a hearing disability. This will be reviewed if any changes occur to the patient/staff population groups, or if there are any legal or legislative changes. 4. An audit regarding patients who were receiving end of life care. The provider had undertaken a baseline review and planned to undertake an audit of identified good practice indicators, by 31 March 2020.

Effective staffing

The practice was able to demonstrate that all clinical staff had the skills, knowledge and experience to carry out their roles. However, we identified some gaps

regarding regular training.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial 1 2
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Partial 2
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial 3
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial 4
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>1. We reviewed evidence the practice nurse had completed core specific training to undertake long term condition reviews, childhood immunisations and cervical screening. Following the inspection, the provider submitted evidence of updates regarding practice nurse training, including for family planning. However, we have not received evidence to date that the staff had? undertaken comprehensive initial training regarding this. The provider could demonstrate the healthcare assistant (HCA) had undertaken core specific training to undertake roles they carried out. For example, automatic blood pressure monitoring (ABPM), diabetes and long term condition reviews.</p> <p>2. The provider had a system in place regarding training for staff. However, we found gaps in training. For example, regarding basic life support (BLS), sepsis and equality and diversity. We saw that three out of nine non-clinical staff had not undertaken BLS training; one out of eight GPs' had not completed sepsis training; eight out of nine non-clinical staff and two out of eight GPs' had not undertaken equality and diversity training. In addition, seven out of nine non-clinical staff had not undertaken Prevent training. Following the inspection, the provider submitted evidence of four staff training records regarding Prevent training; one set of safeguarding training for adults and children at level two for the practice manager and four spreadsheets regarding BLS, equality and diversity, Prevent and sepsis. Following the inspection, the provider submitted evidence of standard and advanced workbooks related to receptionists' competency training. However, the provider did not submit certificates to demonstrate that training had in fact been completed.</p> <p>3. We reviewed five staff records regarding induction programmes for new staff; out of these four out of five records did not contain evidence regarding this. Following the inspection, the provider submitted evidence of two induction checklists, one for healthcare assistants/phlebotomist and the second for all other staff. We will review the</p>	

effectiveness of this at the next inspection.	
4. The provider undertook staff appraisals on an annual basis. However, staff told us the practice nurse and healthcare assistant had 'ad hoc' informal clinical supervision sessions and these meetings were not documented. Following the inspection, the provider submitted a formal clinical supervision plan with the practice nurse and HCA. We will review the effectiveness of this at the next inspection.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
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 ^{1 2}
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y ³
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<ol style="list-style-type: none"> The practice told us they held regular meetings. This included management, clinical and practice (monthly); palliative care (quarterly) to discuss patients on the palliative care register. Staff could demonstrate this with evidence of recorded minutes. The provider held clinical GP partner meetings with each morning to discuss concerns regarding patients and other relevant information. We reviewed evidence of minuted meetings regarding this. The practice could demonstrate a coordinated approach to the management of patients including regular and minuted multi-disciplinary meetings; that accurate information was available and shared with relevant professionals. 	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y

Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.2%	94.5%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.7% (9)	1.4%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y ¹
Policies for any online services offered were in line with national guidance.	N/A
1. We reviewed evidence that the provider audited and monitored the process for seeking consent appropriately. For example, patients' immunisations records regarding measles, mumps and rubella (MMR).	

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
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	38
Number of CQC comments received which were positive about the service.	30
Number of comments cards received which were mixed about the service.	8
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comments cards	Patients reported consistent themes that GPs listened, were knowledgeable, pleasant, calm and supportive.
CQC Comments cards	We saw from eight cards that comments were mixed. These comments concerned access to appointments.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9257.0	421.0	135.0	32.1%	1.46%

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 (01/01/2019 to 31/03/2019)	92.4%	86.2%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	90.3%	83.1%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	96.9%	93.5%	95.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	85.5%	80.3%	82.9%	No statistical variation

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

Any additional evidence
<p>Staff told us they received feedback from patients through a variety of media.</p> <ul style="list-style-type: none"> • Verbal comments • National patient summary • Friends and family information • PPG meetings (Both practice level and network PPG meetings) • Patient Satisfaction Questionnaires • NHS website online reviews <p>Action taken following patient feedback:</p> <ol style="list-style-type: none"> 1. Increasing the number of pre-book appointments available online to patients who had reported difficulties getting through on the telephone at busy times of the day. 2. All correspondence from patients was scanned on to the practice clinical IT system, including any hand-written notes, to ensure there was an auditable paper trail. 3. Clearer signs were installed to highlight the slight slope and door exit button in the corridor. This was following a request from patients. 4. The layout of the reception desk was changed, lowering the height of the front desk. Patients felt those in a wheelchair or accessibility issues may find it difficult to have a confidential discussion with the front desk receptionist. 5. A letterbox was installed in the reception area, to enable patients to post prescription requests.

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

Source	Feedback
Interviews with patients.	Patients told us they felt involved with their care and treatment and that they were given options regarding this. They spoke highly of GPs' and said staff were caring with an open and positive style of communication.

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 (01/01/2019 to 31/03/2019)	96.5%	91.4%	93.4%	No statistical variation

	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.	Partial 1
Information about support groups was available on the practice website.	Y 2
<p>1. The practice provided information on a range of issues, in different languages. These were only available on the practice website. Following the inspection, the provider submitted evidence of a new patient registration form that had been developed.</p> <p>2. Following the inspection, the provider submitted evidence that they pro-actively worked to identify any carers at the point of registration at the practice and on an ongoing basis. For example, they had developed a carer's registration form. The provider should continue to take steps to identify carers within the patient community.</p>	

Carers	Narrative
Percentage and number of carers identified.	0.66% (62)
How the practice supported carers (including young carers).	The provider supported carers within the patient community and signposted them to The Carer's Network and other information and support networks.
How the practice supported recently bereaved patients.	The provider supported recently bereaved patients by one to one appointments and signposted them to relevant information and support networks.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times

Day	Time
Opening times:	
Monday	08.00am-6.30pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm
Appointments available:	
Monday	08.00am-6.30pm
Tuesday	08.00am-6.30pm
Wednesday	08.00am-6.30pm
Thursday	08.00am-6.30pm
Friday	08.00am-6.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9257.0	421.0	135.0	32.1%	1.46%

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 (01/01/2019 to 31/03/2019)	96.3%	92.1%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice provided effective care coordination to enable older patients to access appropriate. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm) services.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> Patients with multiple conditions had their needs reviewed in one appointment. The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm).

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All parents or guardians calling with concerns about a child were offered a same day appointment

when necessary.

- Health visitors were based in the practice premises and were easily accessible.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm).

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.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm).

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The GPs had introduced a 'Safe Surgeries' initiative. This supports general practices to provide care to patients. For example, refugees, asylum seekers, undocumented migrants, and homeless people, who were unable to provide documents to verify their identities.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm).

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.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- A mental health link worker was based at the practice who ran a weekly clinic.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Pre-bookable appointments were also available to all patients at additional locations within the

area, as the practice was a member of a GP federation. Weekday evening appointments were available (6.30pm-8pm) and weekend appointments (8am-8pm).

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

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 (01/01/2019 to 31/03/2019)	89.1%	N/A	68.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	78.2%	68.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	59.4%	65.4%	64.7%	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 (01/01/2019 to 31/03/2019)	73.2%	69.8%	73.6%	No statistical variation

Source	Feedback
For example, NHS	3.3 * overall based on 19 patient reviews.

Choices	<p>1. We reviewed patients reviews on NHS Choices and identified the following:</p> <ul style="list-style-type: none"> • That GPs were kind, very competent and treated patients with respect. • That accessing appointments was difficult and at times reception staff were abrupt and unhelpful. • The doctors and the reception staff were professional, friendly and helpful. Patients would have no hesitation in recommending this surgery.
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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.	20
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	Partial 1 2
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
<p>1. The provider reviewed and responded to all feedback received from patients including direct complaints and comments from NHS Choices website. We reviewed three out of twenty complaints received by the provider. For one out of three complaints, the provider told us that learning points had been shared at a practice meeting. However, when we reviewed the minutes from that meeting we saw this had not been included.</p> <p>2. We saw that two complaints had not been fully documented. For example, we could not review what the complaint was, only the actions the provider had taken.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Letter from a patient was lost in the surgery.	A full apology was given to the patient during a face to face meetings. Practice procedures were modified to prevent a re-occurrence of this.
A patient attempted to request a home visit and could not get through to reception to request a home visit on two separate occasions.	The practice telephoned the patient to explain the best times to request a home visit.

Well-led

Rating: Requires Improvement

- The practice was rated as requires improvement for providing well-led services because: The provider could not demonstrate they had an effective system in place to safely manage patients who had been referred via the urgent two week-wait system.
- The provider could not demonstrate they had a fail-safe system in place to safely manage and monitor cervical screening.
- The provider could not demonstrate they had an effective system in place to monitor and manage patients' test results.
- The provider could not demonstrate they had an effective system in place to safely monitor and manage infection prevention and control practices in particular staff immunisations and certified immunity.
- The provider could not demonstrate they had an effective system in place to monitor and manage staff training.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y _{1 2}
They had identified the actions necessary to address these challenges.	Y ₃
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
1. The GP partners were clear about the challenges they faced and were developing plans and priorities to improve. 2. For example, following the inspection the provider submitted action plans regarding childhood immunisations and cervical screening. In addition, they provided information regarding safety netting systems they were going to implement regarding two-week wait urgent referrals and cervical screening. We will review the effectiveness of these improvements at the next inspection. 3. The provider had identified actions necessary to address challenges in relation to cervical screening. The provider had reviewed their cervical screening approach and submitted evidence to include a cervical screening policy, a cervical smear audit policy and anonymised information regarding their cervical screening failsafe mechanism. We will review the effectiveness of this at the next inspection.	

Vision and strategy

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

	Y/N/Partial
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The practice had a clear vision and set of values that prioritised quality and sustainability.	Y ₁
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y ₂
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 ₃
<ol style="list-style-type: none"> 1. The current GP management team had been in place since January 2019. They strived to provide “Cradle to Grave” NHS care, knew their patient population well, understood where the challenges lay and had a realistic plan to address them. For example, lower than average patient achievement data for cervical screening and childhood immunisations. 2. The GP partnership team had a philosophy of ‘nearby leadership,’ worked alongside the team and modelled behaviours to help improve practice performance. 3. GP partners met on a regular basis to review performance and strategic objectives. 	

Culture

The practice had a culture which drove several aspects of high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice’s speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial ₁
1. We reviewed 18 staff training records regarding equality and diversity training and found 11 staff had not completed this training.	

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

Source	Feedback
Non-clinical staff	Staff told us they felt happy, well supported and it was a happy place to work.

Governance arrangements

There were clear responsibilities, roles and systems of accountability. However, some governance arrangements were ineffective.

	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
1. We found that structures, processes and systems to support good governance were not always effective. For example, safety netting of urgent two-week wait referrals and cervical smear screening. Following the inspection, the provider submitted evidence they were planning to implement new safety netting systems. We will review the effectiveness of this at the next inspection.	

Managing risks, issues and performance

There were clear responsibilities, roles and systems of accountability. However, some governance arrangements were ineffective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial 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.	Partial ₂
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y ₃
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<ol style="list-style-type: none"> 1. We were not assured that comprehensive and effective systems and process were in place and regularly reviewed to manage risk. For example, for urgent two-week wait referrals and cervical screening. Following the inspection, the provider submitted evidence regarding the safety netting of both systems. We will review the effectiveness of this at the next inspection. 2. The provider had some systems in place to identify, manage and mitigate risks. For example, risk assessment regarding fire safety and control of substances hazardous to health (COSHH). 3. The provider held a medical simulation event within the past 12 months. This simulated a real-time emergency followed by a supervised debrief session to staff. Following this event, staff amended some processes as a result. The provider intended to run a similar event in the forthcoming year to test their business continuity planning. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial 1
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>1. The provider could not demonstrate there were effective arrangements for identifying, managing and mitigating risks. For example, the management of two-week wait urgent referrals. Following the inspection, the provider submitted evidence of a new system to safety net urgent two-week wait referrals. We will review the effectiveness of this at the next inspection.</p>	

Engagement with patients, the public, staff and external partners

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

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

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
<p>1. The practice was going to introduce Digital First services, an online consultation tool, to be more effective in allocating appointments with the most appropriate professional to meet patients' needs.</p> <p>2. GPs had introduced a 'Safe Surgeries' initiative. This supports general practices to provide care</p>	

to patients. For example, refugees, asylum seekers, undocumented migrants, and homeless people, who were unable to provide documents to verify their identities.

3. The practice was working towards an 'Autism Friendly' workplace award to make attending an appointment, for those people with an autistic spectrum disorder, a less daunting and more positive experience.
4. The provider was working collaboratively with the Fulham FC Foundation. This work was designed to encourage men, and those people who were potentially socially isolated and did not pro-actively engage healthcare providers, to attend for healthcare and well-being checks.
5. The provider worked closely with CLCH to enhance the District nurse role to include advanced care planning and to promote closer working with the walk in centre in the shared building.
6. The practice was registered as a Parkrun practice. This enabled GPs to model healthier lifestyles, alongside patients and demonstrated the ethic of teamwork.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.