

# Care Quality Commission

## Inspection Evidence Table

### Fulham Cross Medical Centre (1-6744301662)

Inspection date: 27-29 April 2021

Date of data download: 26 April 2021

## Overall rating: Good

The practice was rated as Good because it had improved its systems for recording accurate and detailed medical records since our previous inspection in November 2020 and had sustained the other improvements noted at the last inspection. The practice was aware of the ongoing need to improve cancer screening and child immunisation uptake and was implementing an action plan to tackle these areas.

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

## Safe

## Rating: Good

### Safety systems and processes

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

| Safeguarding   | Y/N/Partial |
|--|-------------|
| There was a lead member of staff for safeguarding processes and procedures.                          | Y           |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y           |
| There were policies covering adult and child safeguarding which were accessible to all staff.        | Y           |
| Policies and procedures were monitored, reviewed and updated.  | Y           |
| Partners and staff were trained to appropriate levels for their role.                                | Y           |
| There was active and appropriate engagement in local safeguarding processes.                         | Y           |
| The Out of Hours service was informed of relevant safeguarding information.                          | Y           |
| There were systems to identify vulnerable patients on record.  | Y           |
| Disclosure and Barring Service (DBS) checks were undertaken where required.                          | Y           |
| Staff who acted as chaperones were trained for their role.   | Y           |

| <b>Safeguarding</b>  | <b>Y/N/Partial</b> |
|--|--------------------|
| 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                  |

| <b>Recruitment systems</b>   | <b>Y/N/Partial</b> |
|--|--------------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).  | Y                  |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.  | Y                  |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.  | Y                  |
| Explanation of any answers and additional evidence:<br>Since the previous inspection, a new regular locum GP had joined the practice. We saw evidence that the practice had carried out the required recruitment checks. |                    |

| <b>Safety systems and records</b>  | <b>Y/N/Partial</b> |
|--|--------------------|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: 11/08/2020 | Y                  |
| There was a record of equipment calibration.<br>Date of last calibration: 11/08/2020   | 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                  |
| A fire risk assessment had been completed.<br>Date of completion: 05/10/2020   | Y                  |
| Actions from fire risk assessment were identified and completed.   | Y                  |

| <b>Health and safety</b>  | <b>Y/N/Partial</b> |
|---|--------------------|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: 10/02/2021  | Y                  |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 10/02/2021   | Y                  |
| Explanation of any answers and additional evidence:<br>The practice had identified staff wellbeing as an issue for further focus given the pressures place on staff during the Covid-19 pandemic. The managers were in the process of identifying and displaying relevant resources, for example around mental wellbeing. |                    |

## 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.<br>Date of last infection prevention and control audit: 02/11/2020 | Y           |
| The practice had acted on any issues identified in infection prevention and control audits.                                  | Y           |
| There was a system to notify Public Health England of suspected notifiable diseases.   | Y           |
| The arrangements for managing waste and clinical specimens kept people safe.   | Y           |

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

|   | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods.  | Y           |
| There was an effective induction system for temporary staff tailored to their role.   | Y           |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.   | 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           |
| Explanation of any answers and additional evidence:<br>Since the previous inspection, a new regular locum GP had joined the practice. We saw evidence of the induction process used to familiarise the doctor with key systems and processes, including safeguarding patients at risk and how to make urgent referrals. |             |

## Information to deliver safe care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.  | Y           |
| There was a system for processing information relating to new patients including the summarising of new patient notes.   | Y           |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.  | Y           |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.  | Y           |
| There was a documented approach to the management of test results and this was managed in a timely manner.   | Y           |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection, we issued a warning notice requiring the practice to improve its clinical record keeping. In response, the practice clinicians had arranged an external audit of their record keeping and acted on the results. As part of this inspection, we carried out a series of standardised searches of the practice's clinical records system. We did not identify any concerns and noted improvements to history taking, safety-netting and the level of detail included. This was a marked improvement.</p> |             |

## 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) (01/01/2020 to 31/12/2020) <small>(NHS Business Service Authority - NHSBSA)</small>   | 0.33     | 0.57        | 0.76            | Significant Variation (positive) |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2020 to 31/12/2020) <small>(NHSBSA)</small>                                       | 11.4%    | 10.2%       | 9.5%            | No statistical variation         |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small> | 6.02     | 5.52        | 5.33            | No statistical variation         |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>  | 11.9‰    | 59.7‰       | 127.1‰          | Significant Variation (positive) |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) <small>(NHSBSA)</small>   | 0.39     | 0.53        | 0.67            | No statistical variation         |

Note: ‰ means *per 1,000* and it is **not** a percentage.

| 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         |

| Medicines management   | Y/N/Partial |
|--|-------------|
| 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           |
| 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           |
| For remote or online prescribing there were effective protocols for verifying patient identity.  | Y           |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.  | Y           |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.   | Y           |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.  | Y           |

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

| Significant events  | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources.     | Y           |
| Staff knew how to identify and report concerns, safety incidents and near misses.           | Y           |
| There was a system for recording and acting on significant events.                          | Y           |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y           |
| There was evidence of learning and dissemination of information.                            | Y           |
| Number of events recorded in last 12 months:  | 7           |
| Number of events that required action:  | 6           |

Examples of significant events recorded and actions by the practice.

| Event                                 | Specific action taken  |
|---------------------------------------|--|
| Delayed referral (cervical screening) | The referral was booked following an initial delay. The practice reviewed the case and amended its cervical screening recall system to include an additional monthly search so that referrals were monitored more closely.                                 |
| Medical emergency on the premises     | Staff identified a patient whose condition was deteriorating. The practice followed its emergency procedures and the patient was transferred to hospital. The practice reviewed the case. No changes to the practices' emergency procedures were required. |

| 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           |
| <p>Explanation of any answers and additional evidence:</p> <p>As part of this inspection, we carried out a series of standardised searches of the practice's clinical records system. We saw evidence that the clinicians took account of national patient safety alerts, for example, when prescribing. The practice had systems in place to identify and share relevant safety alerts with the team.</p> |             |

## Effective

## Rating: Requires improvement

At our previous inspection (November 2020), the practice was rated as requires improvement for providing effective care because consultation notes lacked detail, such as safety-netting advice and sufficient explanation. At this inspection, we found that the practice had improved its clinical record keeping and had addressed these gaps.

However, previously noted progress towards achieving the national targets for cervical screening and childhood immunisation had stalled during the pandemic. The practice remained below average for childhood immunisations and screening indicators and was below average on the published mental health indicator for care planning. The practice provided evidence to show how it was addressing these areas but could not yet demonstrate the impact.

### Effective needs assessment, care and treatment

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

|   | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice.  | Y           |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.  | Y           |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.  | Y           |
| We saw no evidence of discrimination when staff made care and treatment decisions.  | Y           |
| Patients' treatment was regularly reviewed and updated.   | Y           |
| There were appropriate referral pathways to make sure that patients' needs were addressed.  | Y           |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.  | Y           |
| Explanation of any answers and additional evidence:<br>The practice had increased the frequency of staff meetings and had introduced a weekly lunchtime learning session.<br>We saw evidence that the practice was now routinely recording more comprehensive consultation records which included safety-netting details. |             |



## 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.
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- 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.
- 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- Practice performance as measured by the Quality and Outcomes Framework had substantially improved across almost all clinical indicators in 2019/20 compared to the data in 2018/19.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training and competency checks.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.

| Long-term conditions  | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020)<br>(QOF)                                  | 70.1%    | 76.9%       | 76.6%           | No statistical variation |
| PCA* rate (number of PCAs).   | 9.4% (9) | 7.6%        | 12.3%           | N/A                      |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020)<br>(QOF) | 77.8%    | 90.1%       | 89.4%           | No statistical variation |
| PCA rate (number of PCAs).  | 3.6% (1) | 9.4%        | 12.7%           | N/A                      |

| Long-term conditions   | Practice  | CCG average | England average | England comparison       |
|--|-----------|-------------|-----------------|--------------------------|
| The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020)<br>(QOF)     | 73.9%     | 83.4%       | 82.0%           | No statistical variation |
| PCA rate (number of PCAs).   | 8.0% (2)  | 4.2%        | 5.2%            | N/A                      |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020)<br>(QOF)            | 57.6%     | 66.7%       | 66.9%           | No statistical variation |
| PCA rate (number of PCAs).   | 8.6% (8)  | 12.9%       | 15.3%           | N/A                      |
| The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020)<br>(QOF)               | 61.2%     | 73.7%       | 72.4%           | No statistical variation |
| PCA rate (number of PCAs).   | 8.7% (14) | 6.3%        | 7.1%            | N/A                      |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020)<br>(QOF) | 91.7%     | 90.5%       | 91.8%           | No statistical variation |
| PCA rate (number of PCAs).   | 7.7% (1)  | 5.6%        | 4.9%            | N/A                      |

|  |          |       |       |                                      |
|--|----------|-------|-------|--------------------------------------|
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <sup>(QOF)</sup> | 68.4%    | 76.4% | 75.9% | Tending towards variation (negative) |
| PCA rate (number of PCAs).   | 4.3% (4) | 8.7%  | 10.4% | N/A                                  |

## Families, children and young people

## Population group rating: Requires improvement

### Findings

- The practice had not met the minimum 90% for five of five childhood immunisation uptake indicators and had not achieved the 95% uptake required for herd immunity. The practice had been closed for several months in 2018/19 which impacted on recorded uptake rates in 2019/20. The available data has not been updated since our previous inspection so it is not yet possible to see the impact of recent efforts to improve immunisation rates.
- The practice had identified increased uptake of childhood immunisations as a high priority and had developed an action plan. This included ongoing work to encourage parents of children who had not been vaccinated to attend, for example through opportunistic discussion by the GPs and other clinical members of staff. The practice requested that newly registering parents provided evidence of immunisations already received by their children as part of the registration process. The practice was also systematically reviewing its patient list to remove patients who had moved away but not de-registered to improve the accuracy of performance monitoring.
- 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 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 guidance.
- Young people could access services for sexual health and contraception. Practice staff were able to advise patients about how to access local services for contraceptive services not provided on the premises, such as long acting reversible contraceptive implants.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation   | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 10        | 17          | 58.8%      | Below 80% uptake                |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)  | 17        | 29          | 58.6%      | Below 80% uptake                |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)  | 19        | 29          | 65.5%      | Below 80% uptake                |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)   | 20        | 29          | 69.0%      | Below 80% uptake                |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)  | 7         | 18          | 38.9%      | Below 80% uptake                |

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

## Working age people (including those recently retired and students)

## Population group rating: Requires improvement

### Findings

- Published data showed that the practice's cervical screening coverage was markedly below the national target of 80%. Fewer than half of eligible patients had a recorded smear carried out in line with recommended frequency guidelines in their records. The quarterly published snapshot data showed that uptake had stabilised during the later months of the Covid-19 pandemic, increasing from 38% (30 September 2020) to 40% (31 December 2020).
- The practice had identified increased uptake of screening as a high priority and had developed an action plan. This included offering cervical screening appointments outside of working hours at local network 'hub' practices and the recent appointment of a female regular locum GP to ensure there were enough cervical screening appointments available at the practice with a female clinician. The practice was optimistic about the potential of a new initiative to provide women who had not

attended screening with home test kits to detect the HPV virus. The practice was also systematically reviewing its patient list to ensure this was accurate and they were taking account of those patients who preferred to have screening tests carried out in other countries.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The NHS checks programme for patients aged 40 to 74 had been paused at the time of this inspection due to the Covid-19 pandemic. The practice anticipated restarting this programme when pandemic restrictions eased.
- The practice enabled patients to access the service through telephone, e-consult and face to face appointments as appropriate. Patients could order repeat medication without the need to attend the surgery.

| Cancer Indicators   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) <small>(Public Health England)</small> | 40.1%    | N/A         | 80% Target      | Below 70% uptake         |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>   | 44.9%    | 62.1%       | 70.1%           | N/A                      |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) <small>(PHE)</small>   | 39.3%    | N/A         | 63.8%           | N/A                      |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>  | 60.0%    | 93.5%       | 92.7%           | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>  | 50.0%    | 57.6%       | 54.2%           | No statistical variation |

#### Any additional evidence or comments

The practice had produced its own patient information leaflets about the national screening programmes to encourage people to attend when invited; explain the process in a way that was accessible and provide contact details if patients had any questions.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check. We were told that all of the practice's patients with a learning disability had already received an annual health check in 2020/21.
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.

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

**Population group rating: Requires improvement**

**Findings**

- Published performance data for 2019/20 showed that the practice was below average for the proportion of patients diagnosed with severe mental illness with an agreed updated care plan in their records. This is an area that requires improvement.
- 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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators  | Practice  | CCG average | England average | England comparison               |
|---|-----------|-------------|-----------------|----------------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 28.6%     | 85.3%       | 85.4%           | Significant Variation (negative) |
| PCA rate (number of PCAs).  | 30.0% (6) | 10.0%       | 16.6%           | N/A                              |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>  | 100.0%    | 82.6%       | 81.4%           | No statistical variation         |
| PCA rate (number of PCAs).  | 0.0% (0)  | 5.5%        | 8.0%            | N/A                              |

| Any additional evidence or comments   |
|---|
| The practice provided unverified evidence that the proportion of patients with diagnosed schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months had substantially increased since the Quality and Outcomes Framework 2019/20 results were published. The provider informed us that care plans were reviewed quarterly by one GP in the practice who takes the lead for mental health. We did not have any concerns about the quality of care plans that we reviewed during the inspection. |

### 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)         | 405.2    | Not Available | 533.9           |
| Overall QOF score (as a percentage of maximum) | 72.5%    | Not Available | 95.5%           |
| Overall QOF PCA reporting (all domains)        | 5.4%     | Not Available | 5.9%            |

|  | Y/N/Partial |
|--|-------------|
| Clinicians took part in national and local quality improvement initiatives.  | Y           |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Y           |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.                               | Y           |

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

The practice had run a multi-cycle clinical audit of its prescribing of Direct Oral Anticoagulants (DOACs) to ensure that it was following the guidelines issued in a national patient safety alert in October 2019. The safety alert highlighted the importance of calculating creatinine clearance in eligible patients as a check of renal function. The first round of the audit in March 2020 found that 13% of eligible patients' records included the creatinine clearance calculation. This had risen to 78% by October 2020 and 96% by March 2021. Our standardised searches of the clinical records system for this inspection included a check of DOAC management and confirmed that the practice was calculating creatinine clearance in line with the guidelines.

The practice had carried out regular audits of clinicians' consultation records against published professional standards since our previous inspection. Our standardised searches of the clinical records system for this inspection confirmed that the quality of record keeping had greatly improved.

## Effective staffing

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

|  | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment.   | Y           |
| The practice had a programme of learning and development.  | Y           |
| Staff had protected time for learning and development.   | Y           |
| There was an induction programme for new staff.  | Y           |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y           |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.         | Y           |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.  | Y           |

## Coordinating care and treatment

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

| Indicator   | Y/N/Partial |
|---|-------------|
| 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           |



## 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 and tackling obesity.  | Y           |

## 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           |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.   | Y           |
| Explanation of any answers and additional evidence:<br>We saw evidence that the GPs had continued to involve patients in decision making throughout the pandemic, for example, carrying out home visits (in line with guidelines on minimising the spread of infection) to discuss end of life care. |             |

## Well-led

**Rating: Good**

At our previous inspection (November 2020), the practice was rated as requires improvement for being well-led because it had failed to complete its action plan to address and improve the risks associated with poor quality clinical record-keeping. At this inspection, we found that the practice had greatly improved its clinical record keeping and had systems in place to maintain this improvement.

The practice had also markedly improved its clinical performance as assessed by the Quality and Outcomes Framework since it had reopened after a period of closure in 2018/19. The leaders were aware of remaining areas of significantly below-average performance, for example, around cancer screening and childhood immunisations and were implementing an action plan to improve.

### Leadership capacity and capability

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

|   | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability.   | Y           |
| They had identified the actions necessary to address these challenges.  | Y           |
| Staff reported that leaders were visible and approachable.  | Y           |
| There was a leadership development programme, including a succession plan.  | Y           |
| Explanation of any answers and additional evidence:<br>Staff were very positive about the quality of leadership demonstrated by the practice partners and management team. The practice partners had considered succession planning and were intending to recruit an additional partner to the practice as it expanded. |             |

### Vision and strategy

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

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

The practice managers were aware of areas of comparative strength and weakness in performance and potential risks for the future. For example, the practice's patient list had increased by around 20% over the previous 12 months. The practice was monitoring the impact on access to the service. Previously, patients had been typically able to access appointments the same or next day for routine matters. Patients were now able to book routine appointments within a week. The practice was considering expanding appointment capacity if demand continued to rise.

## Culture

### The practice had a culture which drove high quality sustainable care.

|   | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values.   | Y           |
| Staff reported that they felt able to raise concerns without fear of retribution.   | Y           |
| There was a strong emphasis on the safety and well-being of staff.  | Y           |
| There were systems to ensure compliance with the requirements of the duty of candour.   | Y           |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action.   | Y           |
| The practice encouraged candour, openness and honesty.  | Y           |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.   | Y           |
| The practice had access to a Freedom to Speak Up Guardian.  | Y           |
| Staff had undertaken equality and diversity training.   | Y           |
| Explanation of any answers and additional evidence:<br>All the staff we spoke with said the practice had a positive culture and was a good place to work. Staff who had recently worked in other practices compared Fulham Cross Medical Centre favourably. |             |

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

| Source           | Feedback  |
|------------------|---|
| Staff interviews | Some staff highlighted the pressures and stresses of providing care during the Covid-19 pandemic. They were positive about the support provided by the practice which they said had maintained clear channels of communication throughout this period. The practice was putting together a display of additional resources around mental wellbeing for staff at the time of the inspection. |
| Staff interviews | Staff were very positive about the encouragement they received in relation to training and development was discussed through induction and appraisal.   |
| Staff interviews | Staff consistently told us that the practice team had worked hard to improve since our previous inspections. The practice had introduced more regular meetings and staff felt that communication was now very good. Staff members said they would feel able to suggest improvements or report concerns.   |

## Governance arrangements

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

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

## Managing risks, issues and performance

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

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

**The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

|   | Y/N/Partial |
|---|-------------|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.                     | Y           |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Y           |
| There were systems in place to identify and manage patients who needed a face-to-face appointment.                          | Y           |
| The practice actively monitored the quality of access and made improvements in response to findings.                        | Y           |

|  |   |
|--|---|
| There were recovery plans in place to manage backlogs of activity and delays to treatment.   | Y |
| Changes had been made to infection control arrangements to protect staff and patients using the service.   | Y |
| Staff were supported to work remotely where applicable.  | Y |
| Explanation of any answers and additional evidence:<br>The practice was confident it balanced the need to minimise the spread of infection while providing an accessible service. For example, the practice enabled patients to safely access the service face-to-face and remotely, including the appointment booking system. The practice had set up a staff WhatsApp group to facilitate remote communication for non-confidential matters. |   |

### 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 monitor and improve performance.  | Y           |
| Performance information was used to hold staff and management to account.                          | Y           |
| There were effective arrangements for identifying, managing and mitigating risks.                  | Y           |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y           |

### Governance and oversight of remote services

|   | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y           |
| The provider was registered as a data controller with the Information Commissioner's Office.                                      | Y           |
| Patient records were held in line with guidance and requirements.   | Y           |
| Patients were informed and consent obtained if interactions were recorded.  | Y           |
| The practice ensured patients were informed how their records were stored and managed.  | Y           |
| Patients were made aware of the information sharing protocol before online services were delivered.                               | Y           |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.              | Y           |
| Online consultations took place in appropriate environments to ensure confidentiality.  | Y           |
| The practice advised patients on how to protect their online information.   | Y           |

## 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 were systems and processes for learning, continuous improvement and innovation.**

|  | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement.   | Y           |
| Learning was shared effectively and used to make improvements.   | Y           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had responded to the previous inspection report by commissioning an external professional advisor to audit clinical record-keeping. The clinical team had implemented their recommendations with ongoing audit and individual-level feedback. We did not identify any concerns with the records we reviewed.</li><li>• The practice had sustained improvements made following previous inspections, for example in relation to the identification and implementation of national patient safety alerts.</li><li>• The practice had identified the telephone system as an area for potential future investment to improve patient experience following staff and patient feedback.</li></ul> |             |

## Examples of continuous learning and improvement

The practice was aware of areas where its performance was below average, notably its cancer screening and childhood immunisation uptake rates. The partners told us this was a high priority for improvement. The practice had developed an action plan which it was implementing and reviewing regularly.

## 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 practice's 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)     | $\leq -3$              |
| Variation (positive)                 | $> -3$ and $\leq -2$   |
| Tending towards variation (positive) | $> -2$ and $\leq -1.5$ |
| No statistical variation             | $< 1.5$ and $> -1.5$   |
| Tending towards variation (negative) | $\geq 1.5$ and $< 2$   |
| Variation (negative)                 | $\geq 2$ and $< 3$     |
| Significant variation (negative)     | $\geq 3$               |

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- $\%$  = per thousand.