

Care Quality Commission

Inspection Evidence Table

Lilyville @ Parsons Green (1-6226776993)

Inspection date: 11 August 2021, 17-18 August 2021

Date of data download: 04 August 2021

Overall rating: Good

At this inspection, we rated the practice as Good because it had addressed the risks identified at the previous inspection. The practice now had systems in place to ensure that urgent referrals, test results and screening results were being actively monitored. The practice had also introduced innovative ways of working during the Covid-19 pandemic, for example playing a leading role in developing a borough-wide integrated domiciliary service for patients with complex needs.

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

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: The practice had clear systems and processes in place to safeguard patients from abuse and follow-up those at risk. The practice used electronic alerts and icons on the records system to flag patients at risk although full access to these was not always enabled on staff members' smartcards. The practice told us it would review and update system access rights, so all alerts and icons were fully visible to all relevant staff members.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: At our previous inspection, we were not assured that the practice kept the required information in relation to newly recruited staff. At this inspection, the practice demonstrated that the necessary checks had been undertaken; staff were vaccinated in line with guidance and all required information was clearly and securely recorded.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 01/10/2020	Y
There was a record of equipment calibration. Date of last calibration: 01/10/2020	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. Date of completion: 09/2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The practice had carried out a further audit of fire safety and review of the action plan in May 2021. The practice had completed all required actions for example, improving fire safety signage; implementing a personal electrical equipment policy and arranging for ongoing testing of the emergency lighting system.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Various assessments and checks (for example, legionella; security gate; air conditioning; asbestos; automatic doors and lifts). All assessments carried out between January and April 2021.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 13/01/2021	Y
Explanation of any answers and additional evidence: Risk assessments had been updated during the Covid-19 pandemic in line with local and national guidelines. The practice had carried out individual risk assessments in relation to Covid-19 with all members of staff and taken steps to reduce risk and support individuals to work safely.	

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: 20/07/2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice had carried out a detailed infection control audit and review of relevant protocols in preparation for providing a Covid-19 vaccination hub service over the summer.	

Risks to patients

There were 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

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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) <small>(NHS Business Service Authority - NHSBSA)</small>	0.48	0.51	0.70	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) <small>(NHSBSA)</small>	12.0%	11.2%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) <small>(NHSBSA)</small>	5.39	5.55	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) <small>(NHSBSA)</small>	49.5‰	59.2‰	126.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) <small>(NHSBSA)</small>	0.44	0.52	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	3.0‰	4.8‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we noted that the practice was prescribing above average levels of certain types of antibacterial medicines, namely co-amoxiclav, cephalosporins and quinolones. At this inspection, the latest published data showed that this prescribing was now in line with local and national norms.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	13
Explanation of any answers and additional evidence: The practice provided evidence showing that they were open with patients when mistakes occurred in line with the duty of candour.	

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

Event	Specific action taken
Patient not flagged as priority for telephone call back despite presenting with concerning symptoms and contacted 111.	Practice recognised the risk and reception team were instructed not to use the template that had failed to identify the issue. The patient was called back later the same day by a practice GP and managed appropriately.
Abnormal test results were not reassigned to an available GP due to a lack of clarity over how these should be managed over a bank holiday.	The practice amended its protocol so that test results would be reassigned to another GP when the responsible GP was absent for three or more working days.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

Effective

Rating: Good

At this inspection, we rated the practice as Good for providing effective care because it had addressed the risks identified at the previous inspection. The practice now had systems in place to ensure that urgent referrals, test results and screening results were actively monitored. Published performance indicators, for example around antibiotic prescribing were now in line with local and national norms. The practice had also improved the uptake of childhood immunisations since the previous inspection and investigated the reasons underpinning its cervical screening performance.

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

Older people

Population group rating: Outstanding

Findings

- The practice had been actively involved in setting up an "integrated domiciliary service" for Hammersmith and Fulham during the Covid-19 pandemic with one of the partners taking a leadership role. Professionals were able to refer patients experiencing frailty and complex needs to the service for review at a daily virtual multidisciplinary team meeting with GP, community health teams, consultant specialists and social services input. The service had undergone a first stage evaluation which showed that the service was effective in identifying and risk-assessing clinical cases and providing a timely and appropriate clinical response. Initial feedback from patients for example about the use of virtual consultations had been positive. The evaluation found that the service had also helped improve communication between different parts of the health and social services sectors with the service being known and used by various partner agencies, primary care networks and professionals. Further research and evaluation was planned to include analysis of patient outcomes, costs and benefits.

- The practice provided care to a number of patients who lived in a local nursing home. The managers of the care home provided very positive feedback about the practice and described their approach as 'outstanding'. One of the GPs carried out a weekly visit and this had continued throughout the Covid-19 pandemic. We were told that the practice went out of the way to involve patients and their families in decisions about care.
- 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 medicines 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. 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, 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.
- Patients with asthma were offered an asthma management plan.

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) <small>(QOF)</small>	82.0%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	19.4% (76)	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) <small>(QOF)</small>	90.6%	90.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	4.0% (4)	9.4%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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) <small>(QOF)</small>	86.5%	83.4%	82.0%	No statistical variation
PCA* rate (number of PCAs).	2.3% (3)	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) <small>(QOF)</small>	73.7%	66.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	8.7% (17)	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) <small>(QOF)</small>	76.6%	73.8%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.7% (29)	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) <small>(QOF)</small>	93.8%	90.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.3% (3)	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) <small>(QOF)</small>	78.3%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	8.2% (16)	8.6%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Families, children and young people

Population group rating: Good

Findings

- One of the GPs at the practice had identified children with complex needs as a group who would benefit from a more coordinated multidisciplinary approach in primary care. As a result, the practice had set up a monthly paediatric 'hub' meeting. This involved a paediatric consultant and the GP running a community clinic to review the cases of suitable children, followed by a wider educational meeting and discussion. The project was considered so useful it was now being rolled out across the primary care network with positive engagement from other practices.
- The practice has met the minimum 90% for four of five childhood immunisation uptake indicators. The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of five childhood immunisation uptake indicators. This was an improvement since our previous inspection in 2019. At that time the practice had not achieved the 95% target for any of the uptake indicators and was below the minimum 90% for the two-year-old cohort (three indicators).
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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 best practice guidance.
- Young people could access services for sexual health and contraception.
- 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)	118	125	94.4%	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) (01/04/2019 to 31/03/2020) (NHS England)	99	106	93.4%	Met 90% minimum
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)	98	106	92.5%	Met 90% minimum
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)	102	106	96.2%	Met 95% WHO based target
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)	94	112	83.9%	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>

Findings

- Practice performance for cervical screening coverage had not improved since the previous inspection and remained at around 57%, that is, well below the national target of 80%.
- In 2020, the practice carried out a survey of over 200 eligible patients who had not attended for cervical screening in order to understand the reasons and tackle any barriers. They found that around a quarter of patients who responded had been screened privately during the relevant time period. Privately taken samples can no longer be recorded within the NHS programme. The practice had decided not to call these patients for repeat screening under the NHS because they felt this was likely to be of little to no benefit to the patients themselves.
- The survey also showed that some patients reported difficulty obtaining a convenient appointment for cervical screening and some had misgivings about the screening process. In response, the practice had taken steps to increase its screening capacity by recruiting and training up an additional part-time practice nurse. The health care assistant was enrolling on training to become a nursing associate (which would allow them in due course to be able to carry out screening). Some of the GPs were also taking refresher training to enable them to take cervical screening if they were seeing an eligible patient in their surgery. The practice had put a notice on its website with links to helpful resources for patients who were worried about the test and planned to use a voluntary organisation to train reception staff on how to effectively engage patients about cervical screening when pandemic restrictions allowed.
- The practice was also engaging with partners to look at pooling resources to encourage cervical screening attendance as uptake rates tended to be below target across the borough. At the time of the inspection, ideas being pursued included setting up a centralised follow-up service to engage patients who had not attended for their smear and also using a proportion of nursing appointments at the extended hours primary care hub in the evening and weekends for cervical screening. Talks had included some consideration of ways to address local cultural issues.

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: 31/03/2021) <small>(Public Health England)</small>	56.8%	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>	66.4%	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>	58.1%	51.4%	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>	100.0%	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>	57.1%	57.6%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

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

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- 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.
- All staff had received dementia training in the last 12 months.
- 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>	90.1%	85.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	6.6% (5)	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>	87.1%	82.6%	81.4%	No statistical variation
PCA rate (number of PCAs).	8.8% (6)	5.5%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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	England average
Overall QOF score (out of maximum 559)	551.9	533.9
Overall QOF score (as a percentage of maximum)	98.7%	95.5%
Overall QOF PCA reporting (all domains)	7.9%	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 a comprehensive clinical audit programme which included various multi-cycle audits to monitor performance and outcomes. For example, the practice had audited the quality of end of life care for the last three years after identifying some shortfalls against expected standards. The most recent audit cycle (2020/21) showed improvement in the proportion of patients who had died (expected) with a personalised care plan in place; the proportion of end of life care plans on the Coordinate My Care system (83%) and the proportion of cases where the records showed that families and carers were offered support both before and after the death by the GPs or district nurses (89%).
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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

Explanation of any answers and additional evidence:

At the previous inspection, we noted that the practice had identified 0.66% of patients as carers. This had increased to 0.8% at this inspection. The practice had reviewed its processes for identifying carers and included prompts about this on prescription forms; on patient registration forms and with information in the reception area and on the website. Staff who identified patients as carers (for example during a consultation, care planning or when they collected a prescription for another person) could provide information (including easy read resources) and refer the person to local services for further advice and support.

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

Well-led

Rating: Good

At this inspection, we rated the practice as Good for providing well-led care because it had addressed the risks identified at the previous inspection. The practice now had an improved system for reviewing and updating policies. Learning from incidents and complaints was now clearly recorded and embedded in the practice meeting schedule.

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: <ul style="list-style-type: none">• Staff reported that they were well-led and had confidence in the partners.• Staff told us there was a focus on collaboration with partners to overcome challenges, for example, the establishment of the integrated domiciliary service and daily multidisciplinary team meeting to meet the needs of frail older people. This had been triggered by concerns for this group of patients with the onset of the Covid-19 pandemic.	

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

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> One of the partners had introduced a staff wellbeing project during the Covid-19 pandemic in recognition of the high demands faced by the team and the increased risk of stress and 'burnout'. The project included a number of different initiatives over one "mood boost" month designed to improve the team's morale including mindfulness exercises, an anonymised positive feedback initiative and lunchtime walking group and virtual walking challenge. The project had been evaluated with a staff survey. 	

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

Source	Feedback
Staff interviews	<p>All the staff we spoke with described the practice positively. They told us the practice leaders were supportive; valued the team and responded constructively when issues were identified. For example, the practice had recently recruited more GPs in the face of increasing demand.</p> <p>Staff members said they were proud to work for the practice which they described as forward thinking and caring.</p>

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had invested in an electronic document management system which supported their governance systems, for example the practice procedures for policy review and version control were improved and there was clearer oversight of training completion and recruitment checks including staff immunisation status.• The practice had a clear structure of staff, clinical and management team meetings. These were well documented with any actions and learning.	

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
Explanation of any answers and additional evidence: The practice had acted to address the risks identified at the previous inspection for example in relation to monitoring urgent referrals, cervical screening results and managing test results in a timely way.	

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
<ul style="list-style-type: none"> • The practice was experiencing high levels of demand at the time of the inspection. It had responded by carrying out periodic access audits in 2020 and 2021 and enabling patients to access the service in a range of ways, for example through online booking; telephone triage and the NHS e-consult service. The practice doors were open and patients who were unable to use alternative methods could attend the practice in person to book an appointment. • Recent feedback from the PPG suggested that some patients were under the incorrect impression that the practice was closed. In response, the practice had updated its messaging, for example on its website to clearly state that the practice was open and advising patients how they could access the service. • The practice had continued to carry out home visits when appropriate throughout the pandemic with appropriate PPE and made weekly visits to patients living in a local care home. • However, telephone access at busy times of the day remained problematic with patients reporting very long waits to get through to reception. The practice was in the process of recruiting additional reception staff to answer the telephone and reviewing the scope to increase the number of active telephone lines. • The practice had successfully hosted the local Covid-19 vaccination hub during the spring and early summer of 2021. 	

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
Explanation of any answers and additional evidence:	
We received positive feedback from managers in partner agencies about the collaborative leadership displayed by the practice and the positive impact for patients who needed coordinated care.	

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:	
At our previous inspection we noted that information and learning from complaints was not always well documented. The practice now clearly documented how it used written and verbal complaints, online comments and positive comments to learn from and improve its systems and processes and identify training gaps. For example, the practice had recently reviewed the way the reception team managed test and sample kits to protect patient confidentiality at the reception desk following a verbal complaint.	

Examples of continuous learning and improvement

<p>The practice provided numerous examples of continuous learning and improvement.</p> <ul style="list-style-type: none"> • It had a comprehensive audit programme covering clinical and non-clinical topics. Audits were typically carried out for multiple cycles to ensure observed improvements were sustained. • The practice participated in medical research projects that were of potential benefit to the patient population. • Practice GPs were active in the local primary care network and GP federation. The practice had played an instrumental role in some successful initiatives that were being rolled out across the borough, for example the integrated domiciliary service.
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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)	≤ -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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.