

Care Quality Commission

Inspection Evidence Table

Brompton Medical Centre (1-4719674064)

Inspection date: 21 June 2022

Date of data download: 21 April 2022

Overall rating: **Good**

We rated the practice as Good overall because:

- The provider had made improvements to the practice's systems, practices and processes so that people were kept safe and safeguarded from abuse.
- The arrangements for managing medicines had been improved so that patients were kept safe.
- Improvements had been made so that patients' needs were assessed, and care as well as treatment were delivered in line with current legislation, standards and evidence-based guidance.
- Improvements had been made to the care and treatment (including reviews) of patients with long-term conditions, such as asthma, chronic obstructive pulmonary disease (COPD), hypertension, atrial fibrillation, and patients experiencing poor mental health (including dementia).
- The provider was aware of published performance data relating to childhood immunisations as well as some cancer screening and was continuing to take action to improve uptake by relevant patients.
- Improvements had been made to processes for managing risks, issues and performance.
- Clinical and internal audit were now being used to monitor quality as well as to make improvements.
- The practice now had an active Patient Participation Group (PPG).

Safe

Rating: Good

We rated the practice as Good for providing safe services because:

- The provider had made improvements to the practice's systems, practices and processes so that people were kept safe and safeguarded from abuse.
- The arrangements for managing medicines had been improved so that patients were kept safe.

Safe systems and processes

The provider had made improvements to the practice's systems, practices and processes so that people were kept safe and safeguarded from abuse.

Safeguarding	
There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Yes
GPs and staff were trained to appropriate levels for their role and knew how to identify and report concerns.	Yes
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely manner.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
Notices in the practice advised patients that chaperones were available if required.	Yes

Additional evidence or comments
<p>During our inspection in April 2019 we found that the practice's computer system alerted staff of children that were on the risk register. However, it did not alert staff of all family and other household members of children that were on the risk register.</p> <p>At our inspection in June 2021 we found that the practice's computer system alerted staff of children that were on the risk register as well as adults on the vulnerable adult register. However, it did not alert staff of all family and other household members of children that were on the risk register or vulnerable adults on the vulnerable adult register.</p> <p>At this inspection we found that improvements had been made and the practice's computer system alerted staff of all family and other household members of children that were on the risk register and vulnerable adults on the vulnerable adults' register.</p>

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

Safety systems and records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Yes
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	Yes
Records showed that the fire alarm system was tested regularly.	Yes
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

We observed the premises to be clean and all areas accessible to patients were tidy.	Yes
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes
There was an up to date infection prevention and control policy.	Yes
There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified.	Yes
Relevant staff were up to date with infection prevention and control training.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Additional evidence or comments	
Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.	

Risks to patients, staff and visitors

Risks to patients, staff and visitors were assessed, monitored or managed.

The provider had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Yes
Staff knew how to respond to emergency situations.	Yes
All staff were up to date with basic life support training.	Yes
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Yes
Records showed that emergency equipment and emergency medicines were checked regularly.	Yes
Emergency equipment and emergency medicines that we checked were within their expiry dates.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
There was written guidance for staff to follow to help them identify and manage deteriorating or acutely unwell patients.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Yes
There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives.	Yes
There was an up to date legionella risk assessment and an action plan to address issues identified.	Yes

Information to deliver safe care and treatment

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

Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results, and this was managed in a timely manner.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Appropriate and safe use of medicines

The arrangements for managing medicines had been improved so that patients were kept safe.

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.77	0.79	0.76	No statistical variation
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). (01/01/2021 to 31/12/2021) (NHSBSA)	11.6%	9.8%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	5.71	5.75	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	103.6‰	133.4‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.67	0.63	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	6.4‰	6.8‰	6.8‰	No statistical variation

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

Medicines management	
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescription forms and pads were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
Up to date local prescribing guidelines were in use.	Yes

Additional evidence or comments	
<p>At the time of this inspection, NHSBSA published results showed that the practice was performing in line with local and England averages for all six of the indicators for the prescribing of antibiotics and hypnotics.</p> <p>At our inspection in June 2021 none of the Patient Group Directions (PGDs) we looked at had been completed correctly. After our inspection the provider wrote to us with evidence to show that they had revised the PGDs used at Brompton Medical Centre and that all PGDs had now been completed correctly.</p> <p>At this inspection all of the PGDs we looked at had been completed correctly.</p> <p>At our inspection in June 2021 we found that prescribing did not always follow best practice guidance for the management of some high-risk medicines. For example, warfarin and lithium.</p> <p>At this inspection we looked at the records of five patients who were prescribed warfarin and three patients who were prescribed lithium. We found that the provider had made improvements so that prescribing now followed best practice guidance for the management of these high-risk medicines.</p>	

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	Yes
There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses both internally and externally.	Yes
Number of events recorded in last 12 months:	4
Records showed that the practice had carried out a thorough analysis of reported significant events.	Yes
There was evidence of learning and dissemination of information from significant events.	Yes

Additional evidence or comments

We looked at the records of one significant event that had been recorded in the last 12 months. Details of the event, which involved a patient that had been assaulted, had been reported by staff completing the relevant form. The event was investigated, and necessary action taken. Learning from the event was shared with relevant staff.

Safety alerts	Y/N/Partial
The practice had systems for managing safety alerts.	Yes
Information from safety alerts was shared with staff.	Yes
Staff understood how to deal with safety alerts.	Yes
The practice acted on and learned from safety alerts.	Yes
The practice kept records of action taken (or if no action was necessary) in response to receipt of all safety alerts.	Yes

Effective

Rating: Good

We rated the practice as Good for providing effective services because:

- Improvements had been made so that patients' needs were assessed, and care as well as treatment were delivered in line with current legislation, standards and evidence-based guidance.
- Improvements had been made to the care and treatment (including reviews) of patients with long-term conditions, such as asthma, chronic obstructive pulmonary disease (COPD), hypertension, atrial fibrillation, and patients experiencing poor mental health (including dementia).
- The provider was aware of published performance data relating to childhood immunisations as well as some cancer screening and was continuing to take action to improve uptake by relevant patients.

Effective needs assessment, care and treatment

Improvements had been made so that patients' needs were assessed, and care as well as treatment were delivered in line with current legislation, standards and evidence-based guidance.

The practice had systems and processes to help keep clinicians up to date with current evidence-based practice.	Yes
Staff had access to guidance from NICE and used this information to deliver care and treatment that met patients' needs.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Additional evidence or comments	
Improvements had been made to the care and treatment (including reviews) of patients with long-term conditions, such as asthma, chronic obstructive pulmonary disease (COPD), hypertension, atrial fibrillation, and patients experiencing poor mental health (including dementia).	

Monitoring care and treatment

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

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

Effective care for the practice population

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. Health checks, including frailty assessments, were offered to patients over 75 years of age. Influenza, shingles and pneumonia vaccinations were offered to relevant patients in this age group. The practice had systems to inform eligible patients to have the meningitis vaccine. For example, before attending university for the first time. Chlamydia screening was available for relevant patients. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long-term conditions

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.

At our inspection in June 2021 we looked at the records of 45 patients who were diagnosed with long-term condition such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, atrial fibrillation (AF), mental health conditions and dementia. Records showed that improvements were required to the care and treatment (including reviews) of some patients with asthma, COPD, hypertension, AF, and mental health conditions (including dementia).

At this inspection we looked at the records of 28 patients who were diagnosed with long-term conditions such as asthma, COPD, hypertension, AF and mental health conditions (including dementia). The provider had made improvements so that the majority of these patients were now receiving care and treatment (including reviews) that was in line with best practice guidance. Records of two patients that were diagnosed with mental health conditions showed that up to date blood tests were required as well as some other checks. For example, a record of their BMI and blood pressure. Records of one patient who was diagnosed with dementia showed that they were overdue a review.

After our inspection the provider told us that two of these patients had been contacted and booked in to see a GP on 24 June 2022 to help ensure their care and treatment was up to date and following best practice guidance. The provider also told us that they had not been able to contact the third patient by telephone so had sent a letter and text message asking them to contact the practice so that a relevant appointment could be booked for them.

Records showed that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

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.

We completed a series of searches on the practice's clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches showed that the practice identified patients with commonly undiagnosed conditions. For example, diabetes and chronic kidney disease (CKD).

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) (01/04/2020 to 31/03/2021) (NHS England)	41	46	89.1%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England)	48	56	85.7%	Below 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) (01/04/2020 to 31/03/2021) (NHS England)	47	56	83.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	48	56	85.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)	34	38	89.5%	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>

Additional evidence or comments
<p>Childhood immunisations were carried out in line with the national childhood vaccination programme.</p> <p>At our inspection in April 2019 NHS England published results showed uptake rates were lower than the target percentage of 90% or above in three out of the four indicators.</p> <p>At our inspection in June 2021 we saw that the number of children of an age where immunisations were indicated had increased by approximately one third. However, NHS England results published in March 2020 showed that uptake rates were lower than the target percentage of 90% or above in all five of the indicators.</p> <p>At the time of this inspection NHS England results (published in March 2021) showed that uptake rates for three of the five indicators had improved. However, uptake rates remained below the target of 90% or above in all five indicators. The provider was aware of this performance and staff told us that the deficit was mainly due to a few parents declining to have their children immunised. All parents of children who were due or overdue immunisation had been contacted to encourage uptake, but some</p>

parents still declined to have their children immunised. Despite this, staff told us that children who failed to attend for immunisations were continually offered further appointments during which to receive them.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/09/2021) (Public Health England)	65.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	50.7%	63.3%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	56.1%	68.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	66.7%	56.3%	55.4%	No statistical variation

Additional evidence or comments

At our inspection in June 2021 published results showed that the practice's uptake for cervical screening as at December 2020 was below the 80% coverage target for the national screening programme.

At the time of this inspection published results showed that the practice's uptake for cervical screening as at September 2021 had improved but remained below the 80% coverage target for the national screening programme. However, unverified data showed that this had improved to:

- 73% for eligible patients aged 25 to 49 years.
- 81% for eligible patients aged 50 to 64 years.

The provider was aware of these results and staff told us that patients who failed to attend their cervical screening appointment were automatically booked in for another to encourage attendance. Staff also told us that results for the age group 25 to 49 years were detrimentally affected by some patients only staying registered with the practice for a short period of time (transient due to being army personnel).

Published results showed that performance for breast cancer screening and bowel cancer screening was below local and England averages. The provider was aware of these results and staff told us that searches of the practice's computer system were carried out to help identify patients who failed to attend for breast cancer screening. These patients were contacted by the practice and advised as well as encouraged how to re-book for this type of screening. Practice staff also contacted patients who failed to attend for bowel cancer screening and encouraged them to re-book for this type of screening.

At our inspection in April 2019 we found that the number of new cancer cases treated which resulted from a two week wait referral was significantly lower than local and national averages.

At our inspection in June 2021 published results showed that performance related to the number of new cases treated that resulted from a two week wait referral remained significantly lower than local and national averages.

At the time of this inspection published results demonstrated improvement and that performance related to the number of new cancer cases treated that resulted from a two week wait referral was now better than local and England averages.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

There was an induction programme for new staff.	Yes
The learning and development needs of all staff were assessed.	Yes
All staff were up to date with essential training.	Yes
All staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation.	Yes
Clinical staff were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice.	Yes
There was a clear approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

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

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes

Helping patients to live healthier lives

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

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health. For example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

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

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Well-led

Rating: Good

We rated the practice as Good for providing well-led services because:

- Improvements had been made to processes for managing risks, issues and performance.
- Clinical and internal audit were now being used to monitor quality as well as to make improvements.
- The practice now had an active Patient Participation Group (PPG).

Leadership, capacity and capability

There was compassionate and inclusive leadership at all levels.

Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
Leaders had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
Additional evidence or comments	
Clinical leadership (including clinical supervision) at Brompton Medical Centre was provided by one of the GP partners, although all staff were able to contact any of the GP partners at any time if required.	
Overall leadership was provided by Sydenham House Medical Group centrally by staff. This included seven GP partners, a managing partner, a service improvement manager, a clinical governance manager, a service delivery manager, a nurse manager and two trainee managers.	
Staff told us that the GP partners and practice management were approachable and always took time to listen to all members of staff.	

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes

Additional evidence or comments

The provider had a statement of purpose which reflected the visions of the practice.

Culture

The practice had a culture of high-quality sustainable care.

Staff told us there was an open culture within the practice and they felt confident and supported to raise any issues.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes

Additional evidence or comments

Staff told us they felt respected, valued and supported locally by the practice and by their colleagues. They also told us that felt supported by the Sydenham House Medical Group management team.

Governance arrangements

There were processes and systems to support good governance and management.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Yes
The provider had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date.	Yes

Additional evidence or comments

We looked at 21 governance documents and found that they were up to date and contained a future review date.

Managing risks, issues and performance

Improvements had been made to processes for managing risks, issues and performance.

There were effective arrangements for identifying, recording, managing and mitigating risks.	Yes
There were processes to manage performance.	Yes
Clinical and internal audit was used to monitor quality and to make improvements.	Yes

Records showed that the provider had analysed all clinical audit results and implemented action plans to address findings.	Yes
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	Yes
There was written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes

Additional evidence or comments

At our inspection in June 2021 the provider was unable to demonstrate their processes and systems were effective in the management of risks from:

- The practice's computer system not alerting staff of all family and other household members of children that were on the risk register and adults on the vulnerable adult register.
- Management of appropriate authorisations to allow staff to administer medicines.
- Management of the prescribing of some high-risk medicines.

At this inspection we found that sufficient improvements had been made so that patients were now being kept safe and safeguarded from abuse.

At our inspection in June 2021 we found that some processes to manage current and future performance were not sufficiently effective. We also found that improvements to care and treatment were required for some types of patient reviews and well as subsequent follow-up activities. For example, asthma reviews, hypertension reviews, atrial fibrillation reviews, and mental health reviews (including dementia).

At this inspection we found that actions had been taken by the provider and were ongoing to help improve performance related to child immunisation and some cancer screening uptake rates. Action had also been implemented by the provider resulting in improvement to care as well as treatment (including reviews) for patients with long-term conditions. However, further improvements were required for some patient with mental health conditions (including dementia).

At our inspection in June 2021 staff told us that no clinical audits had been carried out during the last 12 months due to the additional pressures caused by the pandemic and varying staffing levels during the pandemic.

At this inspection records showed that the provider had carried out multiple clinical audits across all locations where they delivered regulated activities. Results of these audits had been analysed and, where necessary, action plans had been developed to address issues identified. Some audits had been repeated, demonstrating improvements, and other were scheduled to be repeated to complete the cycle of clinical audit. Results from all audits were shared across all locations where the provider delivered regulated activities.

The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes

The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems to help identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans to help manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operation information was used to help monitor and improve performance.	Yes
The provider submitted data or notifications to external organisations as required.	Yes
There were arrangements in line with data security standards for the integrity and confidentiality of patient identifiable data, records and data management systems.	Yes

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to help ensure they delivered high-quality and sustainable care.

Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
The practice gathered feedback from patients through the PPG.	Yes
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Additional evidence or comments

At our inspection in June 2021 we found that the practice did not have an active Patient Participation Group (PPG) but was in the process of recruiting patients to one.

At this inspection the practice had an active PPG and records showed that they last met on 18 May 2022.

The practice monitored feedback received from the national GP patient survey. Results published in July 2021 showed that patient satisfaction across all areas was in line with local and national averages.

Staff told us they felt respected, valued and supported locally by the practice and by their colleagues. They also told us that felt supported by the management team.

Reviews left on the NHS Choices website

Total reviews	1
Number of reviews that were positive about the service	1
Number of reviews that were mixed about the service	0
Number of reviews that were negative about the service	0

Experience shared with CQC directly via our website

Total received	1
Number received which were positive about the service	0
Number received which were mixed about the service	0
Number which were negative about the service	1

Examples of feedback received	Source
Feedback about the practice was minimal and predominantly positive and there were no common themes in the negative comments we saw.	Reviews left on the NHS Choices website and experience shared with CQC directly via our website over the last 12 months.

Continuous improvement and innovation

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

The practice made use of reviews of incidents.	Yes
Learning was shared effectively and used to make improvements.	Yes
Additional evidence or comments	
Significant events and complaints were used to make improvements and any learning shared with relevant staff. For example, relevant staff were made aware of learning from a complaint where a patient had been prescribed the wrong medicine which was only discovered when the patient went to a local pharmacy to collect it.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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