

# Care Quality Commission

## Inspection Evidence Table

### Sydenham House Medical Centre (1-590230296)

Inspection date: 10 January 2023

Date of data download: 13 December 2022

**Overall rating: Good**

# Safe

## Rating: Good

### Safety systems and processes

**The practice's systems, practices and processes helped keep people safe and safeguarded from abuse.**

| <b>Safeguarding</b>   |     |
|---|-----|
| 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 |
| <b>Additional evidence or comments</b>  |     |
| The practice's computer system alerted staff of children that were on the risk register. We looked at the records of five such children and found that the practice's computer system also alerted staff to all family and other household members of these children. |     |

| <b>Recruitment systems</b>  |     |
|---|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).                             | Yes |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) 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 |

| <b>Safety systems and records</b>  |     |
|--|-----|
| 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

**There were systems and processes to help maintain appropriate standards of cleanliness and hygiene.**

|  |     |
|--|-----|
|  |     |
| 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 |

## Risks to patients, staff and visitors

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

|  |     |
|--|-----|
|  |     |
| 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 practice had systems for the appropriate and safe use of medicines, including medicines optimisation. The provider was responsive to our findings relating to the prescribing of some high-risk medicines.**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

| Indicator  | Practice | SICBL average | England average | England comparison                   |
|--|----------|---------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)   | 1.04     | 0.85          | 0.82            | 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). (01/10/2021 to 30/09/2022) (NHSBSA)                                       | 7.5%     | 8.6%          | 8.5%            | No statistical variation             |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) (NHSBSA) | 6.49     | 5.75          | 5.28            | Tending towards variation (negative) |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)  | 129.3‰   | 132.5‰        | 128.0‰          | No statistical variation             |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)   | 0.41     | 0.60          | 0.58            | No statistical variation             |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)   | 6.0‰     | 6.8‰          | 6.7‰            | 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     |
| There was a process for monitoring patients' health in relation to the use of medicines including high-risk medicines with appropriate monitoring and clinical review prior to prescribing. | Partial |
| 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 |
| 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.   | Yes |
| <b>Additional evidence or comments</b>  |     |
| At the time of our inspection NHSBSA published results showed that the practice was performing in line with local and England averages when prescribing most antibiotics and some hypnotics.  |     |
| During our inspection we looked at the records of: <ul style="list-style-type: none"> <li>• Five patients who were prescribed warfarin and found four had been prescribed this high-risk medicine without an up to date blood test result being recorded in their records. Records showed one of these patients had been contacted on four occasions but had failed to attend for relevant blood tests. During our inspection staff contacted two of these patients to book them in to have relevant blood tests carried out. After our inspection the provider sent us evidence to show that the latest blood test result (from December 2022) had been added to one of these patients' records.</li> <li>• Five patients who were prescribed methotrexate and found best practice guidance was being followed for the prescribing of this high-risk medicine.</li> <li>• Three patients who were prescribed lithium and found best practice guidance was being followed for the prescribing of this high-risk medicine.</li> <li>• Four patients who were prescribed zopiclone and found best practice guidance was being followed for the prescribing of these high-risk medicines.</li> </ul> |     |

## Lessons learned and improvements made

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

| <b>Significant events</b>   | <b>Y/N/Partial</b> |
|---|--------------------|
| There was a system for recording and acting on significant events.  | Yes                |
| There was 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:  | 20                 |
| 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                |
| <b>Additional evidence or comments</b>  |                    |
| We looked at the records of two significant events that had been recorded as taking place within the last 12 months. We saw details of the event reported by staff had been investigated, and necessary action taken. Records showed that learning had been discussed at relevant meetings to help reduce the risk of it happening again. For example, staff were reminded to forward relevant incoming |                    |

correspondence to clinical staff for action following a recent error that took place when a letter was not acted upon in a timely manner.

| <b>Safety alerts</b>   |     |
|--|-----|
| 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 |
| <b>Additional evidence or comments</b>   |     |
| During our clinical searches, we reviewed two safety alerts and found they had been managed well.                      |     |

# Effective

## Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care as well as treatment were delivered in line with current legislation, standards and evidence-based guidance. The provider was responsive to our findings relating to some patient reviews.**

|   |         |
|---|---------|
|   |         |
| 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.  | Partial |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.  | Partial |
| We saw no evidence of discrimination when staff made care and treatment decisions.  | Yes     |
| Patients' treatment was regularly reviewed and updated.   | Partial |
| 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     |
| <b>Additional evidence or comments</b>  |         |
| Patients with some long-term conditions, such as asthma, diabetes and patients receiving palliative care were receiving relevant reviews. We found that improvements were required to some reviews of patients with chronic obstructive pulmonary disease (COPD), hypertension, atrial fibrillation (AF) mental health conditions and dementia. However, the provider took action after our inspection to make the required improvements. |         |



## 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 with suspected hypertension were offered ambulatory blood pressure monitoring. All patients with a learning disability were offered an annual health check. 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. 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.

We looked at the records of:

- Five patients who were diagnosed with asthma. Records showed that all of these patients had received a review in line with best practice guidance.
- Five patients who were diagnosed with chronic obstructive pulmonary disease (COPD). We saw reviews made reference to local best practice guidance. However, we looked but could not find any evidence to show that any of these patients' reviews followed best practice guidance (Global Initiative for Chronic Obstructive Lung Disease – GOLD guidance). After our inspection the provider wrote to us with evidence to show that GOLD guidance was used to grade these patients' conditions which in turn evidenced the reason why relevant medicines were then prescribed.
- Five patients who were diagnosed with diabetes. Records showed that all of these patients had received a review in line with best practice guidance.
- Five patients who were diagnosed with hypertension. Records showed two of these patients were overdue relevant blood tests. After our inspection the provider sent us evidence to show both these patients had been contacted and provided with access to appointments to have relevant blood tests carried out.
- Five patients who were diagnosed with atrial fibrillation (AF). One of these patients' records contained a CHADSVASC score (a scoring method used to predict a patient's thromboembolic risk) dated July 2022. However, we looked but could not find evidence to show they were being prescribed relevant anticoagulation medicine. After our inspection the provider sent us evidence to show this patient attended the practice for a further review which identified it was safe for the patient to continue taking existing prescribed medicines and that no additional medicines were required.
- Five patients who were diagnosed with mental health conditions. Three of these patients' records showed they were overdue relevant tests or investigations. For example, blood tests, cervical cancer screening or a diabetes review. After our inspection the provider sent us evidence to show these patients had been contacted and either booked in for further review or offered relevant tests / investigations.
- Five patients who were diagnosed with dementia. One of these patients' records showed they were overdue relevant tests or investigations. For example, breast cancers screening. After our inspection the provider sent us evidence to show this patient's carer had been contacted and attendance for breast cancer screening discussed.
- Five patients who were receiving palliative care and found 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. However, our searches showed there were 157 patients with a potential missed diagnosis of chronic kidney disease (CKD) who had not had relevant blood tests carried out in the last 18 months. The provider was aware of

these patients and had developed an action plan to take relevant action by the end of January 2023. For example, patient who required further blood tests were being contacted and offered relevant appointments to help confirm if they had CKD or not and to enable further care and treatment if required.

Our searches also showed there were 257 patients who were prescribed angiotensin converting enzyme inhibitor medicine that did not have relevant blood tests results recorded in their records during the last 12 months. The provider was aware of our findings and had an action plan to address the situation. For example, regular monitoring of patient who were overdue blood tests was being carried out so text messages could be sent asking them to book an appointment for relevant blood testing. The plans included escalation action if a patient were not to comply. For example, additional telephone calls were to be made to encourage attendance for relevant blood testing and if necessary the amount of medicine prescribed was to be reduced.

| 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) (UKHSA COVER team) | 253       | 269         | 94.1%      | 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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)  | 212       | 236         | 89.8%      | 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) (UKHSA COVER team)  | 212       | 236         | 89.8%      | 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) (UKHSA COVER team)   | 212       | 236         | 89.8%      | 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) (UKHSA COVER team)  | 265       | 310         | 85.5%      | 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

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England and Improvement results (published in March 2021) showed that uptake rates were below the target of 90% or above in four out of the 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 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. Health visitors were also informed of children who failed to attend for immunisations to enable healthcare staff from outside of the practice to also encourage uptake.

| Cancer Indicators  | Practice | SICBL 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: 30/06/2022) (UK Health and Security Agency) | 68.2%    | 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) (UKHSA)   | 45.3%    | 63.4%         | 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) (UKHSA)  | 66.3%    | 68.0%         | 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) (UKHSA)  | 58.7%    | 56.4%         | 55.4%           | No statistical variation |

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

### Additional evidence or comments

Published results showed that the practice's uptake for cervical screening as at June 2022 was below the 80% coverage target for the national screening programme.

The provider was aware of these results and was taking action to improve uptake. For example, staff told us patients who were due or overdue cervical screening, were identified and sent either a text message or letter inviting them for screening. The practice's computer system alerted staff to patients who were due or overdue cervical screening so they could encourage screening during any contact with the practice. Patients who failed to attend for cervical screening were telephoned by staff and encouraged to attend for screening.

Unverified data showed uptake of cervical screening by eligible patients was to date:

- 66% for patients aged 25 to 49 years.
- 71% for patients aged 50 to 64 years.

Published results showed that the practice's uptake for breast cancer screening was below local and England averages.

The provider was aware of these results and was taking action to improve uptake. For example, staff told us patients who were due or overdue breast cancer screening, were identified and sent either a text message or letter inviting them for screening. The practice's computer system alerted staff to patients who were due or overdue cervical screening so they could encourage screening during any contact with the practice.

Published results showed that the practice's uptake for bowel cancer screening was in line with 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 |

# Caring

## Rating: Good

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

|   |     |
|---|-----|
| Staff understood and respected the personal, cultural, social and religious needs of patients.                      | Yes |
| Staff displayed understanding and a non-judgmental attitude towards patients.                                       | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |

### National GP Patient Survey Results published in July 2022

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| Indicator   | Practice | CCG average | England average | England comparison                   |
|---|----------|-------------|-----------------|--------------------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)                   | 73.0%    | 82.1%       | 84.7%           | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022) | 69.8%    | 80.8%       | 83.5%           | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)                              | 88.9%    | 92.0%       | 93.1%           | No statistical variation             |

|  |       |       |       |                          |
|--|-------|-------|-------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)  | 56.4% | 66.8% | 72.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022) | 85.7% | 89.0% | 89.9% | No statistical variation |

### Additional evidence or comments

Feedback about the practice from the national GP patient survey published in July 2022 was in line with local and England averages in three out of the five indicators.

The provider was aware of these results (including where they were tending towards variation negative) and was taking action to improve patient satisfaction. For example, planned actions were discussed at meetings so that all staff were aware of improvements required.

## Involvement in decisions about care and treatment

### Staff helped patients to be involved in decisions about care and treatment.

|   |     |
|---|-----|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.                     | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services.   | Yes |
| Interpretation services were available for patients who did not have English as a first language.   | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information about support groups was available on the practice website.   | Yes |

| Carers  | Narrative  |
|---|--|
| Percentage and number of carers identified.                 | The practice had identified 283 (1%) patients who were carers.   |
| How the practice supported carers (including young carers). | Carers were identified during the registration process and during consultations. At the start of the pandemic all patients were contacted by text message to help identify carers. This meant that the practice could update their records accordingly as well as be able to offer covid and other relevant vaccinations to carers. Patients who received care were asked by staff who their carers were to help establish if any were also patients at the practice. There was also a notice board in the waiting room that encouraged patients who were also carers to identify themselves to staff. |



|  |   |
|--|---|
|  | <p>Patients who were carers could access flexible appointments to meet their needs around those of their caring duties and home visits for carers were available if they were not able to leave the person they cared for.</p> <p>Patients who were carers were able to be referred to a social prescriber or other services who could advise and arrange relevant packages of support.</p> |
| How the practice supported recently bereaved patients. | Bereaved patients were sent a sympathy card and offered a telephone call to speak with practice staff about their bereavement. There were also posters in the practice that directed patients to bereavement support services.  |

## Privacy and dignity

### The practice respected patients' privacy and dignity.

| Privacy and Dignity   |     |
|---|-----|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk.                        | Yes |

# Responsive

## Rating: Good

### Responding to and meeting people's needs

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

|  |     |
|--|-----|
|  |     |
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided.    | Yes |
| The facilities and premises were appropriate for the services being delivered.                                   | Yes |
| The practice made reasonable adjustments when patients found it hard to access services.                         | Yes |
| There were arrangements for people who need translation services.  | Yes |
| All patients had been allocated to a designated GP to oversee their care and treatment.                          | Yes |
| The practice complied with the Accessible Information Standard.  | Yes |

| Further information about how the practice is responding to the needs of their population   |  |
|---|--|
| Patients had a named GP who supported them in whatever setting they lived.  |  |
| The practice was responsive to the needs of older patients and offered urgent appointments for those with enhanced needs and complex medical issues.          |  |
| The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.                           |  |
| Appointments were available outside of school hours so that school age children did not need to miss school in order to receive care and treatment.           |  |
| The practice held a register of patients living in vulnerable circumstances including those with a learning disability.                                       |  |
| People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers. |  |
| Services were provided to patients who were residents in local care homes.  |  |
| The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.  |  |
| Patient toilets were available that included ones that were suitable for use by people with mobility issues.  |  |

Purpose built baby changing facilities were available.

A hearing loop was available at the practice receptions to assist patients who were hard of hearing or deaf.

## Access to the service

### People were able to access care and treatment in a timely way.

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

| Practice Opening Times        |               |
|-------------------------------|---------------|
| Sydenham House Medical Centre |               |
| Day                           | Time          |
| Monday                        | 8am to 6.30pm |
| Tuesday                       | 8am to 6.30pm |
| Wednesday                     | 8am to 6.30pm |
| Thursday                      | 8am to 6.30pm |
| Friday                        | 8am to 6.30pm |
| Saturday                      | 8am to 2pm    |
| Musgrove Park branch surgery  |               |
| Day                           | Time          |
| Monday                        | 8am to 6.30pm |
| Tuesday                       | 8am to 6.30pm |
| Wednesday                     | 8am to 6.30pm |
| Thursday                      | 8am to 6.30pm |
| Friday                        | 8am to 6.30pm |
| Hollington branch surgery     |               |
| Day                           | Time          |
| Monday                        | 8am to 6.30pm |
| Tuesday                       | 8am to 6.30pm |
| Wednesday                     | 8am to 6.30pm |

|          |               |
|----------|---------------|
| Thursday | 8am to 6.30pm |
| Friday   | 8am to 6.30pm |

|   |     |
|---|-----|
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages).       | Yes |
| Patients were able to make appointments in a way which met their needs.   | Yes |
| Patients had timely access to appointments / treatment and action was taken to minimize the length of time people waited for care, treatment or advice. | Yes |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).                                       | Yes |
| There were systems to support patients who face communication barriers to access treatment.   | Yes |
| Patients with the most urgent needs had their care prioritised.   | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours.   | Yes |
| There were systems to monitor the quality of access and make improvements.  | Yes |

#### **Additional evidence or comments**

Patients were able to book appointments by telephone, online and in person.

The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.

The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

Home visits were provided by practice staff when necessary.

We looked at the practice's appointments system and saw that the next available face to face appointment with a GP was 10 January 2023 and the next available face to face appointment with a nurse was 12 January 2023.

#### **National GP Patient Survey Results published in July 2021**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

| Indicator   | Practice | SICBL average | England average | England comparison                   |
|---|----------|---------------|-----------------|--------------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022) | 10.4%    | N/A           | 52.7%           | Significant Variation (negative)     |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)                             | 34.3%    | 48.6%         | 56.2%           | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)                    | 32.1%    | 48.2%         | 55.2%           | Variation (negative)                 |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)                             | 62.9%    | 68.2%         | 71.9%           | No statistical variation             |

#### Additional evidence or comments

Feedback about the practice from the national GP patient survey published in July 2022 was below local and England averages (significantly so for patient satisfaction with the ease of getting through to someone at their GP practice on the telephone).

The provider was aware of these results and had taken action to improve patient satisfaction. For example, a new telephone system had been installed in August 2022 to help improve access to the practice and its branch surgeries by telephone. Ongoing action was also being taken and monitoring of the effects of these improvements was taking place. For example, ongoing monitoring of access by telephone showed the number of telephone calls answered by staff had increased from 16,303 per month in July 2022 to 19,737 per month in October 2022. Ongoing monitoring of access to appointments showed the number of appointments offered to patients had increased from 5,405 for the month of September 2022 to 5,606 for the month of November 2022.

## Listening and learning from concerns and complaints

**Complaints were listened to and used to improve the quality of care.**

| Complaints  |     |
|---|-----|
| The practice had a system for handling complaints and concerns.   | Yes |
| The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.   | Yes |
| Information was available to help patients understand the complaints system.  | Yes |
| Number of complaints received in the last 12 months.  | 31  |
| Additional evidence or comments   |     |
| We looked at the records of two complaints reported within the last 12 months. Records showed that these complaints had been acknowledged and, after investigation, replied to in writing. Records also |     |

showed that learning from the complaints had been shared with relevant practice staff. For example, records showed that learning from a complaint had been discussed at a meeting where relevant staff were reminded to ensure patients sent to other organisations for tests and investigations were provided with the relevant forms to take with them.

## Well-led

### Rating: Good

#### 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 |
| <b>Additional evidence or comments</b>   |     |
| Clinical leadership including clinical supervision was provided by two of the GP partners.                                       |     |
| Staff told us that the GP partners and management team 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 |
| <b>Additional evidence or comments</b>  |     |
| 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 |
| <b>Additional evidence or comments</b>   |     |
| Staff told us they felt respected, valued and supported locally by the practice and by their colleagues.               |     |

## 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 |

## Managing risks, issues and performance

**Processes for managing risks, issues and performance were effective. Required improvements identified by our inspection were addressed by the provider.**

| There were effective arrangements for identifying, recording, managing and mitigating risks.                                       | Partial |
|--|---------|
| There were processes to manage performance.  | Partial |
| 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     |
| <b>Additional evidence or comments</b>   |         |



Our inspection identified that improvements were required in relation to the management of risks from:

- Prescribing of some high-risk and some other medicines

After we told the provider about these findings from our inspection we saw evidence to show they had subsequently taken action to address them all.

We found that some processes to manage some current and future performance were not sufficiently effective. Improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities. For example, chronic obstructive pulmonary disease (COPD) reviews, hypertension reviews, atrial fibrillation reviews, mental health reviews and dementia reviews.

After we told the provider about these findings from our inspection we saw evidence to show they had taken action to address them all.

**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

Records showed that the practice's Patient Participation Group (PPG) met regularly and their views were acted upon to help make improvements.

The practice monitored feedback received from the national GP patient survey as well as the friends and family test questionnaire and took action to make improvements when necessary. For example, improving access by telephone and the number of appointments available.

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.

| Experience shared with CQC directly via our website   |    |
|---|----|
| Total received  | 18 |
| 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          | 18 |

| Reviews left on the NHS Choices website                |   |
|--|---|
| Total reviews  | 6 |
| Number of reviews that were positive about the service | 0 |
| Number of reviews that were mixed about the service    | 0 |
| Number of reviews that were negative about the service | 6 |

| Examples of feedback received   | Source  |
|---|---|
| <p>Common themes identified from reviews left on the NHS Choices website or in feedback we received from patients about services at Sydenham House Medical Centre were:</p> <ul style="list-style-type: none"> <li>• Some patients found it difficult getting through to the practice by telephone.</li> <li>• Some patients found it difficult accessing appointments, especially when using the practice’s eConsult online appointment booking system.</li> <li>• Some patients experienced difficulty obtaining repeat medicines.</li> </ul> | <p>Reviews left on the NHS Choices website and experience shared with CQC directly via our website over the last 12 months.</p> |

## 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   |     |
| <p>Significant events and complaints were used to make improvements and any learning shared with relevant staff at this practice. For example, learning from a significant event had been shared at a staff meeting and clinical staff were reminded not to prescribe steroid cream for some specific conditions following a prescribing error.</p> |     |

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.
- **UKHSA:** UK Health and Security Agency.
- **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.