

Care Quality Commission

Inspection Evidence Table

Downham Family Medical Practice (1-543965384)

Inspection date: 30/06/2022

Date of data download: 18 June 2022

Overall rating: Requires improvement

A focused announced inspection was carried out at Downham Family Medical Practice on 30 June 2022. We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach. As part of the inspection there was a remote review of clinical records prior to the visit on 29 June 2022.

At this inspection on 30 June 2022, the practice was rated Requires improvement overall because the arrangements for identifying, monitoring and managing risks to patient safety were not effective. There were safety systems and processes and the evidence of implementation, however, leaders did not have adequate oversight of all risks. Governance around patient safety issues was lacking.

Safe

Rating: Requires improvement

Safe is rated as requires improvement because:

- The provider did not always have adequate oversight of the risks associated with the areas of the building they occupied. For example, risks relating to the fire safety of the building. The provider did not routinely review historical safety alerts to ensure compliance.
- There were shortfalls in the management of infection prevention and control, specifically actions in response to the Legionella risk assessment.
- There was a process for recording and acting on significant events and staff could describe the process. However, only one event had been reported and investigated in the last 12 months.
- The process for reviewing historical safety alerts was not always effective.

Safety systems and processes

In the main, the practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y ¹

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y ²
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. The provider had reviewed their policies for safeguarding. We saw that staff had access to local safeguarding information and that staff were aware of who the adult and children's safeguarding leads were at the practice and had appropriate knowledge of when to report concerns and seek advice.</p> <p>2. There was a system to check the DBS status of staff. However, the provider could not assure us that they had checked the DBS status of one member of reception staff before they commenced employment. A risk assessment had not been completed in the absence of a DBS check. We asked about processes for checking the DBS status of staff before they commenced employment, including how the managers ensured staff remain suitable for the role. The provider told us they received an automatic email reminder three months before DBS checks were due to expire.</p> <p>All staff including those who acted as chaperones had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The provider had a record of which staff had completed chaperone training.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>1. At this inspection we reviewed three staff files. There was no record of a signed contract or proof of identity for one non-clinical staff member. At the time of the inspection, the practice manager had identified missing information in staff recruitment folders which was documented in an action plan to ensure the practice met requirements.</p> <p>2. The practice infection control policy included reference to vaccination/immunity to Hepatitis B for all staff who might come into contact with body fluids, clinical waste and sharps in the course of their duties. Records we checked showed staff had been screened and completed a Hepatitis B immunisation course. However, there was no record to show the cleaners, who were employed by an external company, had completed IPC training or of their Hep B status.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17/03/2022	Y ¹
There was a fire procedure.	Y
Date of fire risk assessment: 18/01/2022	Y
Actions from fire risk assessment were identified and completed.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <p>The practice is located in a building which is owned and maintained by NHS Property Services Limited (NHSPS). The building maintenance is carried out by an external facilities management company. Fire safety checks were the responsibility of NHSPS. The practice had obtained a copy of the latest health and safety risk assessment which we were shown. The managers provided evidence that the practice had responded to all of the assessor's recommendations.</p>	
Health and Safety risk management	
<p>1. Although the practice did not manage the building, the provider showed us evidence of a programme of health and safety risk assessment undertaken by the facilities management company. At this inspection, we saw documented actions that had been taken in relation to health and safety and those in progress, and this was monitored. Staff at the practice told us they reported health and safety issues to the facilities management service.</p>	
<p>However, the provider did not have an effective system to assure themselves of the working status of the fire alarms. For example, practice staff were not able to provide evidence of weekly fire alarm tests and no evidence of regular attempts to get assurances about the working status of the fire alarm.</p>	
<ul style="list-style-type: none"> • Staff told us that NHS property services were responsible for installing, maintaining and testing the fire alarm system. The practice arranged for an external maintenance contractor to service the fire alarm system every six months and carry out the weekly fire alarm testing. At this inspection, the practice did not keep an up to date log of weekly fire alarm checks and it was not clear whether any identified faults had been investigated and actioned. • NHS Property services was responsible for carrying out fire evacuation drills. Fire drills were carried out monthly by the facilities management. During our inspection, staff at the practice were not able to show us a record of fire drills or of follow up on any actions identified. Staff we spoke to were clear about the fire evacuation procedure and the assembly points at the site. • The fire extinguishers had been inspected in March 2022, but no service certificate was kept by the practice. 	
<p>Immediately following our inspection, the practice sent us copies of the last 3 months fire drills and a copy of the log of fire alarm tests over the last four months. The practice informed us after the inspection that they had discussed fire safety with the property managers who had since set up leaseholder and tenant meetings to ensure health and safety reports were available at all times including information about actions required to keep people safe. Following the inspection staff told us they had obtained up to date reports of the fire alarm testing, logs of fire drills carried out and a copy of service certificate for the fire extinguishers on the premises.</p>	

2. The practice sent us a copy of the fire risk assessment carried out by the facilities management company for the building. The fire risk assessment recorded that a six monthly service of the fire alarm system in the building was completed on 1 November 2021 and remedial actions were completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Internal IPC check 01/05/2022 and CCG audit 17 June 2022	Y ¹
The practice had acted on any issues identified in infection prevention and control audits.	Partial ²
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. At this inspection, infection risks to staff and people using the service were being assessed and managed. We were not able to review the practice's most recent IPC risk assessment carried out by an independent reviewer on 17 June 2022. However, the practice had carried out their own risk assessment in relation to infection prevention and control and we saw evidence of actions completed. On the day of the inspection, we observed the practice was clean and tidy. The cleaning of the premises was done by the facilities management company which audited performance and had risk assessments in place. For example, relating to substances hazardous to health. The practice had oversight to make sure cleaning was carried out appropriately.</p> <p>2. The practice had obtained a copy of the legionella risk assessment report for the building carried out by a risk assessor for the facilities management service, in March 2021. It was not clear how the practice monitored legionella control. There was no log book of recommended checks to manage the risk of legionella within the water system. We were told that the facilities management company was responsible for implementing the recommendations. There was no record that the practice had responded to all of the assessor's recommendations.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y ¹

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice used a sepsis decision and support tool which was posted in the reception area and clinical rooms. The receptionists had completed sepsis training. The receptionists explained that when patients called the practice and said they were very unwell, they would speak with the GP or call the emergency services. In addition, staff had a flow chart for them to follow to identify anyone who may require urgent treatment.</p>	

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization. Although systems were in place to review monitoring results, there was no effective oversight of risk assessing prior to prescribing.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.03	0.59	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	8.7%	9.1%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.44	5.62	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	97.4‰	71.7‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.51	0.39	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.1‰	4.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ¹

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y ²
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial ³
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches are visible to the practice.</p> <p>1. The practice had a written protocol for repeat prescribing of medicines which needed monitoring. However, managers did not have an effective system to check that prescribers were following the protocol. At this inspection, not all staff were properly checking that monitoring was up to date and that it was safe to issue a prescription. There was no indication in some patient's clinical records (which would be good practice) that the results of a test were considered when issuing a prescription and there was no explanation in the clinical record for departing from the current national prescribing guidance.</p> <p>2. High Risk Medicines</p> <p>Patients on high risk medicines whose records we looked at had appropriate monitoring completed. The provider was able to demonstrate that there were safe systems in place to prescribe medicines to patients where specific, frequent, monitoring was required. For example, all patients taking methotrexate (a medicine used to treat inflammatory conditions) had the required monitoring.</p> <ul style="list-style-type: none"> There were 21 patients taking spironolactone (a medicine used to treat heart failure). The CQC search identified seven patients who had not had the required monitoring. We looked at a sample of five patient records. Two of the five patients had not responded to requests 	

Medicines management	Y/N/Partial
<p>to come in for monitoring. There was a record of attempts to contact these patients but no follow up protocol for these hard to reach patients. Three patients were monitored in secondary care under the hospital renal team. All patients on direct-acting oral anticoagulants (medicines used to thin blood) had the required monitoring.</p> <p>Following this inspection, we asked the provider to complete a review of all patients where concerns had been highlighted during the inspection. Where our searches identified gaps in monitoring, the practice was able to provide evidence that patients had been recalled for monitoring and there was a clear plan in place to follow up those patients who had not attended.</p> <p>We spoke to the senior GP partner about the concerns identified during the records review and the risk to patients' health and wellbeing. The senior GP partner told us the practice had a call and recall protocol to improve coordination of health checks and reviews. The practice told us that the PCN pharmacy team support the practice by running searches and doing remote medicine reviews with patients, where appropriate. Staff told us some patients have not wanted to come into the surgery during the pandemic. The lead GP told us that patients who require blood tests or who are due for review are sent a letter from the patient's doctor encouraging them to attend for a blood test.</p> <p>3. At this inspection, there was a log of emergency medicines but staff had not maintained the log of medication expiry dates. When we checked the stock of emergency medicines, we found two expired hydrocortisone medicines in the box of emergency medicines. When we raised this with the practice manager, they immediately removed the medicines to dispose of safely and ordered new medicines which would be delivered the next day.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial ¹
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial ²
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence:	
Recording significant events	
1. There was a significant events policy, but it was not clear that staff had always followed the procedure outlined in the policy to ensure that all significant events were documented, communicated and reviewed. For example, we asked to see the log of significant events over the	

last 12 months and found two entries; one COVID infection incident dated 19 December 2020 and the next significant event logged was dated 7 April 2022. Managers told us that there had been no significant events during the COVID19 pandemic.

2. Staff told us significant events were discussed in team meetings and meetings were minuted and learning was shared by email to all staff. We saw one example of a significant event which had been discussed in clinical team meetings but learning was not recorded in detail. Staff told us the learning would be shared with those staff through other meetings. We asked staff if they knew how to report safety incidents. Staff were able to give an example of when they had learned and made improvements when things went wrong.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Although the practice had a system to manage safety alerts, systems for reviewing historical safety alerts were not always effective. For example;</p> <ul style="list-style-type: none"> Seven patients of childbearing age prescribed sodium valproate or carbimazole (medicines for managing epilepsy and hyperthyroidism). We looked at a sample of five patients and found three patients who had not had the required monitoring. In two of these patients' records there was no evidence recorded in the clinical notes to show patients had been made aware of the risks if they were of childbearing age and advised about contraception. <p>We saw evidence of new safety alerts being discussed and reviewed in weekly clinical team meetings. For example, our review of clinical records showed that the practice had acted in response to the NHS England and NHS Improvement national patient safety alert (NatPSA) issued in 2021, which specified a number of actions that organisations need to implement. We reviewed a sample of patients with asthma who have been prescribed two or more courses of rescue steroids and found all patients were issued with an NHS Emergency Steroid card, where appropriate. (Steroids are drugs that reduce irritation in the lung. They are used in many lung illnesses). Following our inspection, the practice told us they had appointed a clinical pharmacist to support routine review of historical safety alerts and who will be responsible for safety alerts management.</p>	

Effective

Rating: Requires improvement

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 is rated as requires improvement because:

- The practice had implemented systems which supported the oversight of clinical care, for example a call and recall protocol. However, some areas required strengthening to ensure all patients with long-term conditions, received appropriate monitoring for their conditions.
- There was no effective system of documenting staff appraisals.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: At this inspection we reviewed a sample of patients on medicines which required monitoring and found that for the majority of patients, appropriate action was taken, when required. However, there were a small number of patients who were not monitored appropriately in line with national guidance.	

1. Staff had access to local and national guidelines but had not always used this information to deliver care and treatment that met patients' needs. Although the practice had a comprehensive repeat prescribing and medicine review policy, the systems in place were not always effective. Clinicians did not document that they had looked at a patient's monitoring results prior to prescribing repeat medicines. This meant patients were not always receiving appropriate treatment and monitoring for their conditions.

Long term conditions - Management of patients with hypothyroidism

Our review of patient records in relation to the clinical searches identified that the majority of care records were managed in line with current guidance. We found a small number of clinical records where clinicians had not always reviewed test results in a timely way and had not ensured monitoring results, which may alter patient management, were acted on. For example:

- Review of two clinical records out of a total of two identified by the clinical search, for patients taking a medicine to treat hypothyroidism, showed that these two patients had not received appropriate monitoring. The practice had not identified that monitoring was overdue. There was no evidence Thyroid stimulating hormone (TSH) monitoring had been checked and was valid, before issuing the last prescription. We saw evidence that the practice had attempted to contact the patients to invite them in for blood tests, but the prescription was still issued. There was no explanation in the clinical record for departing from the current national prescribing guidance.
- We spoke to the senior GP partner about the concerns identified during the records review of a sample of patients with long term conditions. Staff told us some patients had not wanted to come into the surgery during the pandemic and had not attended for monitoring of their medical conditions. We asked the provider to review the records of patients identified in our records review and following our inspection the provider confirmed that they had reviewed the medical records of the two patients and invited each patient to come in to take a blood test.
- When we discussed our findings with the provider, we also asked how they review test results when monitoring had happened in secondary care. They informed us that clinicians access and check the local hospital system to see if the required blood tests have been performed via a patient report link and should then manually enter the data with correct test date and results into the patient record on EMIS.

Long term conditions - Management of patients with diabetic retinopathy

At this inspection, the practice could not demonstrate that patients who had diabetic retinopathy had received the required monitoring. There were six patients in total with diabetic retinopathy who's latest HbA1c reading was >74mmol. We looked at five patient records in more detail and found three patients where a medication review had not been coded in the last 12 months. Two of these three patients had received a diabetic review in the last twelve months, but one patient was overdue monitoring and diabetic medication review. One patient had received diabetes monitoring and medication review, but the last blood pressure reading was not in the recommended range and the practice had not followed this up. Two patients prescribed repeat medicines had not been followed up for a review.

We asked the provider to look into these patients and following our inspection the practice sent us evidence that they had reviewed all the patients we identified.

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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. However, at this inspection not all patients had received appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. We spoke to staff who told us the practice ran Ardens searches of the clinical records and lists of patients for call and recall were given to members of the admin team to work from. For example, a list of patients to call to have their blood pressure check. The clinical lead was responsible for oversight of the system of call and recall. Clinicians also sent tasks about individual patients who needed to come in for reviews
- A pharmacist employed by the Primary Care Network (PCN) worked at the practice to support the management of patients with long term conditions and carry out medicine reviews and make referrals to preventative care. The practice had a nurse prescriber to support reviews of patients and carry out health checks.
- The practice was able to refer patients for a minor illness consultation through the Community Pharmacist Consultation Service (CPCS), once a local referral pathway had been agreed. The service connects patients who have a minor illness or need an urgent supply of a medicine, with a community pharmacy.
- All patients with a learning disability were offered an annual health check. The practice kept a register of patients with a learning disability and there were alerts on medical records to help staff identify patients when they contacted the practice. All patients with a learning disability were offered an annual health check. The number of patients on the practice learning disability register was 57, with 14 health checks done and action plan completed so far in this QOF year.
- 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

In the absence of QOF data, the inspection team reviewed results from some additional searches of the clinical records to support the review of long-term condition management;

- Although there were systems for the management and monitoring of patients with long-term conditions, they were not always effective. Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance; we saw that five patients with diabetic retinopathy were not always reviewed to ensure they could be offered treatments or monitoring to improve control. Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 and Improvement)	59	70	84.3%	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 and Improvement)	58	74	78.4%	Below 80% uptake

The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	60	74	81.1%	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 and Improvement)	60	74	81.1%	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 and Improvement)	72	106	67.9%	Below 80% uptake

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

Any additional evidence or comments

- At this inspection, childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the minimum target of 90% in all of the five areas where childhood immunisations are measured. The practice had an action plan to improve uptake;
 - The practice had put a call/recall protocol in place, for patients who were due childhood immunisations.
 - The practice ran weekly immunisations searches for patients that were due immunisations and maintained records of patients that had been followed up.
 - An immunisation coordinator was responsible for call and recall of parents / guardians to book appointments and send reminder letters to parents / guardians who were not contactable by phone.
 - Parents who declined vaccinations were offered a telephone consultation with the practice nurse to discuss their concerns.
 - The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors to follow up when necessary.

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	73.5%	N/A	80% Target	Below 80% target

64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.7%	54.2%	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)	54.3%	60.5%	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)	37.5%	52.0%	55.4%	No statistical variation

Any additional evidence or comments

- The practice told us they had discussed the low scores during their clinical team meetings and had taken action to follow up all women who had not had cervical screening. The practice had a dedicated member of administration staff who did daily cytology recalls of women aged 25 to 64 years. Staff ran searches and contacted the patient and invited all those overdue cervical screening to make an appointment. All non-attenders were flagged on the medical records and the cytology nurse would personally call all patients who did not attend to have a further discussion. Screening was also offered opportunistically to patients. The practice provided Saturday morning clinics as part of the extended hours for patients to have cervical screening done.

Monitoring care and treatment

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

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

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

Any additional evidence or comments

The practice routinely reviewed the effectiveness of the care provided. The practice used information about care and treatment to make improvements. We discussed examples from the practice's quality

improvement plan at the on site visit. This included work in progress following the easing of the COVID19 pandemic restrictions, for example;

- an improvement plan for end of life care (EOLC) to assess the standard of care the practice is providing for patients with advanced serious illness and at the end of their life
- reviewing training and recruitment records and implementing new systems and processes including, using an electronic system to store all policies, meeting minutes and training records
- an action plan to improve the significant event procedures
- working collaboratively with other practices in the the primary care network (PCN).

We saw that the practice had undertaken a range of two cycle audits which demonstrated quality improvement for patients, these audits included looking at patients prescribe Sodium Valproate, an audit of patients prescribed Methotrexate and patients taking Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) There was evidence the practice shared learning and changed practice following improvement activity. For example, following the Sodium Valproate audit the lead GP became a 'valproate champion' in our practice and the physician associate at the practice was trained to take responsibility for running a monthly search for new patients on Valproate. All audits demonstrated quality improvement for patients.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y ¹
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ²
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
1. Staff had undertaken updates and development activities to ensure their knowledge and skills were up to date. Nurses had time blocked out of clinics to attend the Lewisham Nurse Forums as well as any lunch and learn sessions provided by the training hub. The CCG had subscribed the practice to an online eLearning resource for primary care.	
2. Appraisals were not always documented. For example, there was no record of a recent appraisal for either of the two practice nurses. One of the practice nurses had recently qualified as a nurse	

prescriber. The lead GP told us he was responsible for conducting the nurses' appraisals but neither of the nurses had an appraisal documented since 2020. The practice had an action plan in place to improve documentation of appraisals. Following our inspection, the practice told us they had purchased a new web-based compliance platform to improve the management of staff appraisals. A new Operations Manager was appointed after our inspection, whose role will include managing Human Resources activities.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>DNACPR care plans</p> <p>At this inspection, we reviewed a sample of individual care plans of patients who have had a Do not attempt cardiopulmonary resuscitation (DNACPR). Our CQC search did not identify any patients who had a DNACPR decision coded in the patient record. When we ran the Ardens search there were 14 patients coded as having DNACPR. When we spoke with the lead GP they showed us the DNAR decision was recorded in the Coordinate my Care (CMC) care plan for each patient and there was evidence of discussion recorded of the rationale for the decision made. We saw that where possible the patient's views had been sought and respected.</p>	

Well-led

Rating: Requires improvement

Well led is rated as requires improvement because:

- The arrangements for managing risk and oversight of governance did not always operate effectively.
- The provider did not keep all the necessary documentation, particularly for recruitment records, appraisals and staff did not routinely report incidents.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial ¹
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
1. The practice had identified challenges and had taken action to address them including recruiting staff members, upskilling staff, and introducing new IT based systems to put all policies, meeting minutes, significant events all together in one place.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• We saw a detailed business plan, with clear strategies and objectives for the future.	

- The practice informed us about new strategies implemented and plans that they were working on to provide high quality care.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff feedback	Staff were happy working at the practice and felt supported.

Governance arrangements

Some governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>1. Although leaders had identified some issues and had taken action to improve systems, there were some issues we identified at this inspection that leaders had not identified themselves.</p> <ul style="list-style-type: none"> • The governance framework had not ensured that systems and processes were operating effectively. For example, we found during the clinical searches, the systems to manage patients 	

with long term conditions, required improvement. The records we examined provided evidence that overall, the majority of patients with a long-term condition had been monitored and reviewed appropriately. Where our search identified gaps, we asked the practice to review these records and provide evidence of action taken. Immediately following this inspection, leaders took action to address the concerns identified, including initial actions to recall patients for monitoring and reviews, where these were overdue.

- There were gaps in recruitment records – no record of a DBS for one member of reception staff, no signed contract for one of the non-clinical members of staff or proof of identity.
- Managers did not have effective oversight of the appraisal system. We found that staff had received appraisals but these were not always documented. For example there was no record of an appraisal for two members of staff.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, but the practice had not put in place systems to ensure they were effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial ²
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	P
Explanation of any answers and additional evidence:	
<p>1. Assurance systems were not regularly reviewed and operating as intended. Leaders had not identified the need to have an effective process in place to ensure clinicians were viewing patients' monitoring information prior to prescribing. For example, some patients with a long term condition whose records we looked at had not received appropriate monitoring.</p> <p>2. Although we found there were processes for managing risks, leaders did not have oversight of all health and safety risks for the areas of the building they occupied. For example;</p> <ul style="list-style-type: none"> • Fire safety was not adequately managed and monitored. There was no record of a fire drill having been undertaken and no log of fire alarm tests. • Safety alerts had not been managed effectively. There was no system of oversight in place to ensure appropriate actions had been completed. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y ¹
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
1. There was a demonstrated commitment to using data and information proactively to drive and support decision making but the systems for managing patients with long term conditions, needed further improvement. We saw evidence that the practice used the results of clinical audits to improve performance. The practice had purchased Ardens software which improved how alerts and recalls were managed.	

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice informed us they had a meeting with the Patient Participation Group (PPG) in June 2022. 	

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y ¹
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>1. Learning was shared in relation to complaints and audits to drive improvement, but there was limited evidence of learning being shared from significant events. Minutes of team meetings showed that significant events were discussed, however, the minute notes were sparse and did not record the learning or actions agreed in any detail. We checked the significant event log and saw that staff recorded the learning and the actions taken but there was only one event recorded since December 2021.</p> <p>The practice manager, who had been in post for a year, told us they were reviewing training and recruitment records and implementing new systems and processes including, using an electronic system to store all policies, meeting minutes and training records.</p> <p>The lead GP told us that one of the practice nurses had recently qualified as a Nurse Prescriber and had also been awarded Queens Nurse. The title of Queen's Nurse (QN) is awarded to individuals who have demonstrated a high level of commitment to patient care and nursing practice. The practice had also supported the nurse prescriber to take on Nurse facilitator role for Sevenfields Primary Care Network.</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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- 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.