

Inspection Evidence Table

East Croydon Medical Centre

(1-562028441)

Inspection Date:

- Site visit 23 November 2022
- Records review 1 December 2022
- Interviews 30 November – 23 December 2022.

Date of data download: 12/01/2023

The partners who run East Croydon Medical Centre also run another local GP practice (Edridge Road Community Health Centre). The two services have common governance, some common staff and are currently based in the same premises. Instead of arranging two separate inspections, we reviewed systems and processes for both locations at the same time rather than in separate meetings. We arranged to inspect both services at the same time, and as far as possible and convenient for the provider, reviewed them both in one set of inspection activities.

Overall rating: Good

In 2018 we rated the practice as requires improvement for overall. This was because the provider had not established effective processes for staff training, recruitment checks, infection prevention and control, monitoring of high-risk medicines, vaccine cold-chain monitoring, or for ensuring significant events were always identified and recorded fully. There was also no evidence of improvements made in response to low GP patient survey results.

In 2021, we found that sufficient improvement had not been made in respect of monitoring of the vaccine cold chain and one medicine was still not being monitored in accordance with current guidelines.

We also found:

- weaknesses in monitoring of emergency equipment
- incomplete actions to prevent and control infections
- staff knowledge of consent and assessing the capacity of minors
- incomplete responses to complaints
- systems in place for reviewing patients with learning disabilities and identifying those using a high number of inhalers were not effective
- little engagement with patients in respect of below average national patient survey scores, to assess efforts made to improve patient satisfaction
- mixed staff feedback on the practice leadership
- failure of the governance arrangements to identify some areas of concern found at the inspection.

Following this inspection the practice is rated as good.

There had been action to address the issues identified at previous inspections, which were being monitored. Not all actions were completed at the time of the inspection, so the rating for Safe remains as requires improvement.

Safe

Rating: Requires improvement

In 2021 the practice was rated as requires improvement for providing a safe service as we found that systems around the management of medicines had not sufficiently improved. We found expired equipment within both of the practice's emergency supply stores. Staff immunity records were incomplete. However, concerns identified at our previous inspection in relation to recruitment, safeguarding and significant events had been addressed. We found that there were some risks related to infection control and legionella that had been identified and it was either unclear if these had been addressed, as the practice had not received evidence from NHS Property Services.

The practice remains rated as requires improvement for providing a safe service. The practice had successfully improved some systems and processes and we found no issues with the monitoring of the vaccine cold chain or monitoring of emergency medicines.

The provider had recently strengthened the operational management of the practice with new staff to support safety systems and processes. There were still weaknesses in some areas, including records of staff immunity and evidence of actions carried out by NHS Property Services, but there were action plans in place to address these and we saw clear evidence of progress.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but they had not been consistently implemented.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

We looked at 4 records of patients with safeguarding concerns. There were alerts on all 4 of these patients, but there was no evidence of a consistent system to manage household contacts of these patients. Only one of the household contacts had an alert on their record. We spoke to the partners who agreed that previously the systems had not been robust. The partners told us that this had been identified and there was a piece of work underway to check all relevant patients and make the appropriate links.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We looked at the recruitment check records of four staff members; three recruited in 2022 and one recruited in 2019. The file of the staff member recruited in 2019 did not have references (the way that providers usually obtain evidence of conduct in previous relevant previous roles and verify why those roles ended). The files of the staff recruited recently all had evidence of checks carried out in accordance with regulations. <p>The practice manager in post in 2019 had left the practice. A new HR manager started in post in May. They explained that they had assessed the recruitment process and carried out a review of recruitment records and found a number of gaps. Where it was not possible to obtain references for staff employed for over three years, a risk assessment was completed.</p> <ol style="list-style-type: none"> 2. In 2021, we were provided with spreadsheets containing staff vaccination information which were not completed in line with the practice's immunisation policy. We asked the practice manager about this and were told that they had found it difficult to obtain information from staff around vaccinations and that blank spaces on the vaccination records did not mean that staff had declined to have a vaccination but that the practice had been unable to obtain this information from staff. <p>At this inspection, we looked at a summary of staff immunity that showed that records were not yet complete for 11 of 68 staff. We looked at the records of four staff members. One had no immunity details on file. Three had a letter from an occupational health agency confirming that the staff member was fit for their role. This had no details of what had been discussed or confirmed with regards to immunity. The provider had tried but not succeeded in getting details of the immunity checking process for different roles from the occupational health agency.</p> <p>To address this gap, the practice asked staff to provide evidence of their immunisation status and this had been obtained from 40 of 78 staff.</p> <p>The practice had updated their recruitment process, and told us that in future staff immunity records will be received by the practice as well as by the occupational health provider.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial

Date of last assessment:	24/10/2022
There was a fire procedure.	Y
Date of fire risk assessment:	22/03/2022
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice was based in a building managed by NHS Property Services. Health and safety risk assessments had been carried out, but there was some evidence missing of actions taken. We saw evidence of considerable efforts to obtain it and of reasonable action on actions within the provider's control. The practice had recently introduced a new system to increase the effectiveness of how actions were followed up with NHS Property Services and how communication was recorded.</p> <p>In addition to the main clinical premises, the practice had a building used by administrative staff and leased two offices in the building of another practice. Portable electrical equipment had been safety tested at the main premises and the administrative building. Portable electrical equipment in the two separate offices had not been safety tested at the time of the site visit, but this had been booked.</p>	

Infection prevention and control

The practice had systems and processes to prevent and control infection, which were largely effective. Appropriate standards of cleanliness and hygiene were met. However, immunity records for staff were incomplete and there was some evidence missing of actions taken by the premises' management team.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	26/10/22
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was based in a building managed by NHS Property Services. Infection prevention and control audits had been carried out, but there was some evidence missing of actions taken. We saw evidence of considerable efforts to obtain it and of reasonable action on areas within the provider's control. The practice had recently introduced a new system to increase the effectiveness of how actions were followed up with NHS Property Services and how communication was recorded.</p> <p>Immunity records for staff were incomplete.</p>	

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	

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

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

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

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	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) (NHSBSA)	0.37	0.69	0.82	Significant variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	4.9%	8.7%	8.5%	Tending towards variation (positive)
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)	5.45	5.48	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	70.9‰	60.9‰	129.6‰	Tending towards variation (positive)
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)	0.47	0.53	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	3.6‰	4.8‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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 effective medicines reviews for patients on repeat medicines. 1	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, but at the time of the site visit did not document learning and actions effectively or have a system that allowed progress on actions and monitoring of their effectiveness to be tracked. A new system was implemented shortly after the site visit.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	19
Number of events that required action:	19
Explanation of any answers and additional evidence:	

We discussed significant events, looked for evidence of learning and action and looked at how significant events were recorded.

We found evidence that the practice learned and made improvements when things went wrong. However, documentation of significant events (learning, actions, dissemination and monitoring of actions) was not in line with practice policy and did not allow progress to be tracked or monitoring of how effective actions had been.

A new practice manager started at the practice during the inspection process. On the site visit, we spoke to the practice manager about their plan for a new system that would improve how significant events were documented. After the site visit we were sent two examples of recent SEAs that had been documented using a using a new form on a system that linked notes of discussions and logged dates for actions to be reviewed.

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

Event	Specific action taken
A patient attending for a booster injection had an unexpected allergic reaction.	<p>The patient received immediate care, using the practice's supply of emergency medicines and equipment and was transferred to hospital in ambulance.</p> <p>The practice reviewed their systems and made improvements to how emergency medicines were monitored and to staffing (to ensure that no staff member would be left to manage a similar situation on their own).</p>
A patient attended the practice in respiratory distress. The emergency ambulance took one hour to arrive.	<p>The patient received immediate care, using the practice's supply of emergency medicines and equipment and was transferred to hospital.</p> <p>The practice reviewed their systems and increased the amount of oxygen kept on-site, to mitigate the risk that ambulances were delayed again in future.</p>

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

Effective

Rating: Good

In 2021 we rated the practice as requires improvement for effectiveness because:

- the uptake of childhood immunisations and cervical screening was below average
- searches and reviews of patient records indicated that the practice did not have adequate systems to identify patients overusing asthma inhalers
- incorrect coding of medication reviews created a risk that patients prescribed multiple medicines might not have all medication reviewed in line with guidance
- reviews of patients with learning disabilities lacked enough detail to make them meaningful.

At this inspection, we found treatment was delivered in line with current legislation, standards and evidence-based guidance and that medication reviews had been completed in line with guidance.

Uptake of childhood immunisations and cervical screening were still below average, but the practice had an action plan in place, which was beginning to improve uptake.

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 and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

The practice prioritised care for their most clinically vulnerable patients	Y
Explanation of any answers and additional evidence:	

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • 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. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medicines reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Flu, shingles and pneumonia vaccinations were offered to relevant patients. • Same day appointments and longer appointments were offered when required. • All patients with a learning disability were offered an annual health check and unverified data showed that most patients had received a health check in 2021 – 2022, with thirteen (24%) who did not. • 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 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
<ul style="list-style-type: none"> • 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 atrial fibrillation were assessed for stroke risk and treated appropriately. • 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)) <small>(UKHSA COVER team)</small>	233	265	87.9%	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)) <small>(UKHSA COVER team)</small>	227	280	81.1%	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)) <small>(UKHSA COVER team)</small>	226	280	80.7%	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)) <small>(UKHSA COVER team)</small>	227	280	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)) <small>(UKHSA COVER team)</small>	179	263	68.1%	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

The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of five childhood immunisation uptake indicators.

However, the practice had improved uptake since the last inspection. At that time, uptake was below 80% for four of the five indicators, and the percentage of children age 5 who had received two doses of MMR was only 63.9%.

This was a common one amongst practices in the area. In the same period as the data above, the average uptake across NHS South West London was below 95% for all of the five childhood immunisation uptake indicators. The NHS South West London average for the age 1 immunisation indicator was 90%, the average for aged 2 indicators was 85.5% and the average for age 5 MMR uptake was 76.2%.

Staff told us that the transient nature of the practice population presented additional challenges for the practice. We saw data from the practice that showed that in 2021 – 2022 more than 25% of the practice list left and

were replaced by new patients joining the practice. Staff told us that it was sometimes difficult to know whether patients who did not respond to letters, messages and calls were still in the country.

We discussed efforts made by the practice to improve the uptake of childhood immunisations. Staff told us that the system to identify and contact the parents of children due immunisations had been improved, and that there were now dedicated staff members following consistent processes.

The practice had worked with the local immunisation team to look at reasons for the low uptake. One issue that had been identified was incorrect coding, which staff told us was still being addressed. The practice had made other changes including providing appointments for childhood immunisations later in the day and on Saturdays. Partners reviewed data on childhood immunisations every three months with an analysis of the results and how these could be improved.

The practice had undertaken analysis of children who had not received immunisations. We looked at data for aged 12 – 18 months who had not received their first MMR immunisation in the current financial year. We were told that according to the searches, 33 of 227 eligible children had not had their first MMR immunisation. Of those 33:

- five had de-registered from the practice
- the parents of two had declined the immunisation
- one had had registered only recently
- two children had received the immunisation but had not been correctly coded.

We noted that the parents/guardians of the remaining children had been contacted at least twice, and most had been contacted 3 or 4 times, including letters, texts and phone calls from nurses and GPs. We saw examples of discussion with health visitors.

The Lead Nurse had recently completed a Masters in Public Health. There were plans for patient health campaigns, including on childhood immunisation. Nurses had already run one webinar to address child immunisation hesitancy.

The Lead Nurse explained that she was working with the non-clinical team to improve the information collected about immunisations when patients registered with the practice.

Following a successful trial with cervical screening appointments, the practice planned to give patients the option to book appointments online directly from a text message reminder.

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022) _(UKHSA)	58.2%	N/A	80.0%	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)	48.5%	52.3%	61.3%	N/A

Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) _(UKHSA)	60.2%	63.5%	66.8%	N/A
--	-------	-------	-------	-----

Any additional evidence or comments

The practice had not met the national cervical screening target of 80% uptake. This was a long-standing issue, and a common one amongst practices in the area. In the same period as the data above, the average uptake across London was 66% and the average uptake in South West London was 69%.

Staff told us that the transient nature of the practice population presented additional challenges for the practice. We saw data from the practice that showed that in 2021 – 2022 more than 25% of the practice list left and were replaced by new patients joining the practice. Staff told us that it was sometimes difficult to know whether patients who did not respond to letters, messages and calls were still in the country.

The latest verified published data was from June 2022, and was similar to that at the time of the last inspection. The practice had an action plan in place to improve the uptake of cervical screening. Staff told us that the uptake was improving, and there was some evidence that indicated this, but this cannot be compared directly with the verified data.

The practice had improved the processes for contacting patients to invite them for screening, and to follow up if they did not respond. There was now a dedicated staff member, and processes had been made more efficient, with text messages sent in batches rather than individually. All patients received at least two invitations, by different methods, and had alerts on their records so that clinical staff could engage with patients opportunistically.

Following a successful trial, patients now had the option to book appointments online directly from a text message reminder. Staff told us that this had increased uptake significantly such that all of the appointments slots for cervical screening made available during the trial were fully booked, and patients had booked who had not responded to other types of messages for more than 5 years.

Data on uptake was reviewed every three months by the partners.

The Lead Nurse had recently completed a Masters in Public Health. There were plans for patient health campaigns, including on cervical screening. Nurses had already participated in a public health forum.

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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice carried out 30 audits in the previous 3 years, of which 21 were two-cycle audits (which check what improvement has been made following changes from the first cycle).</p> <p>Areas audited included prescribing, medicines use (including antibiotics and controlled drugs) and speed of cancer diagnosis.</p> <p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice carried out audit to improve the prescribing of short-acting inhalers for people with asthma.</p> <ul style="list-style-type: none"> Patients identified as receiving more than 6 prescriptions (of 2 inhalers at a time) were contacted and offered assessment of their asthma control. Patients then had a review with the asthma nurse or one of the pharmacy team. Progress was tracked and data reviewed after 3 months. This showed that there had been engagement with 15 of 19 patients. However, 11 of these 15 patients had subsequently ordered/been prescribed further short-acting inhalers. The practice recognised that further action was needed. The practice invested in additional training for clinical staff, requested and received additional support from the local respiratory team, updated process documents to take into account the latest guidelines – with a specific template for consultations on the over-use of short-acting inhalers. Asthma reviews were only booked with staff who had received the additional training. Searches were run every 4 weeks. The practice had not yet carried out a formal second audit, but the practice shared data showing that the majority of patients had received a review using the new protocols and prescriptions for short-acting inhalers had been reduced. The practice had plans for further improvement, including cascading training to all staff and investment in Fractional Exhaled Nitric Oxide (FeNO) testing. <p>The practice had identified diabetes as an area in need of improvement, following back-logs in care caused by the Covid-19 pandemic.</p> <ul style="list-style-type: none"> The practice engaged with colleagues in the local area to plan the approach and set up a working group. A structured search was used to identify patients in need of support and dedicated administrative support put in place. There were joint meetings with a diabetic consultant. 80 patients attended an education meeting, with external speakers. At the activity the practice was ranked 33rd out of 48 local practices using a measure in place locally of patients who had received all of the expected care to manage their diabetes and reduce the risk of complications. As a result of the activity, patient care had improved such that the practice was ranked 9th of 46 practices (at a time when other practices were also trying to improve). <p>The practice had undertaken a two-cycle audit focusing on the early diagnosis of cancer.</p> <ul style="list-style-type: none"> After the first cycle the practice took action in an effort to improve early cancer diagnosis by improving learning amongst clinicians, increasing awareness of the urgent referral pathway and ensuring safety netting of two week wait referrals. The practice had improved the proportion of those who were diagnosed using the urgent referral pathway from 90% at the first cycle to 100% at the second cycle. The proportion of cancers diagnosed at stages 1 or 2 increased from 90% at the first cycle to 100% at the second cycle. 	

The practice had also completed numerous prescribing reviews and had a system in place to supervise the practice paramedic and clinical pharmacist.

Effective staffing

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

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

Coordinating care and treatment

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

	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 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>From a review of notes where a DNACPR decision had been recorded, we found that where possible the patient's views had been sought and respected and information had been shared with relevant agencies.</p> <p>When we inspected in 2021 one member of the nursing team was not able to outline the legislation around assessing the ability of patients under 16 to consent to care and treatment. At this inspection we saw evidence that the practice had worked to improve the nursing team's familiarity with requirements around capacity and consent and we had no concerns following our discussions with staff.</p>	

Caring

Rating: Good

There was positive feedback from patients about how staff treated people. There was also some mixed and negative feedback, including from the national GP patient survey.

The practice had an action plan in place to improve patient satisfaction. There was some evidence that indicated that the actions taken were beginning to improve patient perceptions, as the most recent feedback available was more positive.

Kindness, respect and compassion

Feedback from patients was generally positive about the way staff treated people, with most patients saying that staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

Patient feedback	
Source	Feedback
NHS Choices	<p>In 2021 we noted that feedback related to the care and compassion shown by practice staff was mixed; with some reports of excellent clinical care. Most of the negative reviews related to the attitude of the reception staff.</p> <p>Since the last inspection there were 11 further reviews of the practice on the NHS Choices site. Of the 11: seven reviewers were wholly negative and four were positive. The negative reviews related to the attitude of reception staff and appointment availability. The positive reviews described staff as helpful and friendly and gave accounts of timely and responsive care.</p> <p>The four positive reviews were all the most recent, posted after July 2022.</p>
Feedback to CQC	<p>We received feedback from three patients in the last 12 months, which were all negative. Two related to clinical care and one was about reception staff.</p>
Friends and Family Test	<p>The practice used the Friends and Family Test to get feedback from patients. Between April and September 2022, the practice received 134 responses. Overall 88% said that they would be likely to recommend the practice, with 49% of these saying this was very likely.</p> <p>There were lots of positive comments describing staff (clinical and non-clinical) as friendly, helpful, and caring. Only two patients gave negative feedback about how staff behaved. One related to reception staff, the other did not specify which staff group it related to.</p>

	The practice reviewed feedback and used it as part of monitoring.
--	---

National GP Patient Survey results

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	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)	77.6%	86.4%	84.7%	No statistical variation
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)	70.1%	84.8%	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)	94.0%	94.0%	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)	52.0%	77.0%	72.4%	Tending towards variation (negative)

Any additional evidence or comments

National GP Patient Survey results for the practice were lower than at the time of the last inspection, although this was in the context of lower results nationally.

The practice had reviewed the national GP patient survey results and had an action plan in place to improve patient satisfaction, which was being monitored.

East Croydon Medical Centre was currently based in the premises of another practice, while new premises were built, limiting the number of face-to-face appointments that could be provided. The new building had been delayed. The practice believed that this had a significant impact on the 2022 National GP Patient Survey results. We saw some evidence for this in the comments of the Friends and Family Test.

Staff told us that when in the new building all appointments would be face-to-face, unless patients requested otherwise, and that there would be fewer locum GPs used – making it easier to build a rapport with patients.

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence

At the time of the last inspection, we noted that the practice had made changes in response to patient feedback, but had not sought feedback to monitor whether these were improving patient satisfaction.

In July 2022, the practice carried out its own survey. This was sent to 5918 patients and 300 patients responded (5%). 70% said that they were satisfied with the care received (rating it as four or five on a five-point scale) and 58% said that they were happy with the reception staff.

The practice had reviewed the results and had an action plan in place to improve satisfaction.

Actions taken to improve how patients perceived staff included:

- Improving the induction system
- Specific training for clinical and non-clinical staff on subjects including customer services, call handling and dealing with difficult customers
- Audits of calls to provide feedback and training for reception staff.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

National GP Patient Survey results

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	England comparison
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)	90.5%	90.8%	89.9%	No statistical variation

	Y/N/Partial
--	-------------

Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	<p>The practice had identified 236 patients who acted as carers in October 2021 (1% of the practice population).</p> <p>This was an increase from the last inspection (when 0.8% had been identified).</p>
How the practice supported carers (including young carers).	The practice sent carers texts to inform them of eligibility for both flu and covid 19 vaccinations. Carers were offered annual health checks and we were told that during the pandemic the Primary Care Network social prescriber contacted all of the practice's carers to provide advice about support services and information on how to access carers allowance. There was information on the practice's website which directed carers to local support services.
How the practice supported recently bereaved patients.	If families experienced bereavement, their usual GP contacted them or sent them bereavement support information. This call was either followed by patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw information on support services was available to patients.

Privacy and dignity

The practice recognised the importance of respecting patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Partial
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had included a question on their survey about whether patients felt they had had enough privacy when talking to reception staff, 57% of patients said yes.</p> <p>The practice had reviewed this and taken steps to improve confidentiality at the reception desk.</p> <p>At the time of the inspection, East Croydon Medical Centre was based in the premises of another practice, while new premises were built. This meant that it was not always possible to offer patients a private room, because of the space restrictions at the time of the inspection. Partners told us that there would be considerably more space when the new building was finished.</p>	

Responsive

Rating: Good

Responding to and meeting people’s needs

The practice understood the needs of its local population and taken steps to organise services to meet these, although this was currently challenging.

At the time of the inspection, East Croydon Medical Centre was based in the premises of another practice, while new premises were built, limiting the number of face-to-face appointments that could be provided.

The practice had an action plan in place and the impact of actions was being monitored. There was some evidence that indicated that the actions taken were beginning to improve patient perceptions, as the most recent feedback available was more positive.

Staff told us that once in the new building (in 2023) all appointments will be face-to-face unless the patient chooses to have a telephone consultation.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection, East Croydon Medical Centre was based in the premises of another practice, while new premises were built, limiting the number of face-to-face appointments that could be provided.</p> <p>Most patients initially received a telephone consultation, but some patients always received a face-to-face appointment based on their circumstances. Approximately half of all consultations provided were face-to-face.</p> <p>The new building had been delayed, but it was envisaged that it would be complete by 1 April 2023. At this point, the partners told us that all appointments would be face-to-face unless the patient chooses to have a telephone consultation.</p> <p>The practice had an action plan in place and the impact of actions was being monitored. There was some evidence that indicated that the actions taken were beginning to improve patient perceptions, as the most recent feedback available was more positive.</p> <p>Staff told us that once in the new building (in 2023) all appointments will be face-to-face unless the patient chooses to have a telephone consultation.</p>	

--

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00 am – 6:30 pm
Tuesday	8:00 am – 6:30 pm
Wednesday	8:00 am – 6:30 pm
Thursday	8:00 am – 6:30 pm
Friday	8:00 am – 6:30 pm
Appointments available during these times.	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• 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 home visits and 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.• Additional nurse appointments were available out of school hours so that children did not need to miss school.• Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.• The practice was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, including on Saturdays, as the practice was a member of a GP federation.• The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and 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 Travellers.• The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

There was mixed feedback from patients about access. There was positive feedback, but also negative feedback, including from the national GP patient survey.

The practice had an action plan in place to improve patient access.

	Y/N/Partial
--	-------------

Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection, East Croydon Medical Centre was based in the premises of another practice, while new premises were built, limiting the number of face-to-face appointments that could be provided.</p> <p>Most patients initially received a telephone consultation, but some patients always received a face-to-face appointment based on their circumstances. Approximately half of all consultations provided were face-to-face.</p> <p>The new building had been delayed, but it was envisaged that it would be complete by 1 April 2022. At this point, the partners told us that all appointments would be face-to-face unless the patient chooses to have a telephone consultation.</p> <p>The practice had invested in a tool that allowed staff to monitor appointment usage. We looked at the most recent week's data. This showed that there were some appointments that had not been used. Staff told us some weeks there are surplus appointments and other weeks not, and that the information was being used to adjust the appointment system.</p> <p>Staff we spoke to told us that the new practice manager had their attended team meetings to discuss the appointment system and invite their input into how it could be improved.</p> <p>At the last inspection, a number of staff we spoke with suggested that the reception team would benefit from additional support. The practice told us that they were trying to recruit more staff for the reception team. At this inspection, staff told us that there had been considerable recruitment, with non-clinical staffing levels described as higher than ever. Staff described stronger support in place, with the recruitment a new practice manager and a full-time human resources manager and operations managers.</p> <p>The Patient Participation Group (PPG) representative told us that data shared by the practice indicated significant improvement in access and that this was supported by anecdotal information. The PPG representative suggested that this was due to increased staffing and the new telephone system. The new telephone system had additional features for patients, such as announcements about queue position, and allowed staff better monitoring data.</p> <p>The practice was piloting a new approach: letting patients leave a voice message with their request rather than wait in a queue. Patients who asked for an appointment were sent details of the slot booked by text message, or were telephoned to discuss who their needs could be best met. Staff we spoke to said that this seemed to be working well.</p> <p>The practice told us that they were looking at other ways to improve access, including:</p> <ul style="list-style-type: none"> • better use of the NHS Community Pharmacist Consultation Service (CPCS) 	

- online consultation options
- triage templates for Reception staff and at
- other tools to allow access to be monitored and audited.

National GP Patient Survey results

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	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)	37.9%	N/A	52.7%	No statistical variation
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)	35.7%	61.1%	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)	31.1%	60.1%	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)	40.5%	72.5%	71.9%	Significant variation (negative)

Any additional evidence or comments

National GP Patient Survey results were lower than in 2021, although they were also lower nationally.

The practice had reviewed the national GP patient survey results and had an action plan in place to improve patient satisfaction with access, which was being monitored.

Since the 2022 National GP Patient Survey the practice had increased clinical and non-clinical staffing and upgraded the telephone system.

In the practice's own survey, run after the changes were made, 57% of patients rated the experience of booking an appointment as generally positive (by choosing to rate it as 4 or 5 on a 5-point scale, where 5 is happy). 62% said that they were able to get a satisfactory appointment/consultation.

In the Friends and Family Test, several patients said that access had improved.

Practice-based surveys and the Friends and family Test cannot be compared directly to the nationally-run, verified, survey.

At the time of the inspection, East Croydon Medical Centre was based in the premises of another practice, while new premises were built, limiting the number of face-to-face appointments that could be provided. The new building had been delayed. The practice believed that this had a significant impact on the 2022 National GP Patient Survey results. We saw some evidence for this in the comments of the Friends and Family Test.

The practice reviewed the survey results and had an action plan in place to improve patient satisfaction with access, which was being monitored.

Patient feedback	
Source	Feedback
NHS Choices	<p>In 2021 we noted that feedback related to the care and compassion shown by practice staff was mixed; with some reports of excellent clinical care. Most of the negative reviews related to the attitude of the reception staff.</p> <p>Since the last inspection there were 11 further reviews of the practice on the NHS Choices site. Of the 11: seven reviewers were wholly negative and four were positive. The negative reviews related to the attitude of reception staff and appointment availability. The positive reviews described staff as helpful and friendly and gave accounts of timely and responsive care.</p> <p>The four positive reviews were all the most recent, posted after July 2022.</p>
Friends and Family Test	<p>The practice used the Friends and Family Test to get feedback from patients. Between April and September 2022, the practice received 134 responses. Overall 88% said that they would be likely to recommend the practice, with 49% of these saying this was very likely.</p> <p>Feedback on access was missed, with positive comments about telephone access and appointments, but others that describe difficulties with making appointments and delays in appointment times. A number of patients commented that they were disappointed not to be able to choose a face-to-face appointment and were looking forward to the move to the new building when more would be available.</p> <p>The practice reviewed feedback and used it as part of monitoring.</p>

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	30
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
<p>The provider of this service runs two GP practices: East Croydon Medical Centre and Edridge Road Community Health Centre. Complaints were managed and monitored across the two services. This number is the number of complaints received by both services.</p> <p>At the last inspection we noted that complaint responses did not include details of organisations patients could escalate concerns to if they were unhappy with the practice's response. This information was given in the responses we looked at during this inspection.</p>	

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaints about attitude of members of the reception team	There were several complaints about reception staff. Patients who complained received an apology. More reception staff were recruited and all staff received customer service training. The practice introduced a system of regular call audits, to give reception staff feedback on their performance.
A patient saw a paramedic. The paramedic sent a prescription for the patient to a GP for signing but this was not signed on the same day. The patient chased this up and was given incorrect information by the reception team.	The patient was sent an apology. The protocol for prescriptions requested by paramedics and physician associates was changed to reduce the risk that prescriptions get 'missed'.

Well-led

Rating: Good

In 2021 we rated the service as requires improvement for being well led because:

- Some staff reported that some of the partners were dismissive and unsupportive which impacted on the practice culture.
- Governance arrangements did not operate effectively in key areas relating to risk and safety
- Although engagement had been attempted with patients via a recent PPG meeting and the practice had made changes in response to patient feedback; there was little evidence that patient feedback had subsequently been sought to identify if action taken had addressed patient concerns.

At this inspection we found improvements and have rated the service as good for this key question.

There was a new management team. Some systems were quite newly-implemented or were being implemented during the inspection, and some weaknesses that had been identified were still being addressed, but action plans were in place and risks were being formally monitored.

Leadership capacity and capability

In 2021, staff feedback on leadership within the practice was mixed and a failure to identify some areas of concern we found during the inspection indicated a lack of oversight.

At this inspection, we noted actions to improve the visibility of leaders and the support for staff. Weaknesses in oversight had been identified and were being addressed.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At the last inspection, we found that leaders within the practice did not have sufficient oversight to enable them to identify some of the concerns raised on inspection. Some staff reported that members of the partnership were not always visible or approachable and could be dismissive of staff concerns. At this inspection, we saw evidence of effective efforts to improve systems and processes. Some issues found at last inspection had been fully resolved – there were no issues with emergency equipment, vaccine fridges or complaints, and no concerns about management of medicines or long-term conditions management from clinical review. The partners had recognised a need to strengthen the management team, and had recruited a new practice manager and a full-time human resources manager and operations manager. There was a clear, documented management structure. Feedback suggested that the new management team had improved the support for staff. Efforts had been made to improve internal communication and cohesion, with regular, documented meetings of nursing, admin, clinical, and reception teams, plus management meetings and meetings of the partners and of the full staff. Staff told us that the new practice manager had attended meetings of the different teams to get to	

know them and their work, and to ask how things could be improved. Methods of communication across the practice had been standardised, with a weekly update email and timely meeting minutes sent to attendees and those who could not attend. The partners had organised social events, including a summer and Christmas parties, an annual Culture Diversity Day and a Secret Santa. The practice was linked, through a Royal College of GPs scheme, with a local park run (a free, weekly 5k event, in areas of open space).

The practice had recognised that administrative staff in a separate building felt isolated from the rest of the practice. A partner and the operations manager now worked from the administration building regularly. There was a weekly midday exercise class there.

The management team had assessed the service. Weaknesses we identified during the inspection had already been recognised and there were action plans in place to address them.

The management team were able to describe further improvements to systems and processes that were planned and we saw some of these being implemented during the inspection process.

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:	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the last inspection, most staff said that they were happy working at the practice and that they felt well supported. However, some staff told us that they felt that members of the partnership were dismissive and combative, that they did not feel valued and were not always confident that concerns raised would be acted upon.</p> <p>For this inspection, in addition to staff interviews we sent a questionnaire directly to all staff members.</p>	

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

Source	Feedback
Staff questionnaires and interviews	<p>Staff described a friendly atmosphere and supportive colleagues.</p> <p>Almost all staff told us that they would feel comfortable raising concerns and most said that they there was a strong emphasis on the safety and well-being of staff.</p> <p>Staff we spoke to said that the new management structure meant that there were more options for raising concerns or queries and that it was now clearer how to get things addressed.</p>

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that although the practice had good systems and processes in most respects which ensured that patients received good quality clinical care; the systems related to the management of vaccines and emergency equipment needed further refinement.</p> <p>We found no issues with vaccine management or emergency equipment at this inspection.</p> <p>There was a new management team. Some systems were quite newly-implemented or were being implemented during the inspection, and some weaknesses that had been identified were still being addressed.</p>	

We asked the provider for a summary of staff training in safeguarding children and vulnerable adults. All staff, with the exception of one still completing their induction, had completed training to an appropriate level for their role. However, we noted that 25% (17 of 68 staff across this service and the second managed by this provider) had completed safeguarding children and vulnerable adults training after the inspection was announced.

Staff told us that access to training records on the computer system had been lost, following a staffing change.

The practice now used an online system to track staff training and store evidence of completion, and there had been a drive to get outstanding training completed, with staff given allocated time.

Staff told us about new measures that had been put in place to ensure training was completed promptly by new staff and then repeated as expected, including protected time induction, the use of automatic reminder emails, and clear protocols to follow up staff who do not complete training when reminded.

We also saw evidence of safeguarding logs in which clinical and non-clinical staff recorded meetings and other events towards the expectations of national guidance.

Managing risks, issues and performance

The practice had clear processes for managing risks, issues and performance. Some systems were quite newly-implemented or were being implemented during the inspection.

Most of the weaknesses that we identified at previous inspections had been effectively addressed. Some weaknesses were still being addressed, but action plans were in place and risks were being formally monitored – in a more sustainable way than we observed at the last inspection.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we noted that assurance systems in relation to vaccine cold chain and the maintenance of appropriate emergency equipment were lacking.</p> <p>We found no issues with vaccine management or emergency equipment at this inspection.</p>	

We did identify some areas of risk that were not fully mitigated. These are described in the Safe section of the evidence table, including gaps in recruitment records and staff immunity records. We reviewed these matters with staff and through documentation and were assured that the extent of the risks had been identified, and there were actions in place to manage and mitigate the risks. Issues had been recorded on a formal risk log and were being monitored.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the last inspection, we found that the practice generally used data and information effectively but there were some areas where it appeared that there was insufficient oversight. These had been recognised and had either been addressed (for example, emergency medicines management) or were being addressed, following a thorough assessment of the issue and the underlying causes (for example, gaps in training evidence).</p> <p>The practice had also strengthened the data and information used for monitoring in other areas, including audits of remote consultations and of calls to the practice and of childhood immunisations and cervical screening uptake.</p>	

Governance and oversight of remote services

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

Staff are supported to work remotely where applicable.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the last inspection we noted that the practice had made changes to services on the basis of the national GP patient survey however they had not undertaken their own survey of patients to determine if changes made had improved patient feedback.</p> <p>At this inspection there was evidence of further substantive efforts to improve services, particularly by increasing the level of reception staffing and the skills of these staff. The practice had carried out its own survey and were using the Friends and Family Test to assess whether patient satisfaction had improved. Feedback was mixed, and practice but there was some evidence that patients had noted and appreciated the improvements made.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We received feedback from a representative of the practice Patient Participation Group (PPG). There is currently one group running, which meets to discuss the two GP practices run by the same provider, which are both operating at present from the same premises.</p> <p>The representative told us that the practice shares updates on survey results, actions being taken, and key developments and activities at the practice with the PPG. The representative said that the practice asks for feedback and suggestions about future developments. For example at the last meeting the PPG received feedback about the drop-in/social sessions they held for carers, and asked for input on other patient groups that might benefit from a focussed session where they can meet other patients with common issues and also listen to speakers and meet practice staff, such as social prescribers.</p>

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement
At the last inspection we noted that the practice had an extensive programme of clinical review and audit.
At this inspection we saw that the practice was extending the culture and methodology of continuous learning and improvement to other, non-clinical, areas of the practice.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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