

Care Quality Commission

Inspection Evidence Table

Charlton House Medical Centre (1-10893062639)

Inspection date: 23 March 2022

Date of data download: 08 April 2022

Overall rating: Not Rated

Safe

Rating: not rated

Safety systems and processes

The practice did not have 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.	N
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in September 2021 we found:</p> <ul style="list-style-type: none">The practice had appointed a safeguarding lead for the protection of both vulnerable adults and children. The practice had created a list of postholders for lead roles within the practice and added the safeguarding leads name. Copies of the leads list were in the GP locum packs and displayed on the practice notice board. However, shortly after our inspection visit, on 27 September 2021, CQC received an email from the new clinical lead advising that he had reviewed his position and decided to withdraw from working at the practice with effect from 28 September 2021. <p>At this inspection we found:</p> <ul style="list-style-type: none">Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient clinical records system which, had it chosen to, would have enabled it to review and develop appropriate policies and procedures and a programme of quality improvement including a full range of clinical audit. However, the provider had only very recently chosen to first seek access on 14 February 2022.The practice had not replaced the safeguarding lead who resigned from the practice in September 2021.	

Information to deliver safe care and treatment

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

	Y/N/Partial	
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial	
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N	
Explanation of any answers and additional evidence: At our September 2021 inspection: <ul style="list-style-type: none">• We had, during our June 2021 inspection, made the practice aware of a cohort of 15 patients who were being prescribed high-risk medicines, but who were not receiving the appropriate level of monitoring to ensure they were receiving safe care and treatment, this included a failure to monitor test results and to ensure these were on patients records prior to continuing to prescribe high-risk medicines. We found 11 out of 15 patients had not been appropriately reviewed. On further review of those patients we found a range of new issues of serious unsafe care, including:<ul style="list-style-type: none">○ Asthma: patients being prescribed up to 30 SABA inhalers in 12-month periods, lack of prescribing appropriate preventer inhalers where patients are on high level of use of SABA inhalers; lack of/inaccurate annual asthma reviews; lack of education plans, enhanced management and no asthma plan on notes for patient on high level usage of SABA inhalers; failure to undertake diabetic foot checks; and prescribing asthma medicines without required blood tests for renal function.○ Failure to follow-up patients who fail to respond to requests for review/blood tests/monitoring.○ No follow-up of patient blood test results showing abnormal raised blood platelets.○ Heart failure – not receiving heart failure reviews.○ Some patient notes record patient is not in UK some medicines continuing to be prescribed.○ Overdue blood tests – patient being prescribed diuretic requiring renal function tests.○ Anaemia – failure to follow up test results indicating anaemia.• We saw minutes of two clinical meetings. These showed: clinical staff including GPs, GP locums and nurses attended the meetings; and a standing agenda had been developed which included: significant events, clinical alerts, training, safeguarding and complex cases. We also saw evidence of practice meetings. However, we saw no evidence of discussion of complex cases or of complex cases which would be discussed within multidisciplinary meetings where expertise from other specialisms would be able to provide support with decision making and in providing appropriate and optimal care.• Shortly after our inspection the clinical lead resigned from the practice. At this inspection <ul style="list-style-type: none">• Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient clinical records system which would, had it chosen to, have enabled it to review and develop appropriate policies and procedures. However, the provider had only very recently chosen to first seek access on 14 February 2022.		

- The practice was aware of the need to monitor patients receiving prescribed medicines including maintaining oversight of test results and ensuring these were appropriately reviewed, entered onto the patient record and acted upon. We were shown a 'Records Management Policy' dating from 2016. However, there was no evidence it had since been reviewed and amended to ensure it met the current needs of patients of the practice.
- Without appropriate and up to date policies and/or procedures to guide clinical and non-clinical staff in reviewing and acting on test results patients would be exposed to harm or a risk of harm.
- the practice had not recruited a clinical lead following the last clinical leads resignation in September 2021. This left the practice without appropriate clinical leadership to ensure clinical staff worked to appropriate standards.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
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. appropriately review patients receiving repeat prescriptions.	N
<p>Explanation of any answers and additional evidence:</p> <p>At our June 2021 inspection:</p> <ul style="list-style-type: none"> • We provided the practice with a list of 15 patients, identified as part of a sample of clinical records reviewed. We found elements of their care and treatment to be unsafe such that those patients were exposed to harm or a risk of harm. <p>At our September 2021 inspection we found:</p> <ul style="list-style-type: none"> • The practice had failed to appropriately review the care and treatment provided for 11 of the 15 patients. In addition, new issues of more serious unsafe care were identified. Remaining concerns amongst these patients included significant over-prescribing of inhalers to patients with asthma, and a failure to appropriately monitor patients being prescribed high-risk medicines. • Within the cohort of 15 patients, two patients, out of three identified at our June 2021 inspection were still being prescribed methotrexate. Only one of those two patients had received a blood test prior to receiving their most recent prescription for methotrexate. • Methotrexate is among a group of medicines known as 'high-risk' medicines due to the need for regular monitoring of patients to whom it is prescribed. It is a medicine that is prescribed for patients with Dermatology, Gastroenterology, and Rheumatology problems. There is a requirement for monitoring for blood dyscrasias and liver damage. There is a requirement for monitoring throughout treatment. The requirement is to monitor a full blood count (FBC), renal and liver function tests. Initial monitoring is more frequent than routine monitoring based on 	

secondary care guidance for example, every one to two weeks after initiating treatment. Thereafter, routine monitoring must occur at least every three months. Failure to adhere to national clinical guidance and standards, without good reason, puts patients at significant risk of harm.

At this inspection we found:

- The practice was aware of the risk of harm and potential to expose patients to harm of failing to monitor its repeat prescribing to patients, including those being prescribed high-risk medicines.
- We were shown a policy, 'High Risk Medicine Monitoring Policy', the practice advised it had developed to ensure clinicians working at the practice followed guidelines when repeat prescribing high-risk medicines? We noted the policy was dated 'Summer 2021' so had not been effectively implemented to guide the practice in resolving monitoring issues for patients during the period between our June and September 2021 inspections.
- We were also shown a 'High-Risk Medicine Monitoring Workflow' spreadsheet which the practice told us it had implemented over a year prior to our March 2022 inspection. The purpose of the spreadsheet was to record patients due to receive monitoring. It would be regularly reviewed by either the clinical lead or a dedicated administrator. However, if, as the practice told us, this spreadsheet had been in operation at the time of our previous inspections where we found unsafe care of patients prescribed high risks medicines it was ineffective. The practice had not developed any new means of ensuring patients prescribed high risk medicines received regular and necessary monitoring to keep them safe.

Effective

Rating: Not Rated

QOF requirements were modified by NHS England 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.

Management of people with long term conditions

Findings

At our September 2021 inspection:

- We reviewed practice performance for care of patients with long-term conditions by reference to its recorded Quality Outcomes Framework (QOF). QOF is a system for the performance management and payment of general practitioners in the National Health Service. At that time the practice was performing significantly below the target performance for most patients with long-term conditions. For example:
 - 45% of patients aged 79 years or under with coronary heart disease had a last blood pressure reading (measured in the preceding 12 months) of 140/90 mmHg or less, compared to a target of 72%.
 - 50% of patients aged 80 years and over with coronary heart disease and a blood pressure reading of 150/90 mmHg or less compared with a target of 86%.
 - 34% of with diabetes, on the register, without moderate or severe frailty had a last HbA1c of 58 mmol/mol or less, indication a poorer level of control, in the preceding 12 months compared to a target of 75%.
 - The practice had improved its performance for patients with atrial fibrillation: 83% of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, were currently being treated with anti-coagulation medicine therapy which was above the target of 70% of patients.

At this inspection we found:

- Since our last inspection the provider had been subject to a suspension and clinical work had been conducted by a caretaker practice. Accordingly, it would not be a measure of the providers efforts to review QOF performance at this inspection. Instead, we concentrated on reviewing previously identified performance issues and what action the provider had taken, and intended to take, to resolve the issues and prevent them from recurring in the future.
- Despite being aware of its significantly below local and national average clinical performance, as measured by QOF, the practice was unable to identify any priority areas to concentrate its initial efforts to improve clinical performance. There was no evidence of a QOF performance remedial plan in order to prioritise the resolving of issues for the most vulnerable patient groups before addressing the issues for less vulnerable patients.
- The practice had not developed and/or updated policies or procedures for clinical work as measured by QOF. Without policies and/or procedures clinical staff would not have the necessary guidance to

ensure they worked to an appropriate standard to ensure patients were not exposed to harm or a risk of harm.

- The practice told us it thought it needed a dedicated team within the practice to manage QOF work. This would include a lead for each area. However, it had not identified and recruited suitable clinical and non-clinical staff to take responsibility for this work or developed a clear plan to mitigate this significant area of risk for patients.

Responsive

Rating: Not Rated

Responding to and meeting people's needs

The practice Services did not meet patients' needs.

	Y/N/Partial	
The practice understood the needs of its local population and had developed services in response to those needs.	N	
Explanation of any answers and additional evidence: At our last inspection: <ul style="list-style-type: none">The practice advised it had a group of patients who regularly travelled abroad for parts of the year without informing the practice they were going to be away. It told us it experienced difficulty in contacting those patients to ensure they underwent necessary clinical monitoring including any necessary blood monitoring and testing that may be required. At this inspection we found: <ul style="list-style-type: none">Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient records system which, had it chosen to, would have enabled it to review and develop appropriate policies and procedures and a programme of quality improvement including a full range of clinical audit. However, the provider had only very recently chosen to first seek access on 14 February 2022.The practice had not carried out audits of its patient population to help identify patient groups that would benefit from enhanced monitoring, including those who spent time outside of the country. It told us some patients regularly travelled abroad and continued, whilst abroad, to receive prescriptions via the Electronic Prescription Service (EPS). Their prescriptions were often collected on their behalf by relatives, so the practice was not aware whether patients were in the UK or abroad.Despite being aware it was failing to adequately monitor prescribing for, and monitoring of, patients, the practice had not developed or updated any policies and/or procedures or programme of clinical audit to enable future clinical and non-clinical staff working at the practice to monitor and review prescription requests. Nor did the practice provide us with any evidence of the education it would give to staff and clinicians to enable them to review prescription requests. Further, it did not have an active clinical lead within the practice to oversee and monitor the implementation and use of a policy and/or procedure for that purpose.		

Well-led

Rating: Not Rated

Leadership capacity and capability

Leaders could not 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.	N
They had identified the actions necessary to address these challenges.	N
Explanation of any answers and additional evidence: At this inspection we found: <ul style="list-style-type: none">• Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient clinical records system which, had it chosen to, would have enabled it to review and develop appropriate policies and procedures and a programme of quality improvement including a full range of clinical audit. However, the provider had only very recently chosen to first seek access on 14 February 2022.• Since our inspection in September 2021 the practice had not developed a programme of clinical audit to monitor and improve practice performance for clinical issues across the patient population.• The practice had not updated existing policies and procedures, or developed new, policies and procedures to guide clinical and non-clinical staff in the running of the practice and which met the current needs of the patient population.• The practice had not developed a programme of education for clinical and non-clinical staff working at the practice to ensure they had the necessary skills to carry out their roles.• Since the resignation of the clinical lead in September 2021 there had been no active clinical lead engaged within the proposed future structure of the practice to ensure future clinical staff worked within practice policies and procedures and national guidelines.	

Vision and strategy

The practice had limited vision, nor did it have a 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.	N
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

At our September 2021 inspection we found:

- The clinical lead had developed a plan to start a review of locum GP consultations. However, there was no active oversight of locums or nurses. However, no reviews had taken place. The appointed clinical lead at the time simply relied on issues being brought to their attention by staff rather than conducting active planned reviews. In addition, shortly after our inspection on 27 September 2021 the new clinical lead notified CQC he was resigning from his involvement in the practice with effect from 28 September 2021. This left the practice with no active clinical leadership placing patients at serious risk of harm.
- The practice was not conducting peer reviews to ensure all clinicians were working to an appropriate standard.
- The practice provided us with copies of: one completed two cycle audit into High opioid prescribing; and the first cycle of an audit of patients with atrial fibrillation but not receiving anticoagulants. However, there was no formal audit plan for the practice or programme of audits to address the priority clinical areas specific to the needs of the practice population identified during our last inspection in June 2021.

At this inspection we found:

- Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient records system which would, had it chosen to, have enabled it to review and develop appropriate policies and procedures and a programme of quality improvement including a full range of clinical audit. However, the provider had only very recently chosen to first seek access on 14 February 2022.
- Following the resignation of the clinical lead in September 2021 there was no active clinical lead to ensure future clinical staff worked within practice policies and procedures and national guidelines.
- The practice had a locum audit policy to review three locum GP consultations per session. However, this did not extend to other clinicians working within the practice including salaried GPs, nurses, HCAs and pharmacists. Nor had the practice developed a policy and/or procedure for active peer review of clinician's work.
- Peer review in a GP practice is an evaluation of a colleague's quality of work. It is measured against a range of information, including patient specific information, practice policies and procedures and local and national guidelines. Its purpose is to encourage quality improvement and consistency amongst the clinical staff.
- At our last inspection the practice had completed one two-cycle audit and started another. However, at this inspection it did not provide us with any evidence of a full programme of clinical audit to monitor and improve clinical care for its patient population of 6,800 people.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Explanation of any answers and additional evidence:	
At our September 2021 inspection we found:	
<ul style="list-style-type: none">• Following our June 2021 inspection, we had issued two warning notices to the practice. Within the warning notices we highlighted to the practice a sample of 15 patients being prescribed high risk medicines who were not receiving necessary monitoring.• When we reviewed those patients during our September 2021 inspection, we found the practice had not reviewed the care of 11 of the 15 patients nor had the practice ensured necessary monitoring of those patients had been undertaken. In addition, new issues of more serious unsafe care were identified as affecting that sample group of patients. We were not assured these patients had received appropriate reviews and monitoring, leaving those patients still exposed to harm or a risk of harm.• Following a review of patient records during our September 2021 inspection we remained not assured the practice was adequately recording the care patients were receiving in secondary care settings.	
At this inspection we found:	
<ul style="list-style-type: none">• Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient clinical records system which would, had it chosen to, have enabled it to review and develop appropriate policies and procedures and a programme of quality improvement including a full range of clinical audit. However, the provider had only very recently chosen to first seek access on 14 February 2022.• We reviewed what the practice had done to improve the future care provided for patients within the same clinical cohorts as the sample group of 15 patients identified in our June and September 2021 inspections. For example:<ul style="list-style-type: none">○ At our previous inspections we had identified concerns surrounding patients with asthma who were being over-prescribed salbutamol inhalers with some being prescribed 24 salbutamol inhalers within a 12-month period, which amounted to double the maximum number of such inhalers recommended by national guidelines. Salbutamol is used to relieve symptoms of asthma and chronic obstructive pulmonary disease (COPD) such as coughing, wheezing and feeling breathlessness.○ The practice was aware of the health risks associated with poorly controlled Asthma. Despite being aware of sources of information and of monitoring templates available, the practice had not prepared or revised a suitable policy and/or procedure to appropriately manage the future care of patients with asthma.○ At our previous inspections we had identified concerns surrounding patients being prescribed high-risk medicines. The practice was aware of the importance of monitoring patients being prescribed high-risk medicines. High-risk medicines are a group of medicines which have a heightened risk of causing significant patient harm when they are used in error, and so require extra monitoring including, for example, regular blood tests.	

We had previously drawn the practices attention to a cohort of patients being prescribed high risk medicines, including methotrexate, bumetanide, lithium and levothyroxine.

- During this inspection the practice expressed an understanding of the need for appropriate monitoring of patients being prescribed high risk medicines. However, it had not developed, or updated policies and/or procedures to meet the needs of patients being prescribed high risk medicines, including ensuring they would receive adequate and appropriate monitoring. Nor had the practice devised or considered an appropriate education programme to ensure clinicians working in the practice in the future were aware of the monitoring required.
- At our previous inspections we had identified concerns surrounding patients with heart failure. The practice was aware of the importance of annual blood pressure monitoring for patients with heart failure. Despite this awareness it was not able to show any evidence of the education it would provide to staff and clinicians to enable them to review such patients and ensure they received appropriate regular monitoring.
- At our previous inspections we had raised concerns about the monitoring of patients with abnormal raised levels of C-reactive protein level (CRP). The practice was aware of the monitoring and appropriate action to take for patients whose blood tests showed abnormal raised levels of CRP. The only policy the practice was able to provide to us was a 'Dealing with Laboratory Results' policy which was dated 2014 and did not appear to have been updated to meet the current needs of the practice population. Nor was the practice able to show any evidence of the education it would provide to staff and clinicians to enable them to review such patients and ensure they received appropriate regular monitoring.
- At our previous inspections we had identified concerns surrounding patients with diabetes. The practice was aware of the importance of monitoring and appropriate prescribing for patients with diabetes. However, despite our highlighting the risks to patients with diabetes during our previous inspections, the practice had not developed an appropriate policy and/or procedure to ensure future appropriate monitoring and care. Nor did the practice provide us with any evidence of an education programme for clinical and non-clinical staff to enable them to appropriately monitor and care for patients with diabetes.
- At our previous inspections we had identified concerns surrounding patients being prescribed controlled medicines. For example, one patients' record showed evidence of medication reviews taking place, however there was no evidence on the patients record of any discussion with the patient about the controlled medicines they were being prescribed. Controlled medicines are subject to strict legal controls because their use may result in addiction if they are not prescribed and used appropriately, including regular medication reviews.
- The practice was aware of the need for monitoring of patients being prescribed controlled medicines such as, tramadol and co-codamol. However, despite being aware of the importance of medication reviews the practice had not developed an appropriate policy and/or procedure to ensure future clinical and non-clinical staff working at the practice would have clear guidance on arranging, undertaking and recording appropriate medication reviews on patients' records. Nor were we provided with any evidence of the education the practice intended to provide to staff and clinicians to enable them to arrange, undertake and record appropriate medication reviews.
- At our last inspection we had identified patients whose blood tests indicated they had anaemia. Anaemia is a condition in which patients lack enough healthy red blood cells to carry adequate oxygen to their body's tissues. Since our last inspection the practice had not developed an appropriate education programme it would provide to staff and clinicians to enable them to review such patients and ensure they received appropriate regular monitoring.

- At our previous inspections we had identified concerns surrounding patients with long-term conditions, including Coronary Heart Disease and Hypertension, Diabetes and Mental Health issues. The practice was aware its performance for care of patients with long-term conditions was significantly below local and national averages. Despite being aware of its poor performance the practice had not developed appropriate policies and/or procedures and clinical audits to ensure appropriate monitoring and care for these patient groups. Nor were we provided with any evidence of an education programme the practice intended provide to staff and clinicians to fit them for their roles.
- Despite having time and opportunity to prepare to resume its role as provider of services, the practice had failed to take timely and appropriate action to prepare for its responsibility to the practice population. Action the practice could have taken included:
 - developing a range of suitable policies and procedures to ensure clinical and non-clinical staff worked to appropriate standards to meet the needs of the patient population;
 - a programme of quality improvement including a range of clinical audits to monitor and help to improve performance;
 - a developed plan to appoint key personnel including a clinical lead to oversee and direct clinical staff;
 - a plan to prioritise its work to give maximum effort to improving patient care for the most vulnerable groups;
 - identifying relevant education and training courses to meet the learning needs of clinical and non-clinical staff to enable them to implement the governance structures and systems.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Explanation of any answers and additional evidence:	
<p>At our September 2021 inspection we found:</p> <ul style="list-style-type: none"> The newly appointed clinical lead planned to introduce a system for supervision of clinical staff. However, it relied on clinicians raising areas of concern, rather than actively discussing issues. In addition, shortly after our inspection visit, on 27 September 2021, the new clinical lead contacted CQC to advise he had re-considered his position and was withdrawing from his role with the practice. This left the practice with no active clinical leadership and placing staff and patients at risk of harm. The practice had undertaken one completed two-cycle audit, together with a first cycle of a second audit. However, there was no formal audit plan for the practice or programme of audits to address the priority clinical areas specific to the needs of the practice population identified during our last inspection in June 2021. <p>At this inspection we found:</p> <ul style="list-style-type: none"> Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population. We noted that despite its suspension the provider had been given unrestricted access to view the patient records system which would, had it chosen to, have enabled it to take action to prepare to resume its role of provider. However, the provider had only very recently chosen to first seek access on 14 February 2022. Shortly after our last inspection the then newly appointed clinical lead resigned from the role and left the practice. The practice had not appointed a replacement. A GP clinical lead combines undertaking clinical work within a GP practice together with having dedicated time to ensure the practice offers high quality safe patient care, the clinical lead takes responsibility for governance and the development of the practice. The practice had not used its time, whilst suspended, to develop an appropriate quality improvement programme, including a programme of clinical audit to monitor and help improve care for the patient population. There were no plans for an education programme to fit staff for their roles. The practice did not have a comprehensive range of policies and/or procedures to ensure clinical and non-clinical staff worked to appropriate standards to meet the needs of the patient population. 	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Explanation of any answers and additional evidence:	
<p>At our September 2021 inspection we found:</p> <ul style="list-style-type: none">• The practice had completed one two-cycle clinical audit and completed a first cycle of a second audit . However, there was no formal audit programme to address the priority clinical areas specific to the needs of the practice population identified during our last inspection in June 2021.• At both our June 2021 and September inspections we found examples of poor record keeping. For example, we advised the practice of a patient being prescribed high-risk medicines despite it not being clear from the patient notes for what medical condition the medicine was being prescribed. The practice did not have an appropriate policy and/or procedure to set the standards for record keeping within the practice. In addition, shortly after our inspection the clinical lead resigned from the practice. <p>At this inspection we found:</p> <ul style="list-style-type: none">• Since our last inspection the provider had been subject to a suspension with clinical and non-clinical work conducted by a caretaker practice. Accordingly, we reviewed the action the provider had taken and intended to take to improve patient care for its patient population We noted that despite its suspension the provider had been given unrestricted access to view the patient records system which would, had it chosen to, have enabled it to review and develop appropriate governance structures. However, the provider had only very recently chosen to first seek access on 14 February 2022.• Despite being aware of the benefits of monitoring and improving care for the patient population, the practice had not developed a programme of quality improvement including clinical audit.• The practice had not developed or updated its policies and procedures to ensure clinical and non-clinical staff worked to appropriate standards to meet the needs of the patient population.• We reviewed with the practice the importance of accurate and up to date patient records. Despite being aware of the risks of harm to patients the practice had not developed an appropriate policy and/or procedure for record keeping.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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