

# Care Quality Commission

## Inspection Evidence Table

### South Norwood Hill Medical Centre (1-547367777)

Inspection date: Clinical records review 15 November 2022, inspection site visit 17 November 2022 and discussion following clinical records review 5 December 2022.

Date of data download: 31 October 2022

## Overall rating: Requires Improvement

### Safe Rating: Requires Improvement

At our last inspection we rated the practice requires improvement as:

- Comprehensive recruitment checks had not been completed
- Risks associated with legionella had not been addressed
- One member of staff had not received basic life support training
- Arrangements for the management of medicines and safety alerts were not always effective at mitigating risk.

Though the practice had taken action to address issues associated with recruitment, training and risks associated with premises we found that the practice had not acted in respect of one of the patient safety alerts we reviewed and medicines reviews lacked detail.

#### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
At our last inspection we found gaps in recruitment information for three of the staff members including the absence of references, induction schedules and confidentiality agreements. We also found that two non-clinical staff members had no evidence of immunisation status in their files and no risk assessment to consider the need for these.	
At this inspection we found that all staff whose files we reviewed had appropriate recruitment checks completed. Most nonclinical staff had received recommended immunisations. Risk assessments had been completed for those who did not want to be vaccinated.	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y
There was a fire procedure.	Y
Date of fire risk assessment: 29 March 2022 Actions from fire risk assessment were identified and completed.	Y
At our last inspection we found that the health and safety risks had not been fully assessed and risk assessment focused exclusively on the premises. Risks highlighted in the practice's legionella risk assessment had not been fully addressed though the practice provided evidence that action would be taken following our inspection.	
At this inspection we found comprehensive risk assessments had been undertaken and that actions highlighted in the practice's legionella risk assessment had been completed	
At our last inspection we found that the practice's fire risk assessment had no action points.	
At this inspection we found that the practice had undertaken a comprehensive fire risk assessments and appropriate steps had been taken to address all the recommended action points.	

## **Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were met.**

<b>Y/N/Partial</b>

Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 7 February 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

### 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
At our last inspection we found that one member of staff had not completed basic life support training though this was completed following our inspection.  At this inspection we found that all staff whose files we reviewed had completed the required training.	

### Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment although most medication reviews we looked at did not contain enough detail.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. <sup>1</sup>	Partial
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.	N/A
Medication reviews we looked at during our inspection lacked detail.	

## Appropriate and safe use of medicines

**Minor issues related to high risk medicines prescribing had been addressed following our last inspection, but medicines reviews were lacking in detail**

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.78	0.69	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	11.2%	8.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	7.82	5.47	5.31	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	43.8‰	60.6‰	128.0‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.31	0.54	0.59	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	3.4‰	4.7‰	6.8‰	Tending towards 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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. <sup>1</sup>	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
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. <sup>2</sup>	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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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
<p>At our last inspection we found that a small number of patients prescribed warfarin who did not have their next test due dates noted and small number of patients prescribed ACE inhibitors had not had the required monitoring, though blood forms were generated for these patients a week prior to our visit.</p>	
<p>At this inspection we did not identify any concerns with the prescribing of high risk medicines. It was evident that a considerable amount of work had been completed to improve in this area. However, we did find that some medication reviews lacked detail, appeared to be undertaken without the participation of the patient and/or medicines were not linked to the correct clinical presentation on the records system. We raised this with staff at the practice who said that this issue had been identified by the PCN pharmacist</p>	

Medicines management	Y/N/Partial
and that clinicians were now more conscious of the importance of detailed record keeping. The clinical lead told us that, following the last inspection they had tried to ensure that all required medicines reviews were completed before our visit. We were told after this inspection that more medicines reviews would be allocated to salaried and locum doctors each week. The clinical lead also told us that they had not received as much support with medicine reviews from the local PCN pharmacists due to staffing issues.	

### Track record on safety and lessons learned and improvements made

**The practice had a system in place to act on and learn from significant events. However, we found that the process for actioning patient safety alerts needed further improvement.**

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 since last inspection	4
Number of events that required action:	4
At our last inspection we found that significant were not being consistently recorded.	
At this inspection we found that events were being consistently recorded. Some staff indicated that they were reluctant to raise concerns though others told us that there was a free and open culture where they could raise concerns without fear of reprisals.	

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

Event	Specific action taken
Failure to follow up when an elderly patient did not attend an appointment which was reported to the practice by the local authority.	The over 75 annual health check process was reviewed to include a home visit from the health care assistant for those patients unable to attend the practice. With a processes to escalate for those fail to attend to lead GP and external agencies reiterated to staff.
Vaccine delivery left outside of fridge and cold chain broken	All reception staff trained on cold chain storage and vaccines policy updated.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial

Staff understood how to deal with alerts.	Partial
<p data-bbox="51 226 1532 338">At our last inspection searches of patients prescribed medicines that were the subject of patient safety alerts indicated that the practice's system to respond to safety alerts was not consistently effective and safe.</p> <p data-bbox="51 371 1532 483">At this inspection we ran a search of medicines alerts. The results showed most alerts had been appropriately handled but that two patient safety alerts had not been actioned. We reviewed the patient records flagged by the search and found:</p> <ul data-bbox="108 517 1532 931" style="list-style-type: none"><li data-bbox="108 517 1532 629">• One alert related to hydrochlorothiazide had been actioned; though the wording of the advice sent to patients was not completely accurate. The provider told us after the inspection they had changed the wording of the advice sent to patients.</li><li data-bbox="108 663 1532 931">• Another alert related to the prescribing of SGLT -2 inhibitors, and the possible development of gangrene flagged 38 patients as not having received appropriate counselling on risk. From our review of five of these patient records we found that four patient had not been informed of the potential side effects of this medicine. However, we did see evidence of this alert being discussed at a clinical meeting with a note to take appropriate action in response to the alert, to issue annual reminders and reminders at the time of initial prescribing. Following our review the practice provided evidence that they had provided advice to the four patients who required this.</li></ul>	

## Effective

## Rating: Requires Improvement

At our last inspection we rated the practice as inadequate for providing effective care as:

- Not all staff had completed mandatory training
- Searches and reviews of clinical records indicated that the systems for identifying and supporting patients with chronic kidney disease, diabetes and asthma were not comprehensive and placed patients at risk of harm.
- The practice had not achieved targets for childhood immunisations and cervical screening.

At this inspection we found that all staff whose files we reviewed had completed the required mandatory training and improvements had been made in the management of patients with long term conditions. However, searches of the clinical systems and subsequent review of patient's records showed that a small number of patients with long term conditions did not have adequate or appropriate follow up. Performance against targets for childhood immunisations and cervical screening remained below national averages though the practice was taking proactive steps to increase uptake. The practice did not have a system to oversee the work of physicians associates.

*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 were delivered in line with current legislation and standards, but reviews of patient records indicated that system to follow up patients needed to be improved.**

	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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Partial
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 prioritised care for their most clinically vulnerable patients.	Y
<p>At our last inspection reviews of patient records showed that patients presenting with possible illness were not consistently followed up including those who had diagnostic results indicating chronic kidney disease and diabetes. The records review also indicated that systems did not ensure that care and treatment were regularly updated.</p> <p>At this inspection we found that the above concerns had been addressed. However, we ran a search on the practice's clinical system to find patients with diabetic retinopathy who had elevated blood sugar levels. This search highlighted 26 patients out of a total list of 423 patients on the practice's diabetic register. We reviewed five of these 26 records. We noted that patients had been contacted by the practice for follow up. However, the contact did not convey the seriousness of the patient's diagnostic results and was considered not sufficiently proactive given the patients' blood results. The number of patients flagged by this search was considered small relative to the size of the practice's diabetic register. It was evident from discussions with the practice that they were aware of this cohort of patients and had held discussions with the local PCN to consider ways of encouraging these patients to attend for monitoring and follow up.</p> <p>We also ran a search of the patients with asthma who had been prescribed two or more courses of rescue steroids. The search identified 16 patients out of 356 on the practice's asthma register. We found that these patients did not have adequate follow up, lack of adjustment to asthma treatment plan following these prescriptions, lack of clarity around whether the consult was over the phone or in person and one patient who was able to obtain steroids by text without being assessed. Again, the numbers identified were small given the size of the practice's asthma register. We were provided with an action plan following our inspection of how the practice intended to manage patients who had an acute exacerbation of asthma.</p>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check. The practice had 42 patients on their learning disability register and had completed health checks for 39 of these patients.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.

- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

At our last inspection we found that the practice did not have effective systems to identify and take appropriate action for all patients who had diabetes and chronic kidney disease or for those being prescribed a high number of SABA inhalers, though we were told that action was taken after our inspection to address this.

At this inspection we found that these areas did not flag as possible areas of concern when we undertook searches of the practice's clinical system. Minutes of clinical meetings showed discussion of patients with long term conditions and plans to improve the quality of clinical care provided to them. However, we saw some areas where follow up and clinical record keeping for patients with long term conditions needed to be improved.

- Aside from these concerns we found that most 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	72	80	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	48	65	73.8%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received	48	65	73.8%	Below 80% uptake

Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	49	65	75.4%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	69	59.4%	Below 80% uptake

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

### Any additional evidence or comments

At our last inspection we saw that the practice was below target for four out of five childhood immunisations. The practice outlined action taken to improve uptake including support from care coordinators to ensure that recalls prompts children to be immunised at the correct time, holding immunisation clinics and getting the HCA to support with nursing tasks to enable the nurse to focus on vaccine delivery. Unverified data provided by the practice also indicated that uptake was higher than the published figures.

At this inspection the only published data was the same data available at our previous inspection. Again, unverified data provided by the practice indicated that uptake had improved. The practice was now aware of the need to immunise children in accordance with the recommended schedule and had been making a concerted effort to contact new parents as soon as they received notification of births so that children could be promptly registered and booked in for immunisations. We were also told that the recent polio immunisation campaign had helped increase the uptake of other childhood vaccines. The practice had also been contacting parents who had their children immunised abroad to obtain copies of certificates which enabled them to be counted as having been vaccinated.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	70.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	68.0%	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)	60.0%	63.4%	66.8%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	83.3%	52.8%	55.4%	No statistical variation
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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.

### Any additional evidence or comments

At our last inspection we found that the practice was below target for cervical screening, though this had improved since our previous visit. At this inspection we again found that there had been further improvement in performance which indicated a positive direction of travel.

We were told at our last inspection of efforts undertaken to improve uptake including support with recalls by the PCN care coordinator, opportunist engagement by the practice nurse and offering appointments at extended access hubs.

The practice had also audited their cervical screening uptake at our last inspection which provided unverified data showing increased uptake.

At this inspection newly published data showed that there had been a slight improvement in the practice's performance against Public Health England targets. Again, unpublished data provided by the practice indicated that uptake had improved. The practice told us that staff had successfully used the children's polio vaccination campaign to offer cervical screening to mothers who were overdue.

The practice had also worked with a local cancer screening organisation to improve performance against targets. The practice was now targeting those who they previously believed could be excluded; including those who had been contacted about screening on three occasions as this was not considered a valid exclusion criteria by Public Health England. Additionally, the practice had a dedicated administrative lead for cervical screening and reception and administrative staff were trained on how to discuss the importance of cervical screening for eligible patients when they called or registered at the practice.

### Monitoring care and treatment

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

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

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

At our last inspection we saw examples of completed clinical audit cycles. At this inspection we were provided with a two cycle audit focusing on urinary tract infections. The proportion of patients screened appropriately prior to being prescribed antibiotics increased from 50% at the first cycle to 84% at the second cycle.

Single cycle audits for broad spectrum antibiotics and minor surgery were also provided.

The practice had a schedule of audits that enabled them to have oversight of their quality improvement activity.

## 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
At our last inspection we found that there were some gaps in staff training and no evidence that some staff members had completed an induction.	
At this inspection we found that all staff whose files we reviewed had undertaken all appropriate training and had completed inductions on file.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
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## Helping patients to live healthier lives

### Staff were not 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

Any additional evidence or comments

## 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. <sup>1</sup>	Y
We undertook a review of records where a DNACPR decision had been recorded which showed that, where possible, patients views had been sought and considered. However, there were difficulties accessing some of the documentations which detailed the decision making process in two of the three records we reviewed.	

## Caring

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

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

Patient feedback	
Source	Feedback
Patients spoken to as part of inspection	Patients we spoke with on inspection said that clinical staff treated patients with care and respect, and they were happy with the quality of treatment and support they received. Feedback about reception staff varied although many patients highlighted that they were aware of the pressures associated with their role.

### 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 average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	81.7%	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)	80.7%	84.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	92.1%	94.0%	93.1%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)				
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)	63.2%	76.9%	72.4%	No statistical variation

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

Any additional evidence
<p>The practice surveyed 51 patients in July 2022. The survey results were as follows:</p> <ul style="list-style-type: none"> <li>93% of patients reported that the manner of the clinician they saw was very good to excellent.</li> <li>84% of patients reported that the clinical care provided was very good or excellent.</li> <li>86% of patients reported that the service offered by reception staff was good, very good or excellent.</li> </ul>

### 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

Source	Feedback
Interviews with patients.	Patients we spoke with spoke highly of the quality of care provided by clinical staff.

### 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 average	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)	85.7%	90.8%	89.9%	No statistical variation

### Any additional evidence

Of the patients surveyed by the practice in July 2022 92% of patients rated clinicians very good or excellent for involvement in decisions around care and treatment.

	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

Carers	Narrative
Percentage and number of carers identified.	287 (approximately 4%)
How the practice supported carers (including young carers).	The practice directed carers to local support services and offered them annual flu vaccinations.
How the practice supported recently bereaved patients.	Staff told us that staff would contact patients if they became aware of bereavements and direct them to local support services including talking therapy.

### Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Requires Improvement

At our previous inspection the practice was rated as good for providing a service that was responsive. Following this inspection, the rating has been downgraded to requires improvement as:

- National GP patient survey scores have fallen below local and national averages in relation to access and patients reported it was difficult to reach the practice by phone. The practice outlined action taken to try and improve access arrangements.

### Responding to and meeting people's needs

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

	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

#### Practice Opening Times

Day	Time
Monday	8:00 am - 6:30 pm
Tuesday	8:00 am - 8:00 pm
Wednesday	8:00 am - 6:30 pm
Thursday	8:00 am - 8:00 pm
Friday	8:00 am - 6:30 pm

#### Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Tuesday and Thursday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments and walk-in services were also available in three GP hubs in Croydon from 8am to 8pm seven days a week.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

**Patient feedback indicated that people were not always able to access care and treatment in a timely way.**

	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	Partial
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	Partial
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

## 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 average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	21.4%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	38.0%	61.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	44.1%	60.1%	55.2%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
appointment times (01/01/2022 to 30/04/2022)				
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)	53.8%	72.5%	71.9%	Tending towards variation (negative)

### Any additional evidence or comments

Patient satisfaction scores related to access had deteriorated since our last inspection though the data from the national patient survey was collected before our last inspection.

The practice's own survey of 51 patients completed in July 2022 found that:

- 46% of patients found access on the phone excellent, very good or good.
- 51% of patients found the experience of making appointments excellent, very good or good.
- 47% of patients rated patient access overall as excellent, very good or good.

The practice had developed a substantial action plan in response to this feedback and had either implemented or were in the process of implementing the following:

- Utilising physicians associate from PCN and employing another physicians associate
- PCN wellbeing coach who assisted in undertaking reviews for patients with diabetes.
- Accessing PCN resources including physiotherapist and pharmacy staff.
- Increased Healthcare Assistant hours and expanded role to do home visits for vulnerable patients requiring health checks.
- Signed up to the NHSE Accelerated practice development programme. which is a 16 week NHS supported programme aimed at improving access using measurable outcomes. The practice told us that their first session identified pressure points in the practice, and they were now working on addressing issues around repeat prescribing as a result.
- Customer care training for staff
- Increasing the number of phone lines
- Recruiting three new reception staff
- Promoting pharmacy first by training staff on how to counter patient objections to the service and changing the answering machine.

As these plans had only recently been implemented, the practice were unable to provide any data to show how these steps had improved access for patients.

Source	Feedback
Patient interviews	Patient feedback was mixed in respect of access to appointments with some patients telling us that it was difficult to get appointments and access the service using the telephone.

## 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.	6
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
At our last inspection we found that the system for recording complaints needed to improve At this inspection we found that all complaints were recorded.	

Examples of learning from complaints.

Complaint	Specific action taken
Prescriptions sent by third party not being actioned in a timely way	Staff to check junk email folders as prescriptions from third parties go into this folder. Prescriptions sent by third parties to be prioritised.
Unprofessional attitude of locum clinician during consultation	Apology issued and locum staff member spoken with.

## Well-led

## Rating: Requires Improvement

At our last inspection we rated the practice as inadequate overall. At this inspection the practice is rated as requires improvement for providing a service that is well led as:

- There had been a significant amount of work undertaken to address deficiencies addressed at our last inspection in respect of systems related to recruitment, training, risk management of premises and aspects of clinical governance.

However

- We found that there were aspects of clinical care that needed further improvement including medicines reviews, aspects of long term condition management and systems to respond to safety alerts; which was identified as a concern at our last inspection.
- There were concerns about the sustainability of the practice's current operating model; particularly the workload of the clinical lead. However, we were told that plans were in place to delegate responsibility following our inspection to ensure the service remained viable.

### Leadership capacity and capability

**Leaders had the capacity and skills to deliver effective care in most areas and it was clear that significant work had been undertaken to make changes following our last inspection. However further work was required to improve the quality and safety of care provided.**

	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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
The service had undertaken significant amount of work to address the concerns identified at our last inspection. For instance, we were told that in order to improve the proportion of patients who required regular blood monitoring the clinical lead had run clinics in the morning and at lunchtime to take blood. We questioned the sustainability of this arrangement and the clinical lead outlined plans to delegate this work using additional HCA and physicians associate hours. Though the number of patients having appropriate blood monitoring had significantly increased we found that the quality of medication reviews needed further focus and improvement.	

## 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

## Culture

**The practice had a positive culture in most respects though some staff reported needing additional training and support and feeling discomfort at raising concerns.**

	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.	Partial
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.	Partial
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.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Some staff said that they did not feel comfortable or were not encouraged to raise concerns which could hinder incident reporting, learning from incidents and compliance with the duty of candour. No staff member reported feeling that they may face retribution for raising concerns.	
Most staff feedback that they felt that they could benefit from additional training and support.	

## Governance arrangements

**Some aspects of governance had improved since our last inspection, but others needed further refinement.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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>At our last inspection we found there were several governance areas that required further improvement including systems related to training, recruitment, risk management, medicines safety alerts and those which identify and respond to patients with undiagnosed long-term conditions.</p> <p>At this inspection we found that systems for recruitment, risk management and training had improved. Additionally, searches of clinical records indicated that identification of patients with undiagnosed long term conditions had improved. However, we did find risks stemming from one safety alert which, though discussed in a clinical meeting, had not been communicated to patients as required. We also found that systems around aspects of long term condition management and medicines reviews needed improvement; though concerns related to the quality of medicines reviews had already been identified by the PCN pharmacist and there were plans to improve in this area.</p>	

## Managing risks, issues and performance

**Systems to deal with patient safety alerts were still not effective but others had improved since our last inspection.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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>At our last inspection we found gaps in recruitment records, that risks identified related to legionella had not been addressed and the systems for responding to safety alerts did not ensure that timely action was taken.</p> <p>At this inspection systems for risk management in relation to premises and recruitment had improved but the processes for responding to safety alerts was still not effective.</p>	

## 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

## 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

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	

## Feedback from Patient Participation Group.

### Feedback

We were told by PPG members that the practice would use the forum to discuss issues including staffing, access, referral delays, delays for the hospital blood testing service and services for long term health conditions including dementia, diabetes and long Covid.

We were told by one PPG member that the PPG had raised concerns about access and as a result the practice had introduced a system to monitor waiting times, the number of calls coming in and the number patients who hung up. Based on this information the practice had increased administrative staff availability during peak times and employed additional staff to answer calls.

## Continuous improvement and innovation

**There were some systems for learning and improvement, but further work was needed in this area.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
At our last inspection we found that the practice was taking a reactive approach to learning and quality improvement having addressed some areas of concern only immediately prior to our inspection.	
At this inspection it was evident that the practice had undertaken a significant amount of work to address the concerns that we had identified and they had proactively surveyed their patients following the publication of the National GP patient survey and developed an action plan to improve access. However, there were some areas where the practice relied on external agencies to identify areas for quality improvement, specifically in respect of the quality of medicines reviews. However, the practice was committed to making improvements based on this feedback.	
Some staff also reported at this inspection that they did not feel supported to raise concerns when things went wrong which could impact on the practice's ability to learn.	

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

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

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

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

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

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

## Glossary of terms used in the data.

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