

## Inspection Evidence Table

Dr Shivraj Chudha

(1-556158120)

Inspection Date: 5-7 September 2023

Date of data download: 05/09/2023

## Context

The practice is based in Southwark, Southeast London and has a patient list of approximately 8,800 patients. Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the fifth decile (5 out of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic makeup of the practice area is 63% White, 15.2% Asian, 13.6% Black, 5.9% Mixed and 2.3% Other.

## Overall rating: Good

### Safe

Rating: Good

#### 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
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
<ul style="list-style-type: none"> <li>• All staff members were up to date with their safeguarding training.</li> <li>• Staff members we spoke to demonstrated knowledge of what constituted a safeguarding incident and showed knowledge of how to raise concerns if a safeguarding incident were to occur. They were able to share examples of potential indicators of abuse and the action required.</li> <li>• There were safeguarding flowcharts available in clinical rooms which were designed to allow staff to escalate concerns to local safeguarding teams.</li> <li>• Safeguarding incidents were discussed in multi-disciplinary meetings and shared with other services where required.</li> <li>• The practice was staffed with clinicians experienced in safeguarding matters. For example, a clinician at the practice was also a part-time member for the Children and Young Peoples' Health Partnership (CYPHP) and the Safeguarding Lead at the practice regularly attended the Southwark GP Safeguarding Forum."</li> </ul>	

Recruitment systems	Y/N/Partial
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
The practice had a recruitment policy in place. We reviewed a random sample of clinical and non-clinical staff files and were satisfied appropriate checks were undertaken prior to employment.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 20 January 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 20 January 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<ul style="list-style-type: none"> <li>• The practice performed regular fire and health and safety risk assessments, and staff members completed their mandatory training.</li> <li>• The fire evacuation procedure was displayed in appropriate areas within the premises and fire extinguishers were routinely checked.</li> </ul>	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met/not met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: April 2023	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
<ul style="list-style-type: none"> <li>We observed appropriate standards of cleanliness and hygiene were followed during the site visit.</li> <li>The practice nurse and practice manager worked collaboratively to undergo annual audits to ensure compliance with infection prevention control (IPC) standards, with the most recent audit taking place in April 2023. The practice also worked with the Integrated Care Board (ICB) to facilitate infection prevention control inspections every 2-3 years.</li> <li>The practice explained how, during the pandemic, they created a 'red room' with access via their car park to ensure IPC protocols could be maintained and patients were socially distanced.</li> <li>The practice had effective systems in place in relation to their responsibilities to protect staff and patients from the risks of legionella bacteria and completed an up-to-date legionella risk assessment.</li> <li>The practice performed annual hand hygiene audits. The most recent audit was completed in April 2023 and results showed all staff members followed hand hygiene protocol and hand hygiene posters were displayed by each sink.</li> </ul>	

### 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
<ul style="list-style-type: none"> <li>A mix of both full-time and part-time staff with varying shift patterns ensured that adequate coverage for sickness and absences was consistently maintained within the practice.</li> <li>Staff members we spoke to could explain the practices' procedures for handling emergencies in the event of a patient's condition deteriorating.</li> <li>Equipment and medication were checked daily to ensure it was in working order and in date.</li> <li>All staff members completed their Basic Life Support and sepsis awareness training.</li> </ul>	

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<ul style="list-style-type: none"> <li>We found clinical records were well maintained and patient information, such as test results, were dealt with in a timely manner by the clinicians.</li> <li>The practice employed an experienced team who led on reviewing and coding the daily workflow of incoming patient information to ensure referrals, test results and patient letters were actioned appropriately in a timely manner. We observed these to be up to date during our inspection.</li> <li>The practice had an effective system to monitor and track two-week-wait and non-urgent referrals.</li> </ul>	

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.52	0.69	0.91	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	7.9%	8.0%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.58	5.50	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	36.0‰	73.2‰	129.5‰	Significant variation (positive)

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.29	0.36	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	3.2‰	4.8‰	6.8‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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
<ul style="list-style-type: none"> <li>During our inspection, we completed a series of searches on the practice's clinical record system.</li> </ul>	

- A search of patients prescribed a disease-modifying antirheumatic drug (DMARD) was performed. We examined five patients who were prescribed the drug methotrexate (a medicine used to suppress the immune system). We found all patients had regular blood tests carried out and were being monitored appropriately. However, we noted in the records we reviewed the day of the week that the patient should take this medicine was not recorded and advised prescribers should inform the patient this medicine should be taken on the same day each week and record this in the patient record.
- We looked at patients who were prescribed angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs). These medicines cause blood vessels to dilate, which lower blood pressure. They require regular blood pressure monitoring because the medicines can contribute to kidney disease and lead to raised potassium. Our clinical record searches indicated that 9 patients out of 443 had not had the required monitoring. Five patient records were examined and although monitoring blood tests were overdue, the practice had recognised this and invited the patients to attend for required testing.
- We saw examples of Patient Group Directions, which were dated and appropriately signed and authorised by relevant staff members.
- There were appropriate arrangements in place for the management of vaccines and to maintain the cold chain. We saw fridge temperatures were routinely monitored and a log of temperature readings were kept. Vaccines reviewed during the site visit were in date and stored appropriately.
- The practice held the recommended emergency medication and stocked medical oxygen and a defibrillator. They were routinely monitored.

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: 2	Y
Number of events that required action: 2	Y

Example of significant events recorded and actions by the practice.

Event	Specific action taken
A patient had a seizure in the waiting area.	Reception staff pressed the panic button and clinical staff attended the patient. Oxygen was provided to the patient and the ambulance were called. A significant event was created and discussed in team meetings. There was learning implemented and discussed during



	this event as there were no scissors in the emergency equipment bag during the incident; this was later added to the bag.
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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
<ul style="list-style-type: none"> <li>MHRA alerts are received both via the practice mailbox and the practice manager's inbox. The clinical pharmacist and practice manager reviewed the drug safety alerts and were responsible for disseminating the information to the relevant clinicians. The pharmacist contacted any relevant patients in the first instance.</li> <li>However, we identified an issue during our remote clinical searches. We reviewed the action taken by the practice in response to a November 2019 MHRA alert regarding a rare but serious risk of Fournier's gangrene associated with SGLT-2 inhibitors (medicines used to treat diabetes). The alert required clinicians to ensure they advised patients taking these medicines to seek urgent medical attention if they experienced severe pain, tenderness, erythema, or swelling in the genital or perineal area, accompanied by fever or malaise. We reviewed 5 patients on these medicines and found three patients had 'discussed risks' recorded without specifically detailing any documentation regarding Fournier's gangrene. We saw there was no documented evidence advising patients about the risks of Fournier's gangrene for two patients. Immediately after the inspection, the practice called the patients to discuss the associated risks. The practice should review its process for actioning safety alerts.</li> </ul>	

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y

We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<ul style="list-style-type: none"> <li>Clinicians told us how they used National Institute for Healthcare Excellence (NICE) guidelines to keep up to date with current standards and evidence-based practice. One of the clinicians at the practice was also a member of the Local Medical Committee and therefore had more oversight of new guidelines and best practice which could be shared in clinical meetings.</li> <li>The practice was accredited as an Education Learning Centre by the Integrated Care Board.</li> </ul>	

## Effective care for the practice population

### Findings

- Our clinical searches reviewed patients with a potential missed diagnosis of diabetes. We reviewed five patient records and found two patients had a missed diagnosis of diabetes. Patients who are assessed for diabetes undergo a haemoglobin (HbA1c) test – a blood test that measures blood sugar levels over the past three months. NICE guidelines advise that the diagnosis of diabetes can be made from a single HbA1c of 48 or greater if a patient has symptoms of diabetes. In other circumstances a second diagnostic level test is required to make a firm diagnosis. We found two patients had blood tests consistent with diabetes but were not coded as diabetic. After the inspection, the practice recalled the patients for review.
- Our clinical record searches looked at patients who had medication reviews in the past three months. We reviewed five patient records and found three medication reviews were completed appropriately with structured templates. However, two records showed medication reviews were coded but contained no detailed analysis/description of the review.
- We reviewed the records of patients with 10 or more prescriptions of benzodiazepines or Z drugs. These medicines should be used for a short-term period as psychological and physical dependence can develop if prescribed for longer periods. Our review of four patient records found all patients had been advised about risk of addiction and attempts to wean the patient off the medication had been made.
- We reviewed records of five patients with diabetic retinopathy (a complication of diabetes) whose latest reading was 74mmol/mol. We found all five patients were being appropriately monitored.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.



- Patients with poor mental health, including dementia, were referred to appropriate services. The practice also had access to a Mental Health Liaison via their Primary Care Network (PCN).

## Management of people with long term conditions

### Findings

- Our searches indicated that 17 patients diagnosed with asthma had received 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 records and found that the practice had not always followed up to check the response to treatment within 7 days.
- Patients with long-term conditions were offered an effective 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 received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	67	73	91.8%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	40	60	66.7%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	48	60	80.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	49	60	81.7%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	31	46	67.4%	Below 80% uptake
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

- The practice were aware they were below World Health Organisation (WHO) targets for childhood immunisations. The practice informed us they had difficulties in immunising some of the children in the practice due to a high volume of parents opposing vaccinations who had negative associations with, for example, the Measles Mumps and Rubella (MMR) vaccine. The practice believed their data on childhood immunisations was skewed due to their involvement in a project whereby the practice registered Afghan refugees. Because of this, the practice inherited a cohort of patients whose childhood immunisation status was either not clear or not input into their data.
- The practice believed they had a strong recall system for parents who did not attend their immunisation appointments. This involved sending text messages, telephone calls and letters and patients.
- The practice promoted the availability of weekend appointments at the Extended Primary Care Service to allow more flexibility with their patients.
- The practice informed us they will be meeting up with the local immunisation teams to find ways to increase the uptake of childhood immunisations in their practice population.

The practice should continue with these efforts to improve the uptake of childhood immunisations.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	44.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	63.8%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	50.1%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	44.4%	50.9%	54.9%	No statistical variation

### Any additional evidence or comments

- The practice were aware they were below the national target for cervical cancer screening and informed us they had difficulties in getting younger patients to attend screening appointments. The practice believed they had a strong team who actively called patients who were due to have a screening test and those who missed their appointments. The practice introduced a new method for patients to book their screening tests as patients at the practice were able to self-book appointments through Accurx. The practice also offered patients appointments at the Extended Primary Care Service between 8am-8pm on weekends to allow patients more flexibility. The practice should continue with this work to improve the uptake of cervical cancer screening.
- The practice performed an audit to ensure the nursing team were taking valid cervical screening samples on a regular basis. The audit found the rate of inadequate smears at the practice were below 1%.
- Patients for whom the practice receive notifications that they failed to attend appointments for bowel and breast cancer screening appointments were sent follow-up text messages to encourage uptake.
- The practice introduced the use of the MacMillan Cancer Safety Netting Template to track two-week-wait referrals. Through this process, they ran searches on a weekly basis to ensure referrals are followed up. This audit is carried out on a weekly basis.

### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<ul style="list-style-type: none"> <li>• The practice carried out a clinical audit into patients suffering from chronic kidney disease (CKD). The aim of the audit was to implement new guidelines in the practice. Data was collected on patients suffering from CKD with and without diabetes and checked if they were prescribed SGLT2-inhibitors. From completion of the first cycle of the audit, the practice were able to identify patients who, using new guidelines, should be prescribed SGLT2-inhibitors. The practice were also able to identify patients who required information and education on the pros and cons of SGLT2-inhibitors. The practice were in the process of completing the second cycle.</li> </ul>	

### 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
<ul style="list-style-type: none"> <li>• The practice had an experienced team with long-term staff.</li> <li>• There was an in-depth induction programme for locum staff.</li> <li>• Regular appraisals were carried out with staff members. We reviewed a sample of appraisals and found evidence of learning and development goals identified and discussed.</li> <li>• Clinical staff demonstrated their continued professional development in different areas of practice and were provided protected time for learning and development.</li> </ul>	

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> <li>• The practice held regular multi-disciplinary meetings to discuss patients with complex needs or those with safeguarding concerns. For example, they held quarterly meetings with the mental health safeguarding team and district nurses.</li> <li>• The practice shared urgent care plans on a software that allowed direct access via the practices' electronic patient record system which was accessible by secondary care organisations.</li> </ul>	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y

Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<ul style="list-style-type: none"> <li>Staff directed patients, where necessary, to self-assessments for mental health issues, such as the Improving Access to Psychological Therapies Programme (IAPT).</li> <li>The practice worked closely with the North Southwark Social Prescribing Service. This service engaged patients to assist with issues such as lifestyle, mental health, social isolation, employment and managing long term health conditions.</li> <li>The practice encouraged patients to measure blood pressure readings at home by loaning blood pressure monitors to those who required it. They were guided on how to use the machine and were asked to bring readings into the clinic for monitoring.</li> </ul>	

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Our clinical review of notes, where a DNACPR decision had been recorded, identified where possible the patients' views had been sought and respected; we saw that information had been shared with relevant agencies.	

## 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-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<ul style="list-style-type: none"> <li>We saw patients being treated with kindness and respect in the reception area.</li> <li>The practice had a large and diverse population. Staff members explained the importance of respecting the social, cultural and religious needs of patients.</li> </ul>	

### Patient feedback

Source	Feedback
Responses from Friends and Family Test	There were positive responses to the practices' Friends and Family Test. For example, one patient said the 'Dr took the time to explain my queries and ask questions about my personal experience which I really appreciated'.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	86.6%	83.0%	85.0%	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 (01/01/2023 to 30/04/2023)	82.2%	81.3%	83.8%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	94.2%	92.2%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	76.4%	67.3%	71.3%	No statistical variation

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

### Any additional evidence

The practice utilised and reviewed responses from the Friends and Family Test, National GP Patient Surveys and discussions held in their Patient Participation Group (PPG) meetings to analyse trends in patient feedback. The practice planned to introduce in-house patient surveys but did not, at the time of the inspection, carry them out.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
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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
<ul style="list-style-type: none"> <li>A social prescriber attended the practice once a week and staff were able to explain how to refer patients to the Social Prescribing service.</li> <li>Patients were signposted to Blackfriars Settlement; a nearby registered charity organisation that provided community services and support.</li> </ul>	
Source	Feedback
Interviews with patients.	We spoke with members of the Patient Participation Group and were told clinical staff members take the time to explain aspects of their care and treatment and that non-clinical staff members treated them with respect.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	91.6%	89.0%	90.3%	No statistical variation
				Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.				Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Y
Information leaflets were available in other languages and in easy read format.				Y
Information about support groups was available on the practice website.				Y
<ul style="list-style-type: none"> <li>The practice used an external interpretation service to assist patients who did not have English as their first language.</li> <li>The practice made reasonable adjustments to patients where appropriate. For instance, notes were added to a patients file who had difficulties in reading/writing so any communication to him was made via a phone call.</li> <li>Some staff members at the practice were able to speak a second language.</li> </ul>				

Carers	Narrative
Percentage and number of carers identified.	The practice identified 278 carers, which represented approximately 3% of the practice population.

How the practice supported carers (including young carers).	Carers at the practice were signposted to support organisations and prioritised for vaccinations and appointment times.
How the practice supported recently bereaved patients.	Bereaved patients were given a telephone call and were directed to support services.

### Privacy and dignity

**The practice respected respect 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
<ul style="list-style-type: none"> <li>Staff informed us how they were able to offer patients a private space to discuss sensitive issues.</li> <li>Nursing staff explained the steps taken to ensure patients are comfortable during cervical cancer screening appointments.</li> </ul>	

## Responsive

## Rating: Good

### 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
<ul style="list-style-type: none"> <li>The practice increased their appointment time from 10 minutes to 15 minutes to allow both patients and clinicians more time during appointments. This has been received positively by both parties.</li> <li>As a result of patient feedback during Patient Participation Group (PPG) meetings, the practice implemented a change to release all same-day appointments from 8am (instead of morning appointments only being released at 8am).</li> <li>Patients were able to self-book certain appointments using a software system that was integrated with a patients NHS account,</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6:30pm
Tuesday	8am – 6:30pm
Wednesday	8am – 6:30pm
Thursday	8am – 6:30pm
Friday	8am – 6:30pm
Appointments available:	
Monday	7:30am – 6:30pm
Tuesday	8am – 6:30pm
Wednesday	8am – 6:30pm
Thursday	7:30am – 6:30pm
Friday	8am – 6:30pm

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

- During the pandemic, the practice worked in partnership with another local practice and the Health Inclusion Team to support the homeless who were residing in a nearby hotel. This involved being on call to support the hotel and community teams with any primary care related issues.
- The practice worked with the GP Federation to support 250 Afghan refugees to implement primary care services, such as health checks. Dedicated clinics were run across two hotels where the refugees were housed. An immunisation clinic was run, and interpretation services were also available.
- The practice registered as a 'Safe Surgery'; a campaign run by Doctors of the World to promote healthcare access to those in vulnerable circumstances.
- 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.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available with the Extended Primary Care Service (EPCS) which operates from 8am-8pm every day.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

#### Access to the service

**People were 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 minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<ul style="list-style-type: none"> <li>Patients were able to book a range of consultation types including face to face, telephone and eConsult. Appointments were available up to two weeks in advance and emergency appointments were available to book on the day.</li> <li>The practice were undergoing a change to their telephony system with improvements, such as allowing patients to have a call-back option, to be introduced.</li> <li>The practice uses a proprietary IT system to review its demand and capacity. Appointment activity showed the average patient waiting times for a telephone call between 23 May 2023 and 20 August 2023 was 1.6 minutes, and the average 3<sup>rd</sup> available slot time was 3.7 days.</li> </ul>	

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	79.6%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	63.6%	49.7%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	63.6%	50.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	72.0%	66.2%	72.0%	No statistical variation
The practice had consistently performed above local and national average in the National GP Patient Survey since 2018 in the first three indicators above.				

Source	Feedback
Feedback from Friends and Family Test	There was positive feedback in relation to access with one patient stating it was 'easy to book appointment. Quick to be seen. Also friendly which helps'.

### 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.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
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

Example of learning from complaints.

Complaint	Specific action taken
Patient unhappy with an invitation for weight management service as the patient had a history of an eating disorder.	The patient was spoken to and offered an apology. The practice discussed the complaint in a meeting and decided to refine their search criteria to exclude patients with eating disorders and to consider other factors which are not completed in the Ardens searches.

**Well-led**

**Rating: Good**

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y

They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<ul style="list-style-type: none"> <li>Leaders believed patient access in obtaining appointments was a challenge to the practice. They believed they are continually addressing these challenges and identifying the necessary actions to address them. For example, the practice are in the process of obtaining a new telephony system to improve access to patients; it had introduced eConsult and routinely monitored call waiting times.</li> <li>Staff members we spoke to reported that the practice management team, including GP partners and the non-clinical management team, were approachable.</li> </ul>	

### 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
<ul style="list-style-type: none"> <li>The practice aimed to deliver a 'patient-centric service' and be the 'leading practice for patient experience and clinical outcomes'. The practice believed increasing appointment times from 10 minutes to 15 minutes reflected this.</li> <li>Staff members we spoke to were aware of the practice vision and values and were passionate in delivering patient-centred care.</li> </ul>	

### Culture

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

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



- The practice consisted of ethnically diverse staff which reflected the diversity of patients within the practice population.
- Staff members we spoke to expressed being able to raise concerns and speak openly and honestly with the management team if required.
- The practice had a whistleblowing policy which staff members were able to access.
- The practice management team spoke passionately about the importance of the well-being of staff. For example, increasing appointment times from 10 minutes to 15 minutes allowed clinicians further time to manage administrative duties.

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

Source	Feedback
Interview with staff	A member of staff stated there is effective leadership at the practice and an 'open-door' policy in which they can discuss any concerns they have. They also stated regular meetings and communication channels (such as a WhatsApp group) allowed better communication with staff members.

### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<ul style="list-style-type: none"> <li>• Clinicians at the practice worked collaboratively to ensure the monitoring of high-risk drugs and the monitoring of patients with long-term conditions was managed effectively.</li> <li>• Responsibilities were shared throughout the practice for a variety of roles including a lead for safeguarding, infection control and managing significant events.</li> <li>• There was governance of the management and maintenance of risk assessment within the practice. There was up to date health and safety, fire and legionella risk assessments carried out with recommended actions completed.</li> <li>• There was oversight on emergency procedures as emergency medication and equipment was stored appropriately and staff were trained and aware on how to respond to emergency situations.</li> </ul>	

### Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<ul style="list-style-type: none"> <li>The practice had a programme of quality improvement activity and clinical audits to improve care and treatment for patients.</li> <li>Appropriate risk assessments were being routinely carried out.</li> <li>The practice had an up-to-date business continuity plan in preparation for major incidents. Staff members we spoke to displayed an understanding on how to maintain the care of patients during major incidents. Staff members were also able to recall the practices' response to a major incident whereby they followed emergency protocol following a patient incident.</li> </ul>	

#### **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
<ul style="list-style-type: none"> <li>The practice used QOF indicators to monitor and improve performance.</li> </ul>	

#### **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
The practice provided examples of how they utilised patient views to improve the service. For instance, increasing appointment times to 15 minutes and introducing a new telephony system. The practice recognised the need to restart their Patient Participation Group (PPG) after the pandemic and continued to increase the number of participants. The practice holds regular meetings with their PPG.	

Feedback from Patient Participation Group.

Feedback
A member of the PPG informed us they felt listened to by all members of the practice. This included the care and treatment they received during their appointments, as well as the reception staff handling the administrative aspect of their appointments.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<ul style="list-style-type: none"> <li>The practice was involved in clinical audits and quality improvement work.</li> <li>The practice shared learning from complaints and significant events.</li> <li>The practice registered as a 'Safe Surgery'; a campaign run by Doctors of the World to promote healthcare access to those in vulnerable circumstances.</li> </ul>	

**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

#### **Glossary of terms used in the data.**

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