

# Care Quality Commission

## Inspection Evidence Table

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

**Inspection date:** Remote interviews 14 March 2022 and site visit 16 March 2022

**Date of data download:** 10 March 2022

## Overall rating: Inadequate

### Safe

### Rating: Requires Improvement

The practice is rated requires improvement for providing safe care as:

- Comprehensive recruitment checks had not been completed
- Risks associated with legionella hadn't 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.

#### Safety systems and processes

**The practice had improved safeguarding systems following our last inspection. However, gaps remained in respect of recruitment, training for emergencies and premises risk management.**

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
At our last inspection we found that the safeguarding adults' policy did not include local authority contact details for staff to make safeguarding referrals and there was no reference to the systems and processes used to report suspected cases of female genital mutilation (FGM).	

Safeguarding	Y/N/Partial
At this inspection we saw that both the child and adult safeguarding policies had reference to FGM including action to be taken when staff were faced with suspected cases. The adult safeguarding policy had also been updated with local external safeguarding leads and points of contact.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
<p>At our last inspection we found that recruitment checks had not been completed for a clinical member of staff and that the practice recruitment policy was insufficiently detailed though was revised after our inspection. At this inspection we found gaps in recruitment information for three of the staff members including the absence of:</p> <ul style="list-style-type: none"> <li>• References</li> <li>• Induction schedules</li> <li>• Confidentiality agreements</li> </ul> <p>Clinical staff whose files we reviewed all contained evidence of immunisations for common communicable diseases. The practice provided a spreadsheet which stated that all staff had received immunisations; although two non-clinical staff members had no evidence of immunisation status in their files and no risk assessment to consider the need for these.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2022	Partial
There was a fire procedure. Date of fire risk assessment: January 2022	Y
Actions from fire risk assessment were identified and completed.	N/A
<p>At our last inspection the provider had not completed a health and safety risk assessment and the premises risk assessment focused on risks associated with equipment and not the premises. At this inspection we found that the provider had completed a premises risk assessment in March 2022 which involved an assessment of risk associated with the building and fixtures. We asked the practice manager for a copy of their health and safety risk assessment and were provided with a copy of the premises risk assessment.</p> <p>The provider submitted a legionella risk assessment that was completed in June 2021. There were several action points that were recommended to be given high priority. The practice told us that a gas supplier had undertaken works which addressed these priority areas. However, the documentation</p>	

provided from the gas supplier did not refer to this work. The practice provided us with details of work that would be undertaken to address the risks identified by the assessment after our inspection.

At our last inspection we found that the practice's fire procedure was not displayed in the practice waiting area and that details of practice fire drills had not been documented.

The practice placed a sign in the reception area following our last inspection. The provider also supplied evidence that they had undertaken two fire drills in September 2021 and one in January 2022. Both contained actions points for how to improve the service's fire evacuation procedure.

The fire risk assessment completed had no action points.

## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 7/2/2022	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
At our previous inspection we found that the room used for minor surgery had inappropriate flooring. At this inspection we found that the flooring had been replaced and had coving which allowed for hygienic cleaning.	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety in most areas but some staff were not adequately trained for medical emergencies.**

	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.	Partial
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 who had not completed sepsis training. At this inspection we found that one member of staff whose training files we reviewed had not completed basic life support training. Training was completed following our inspection.

## 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.	N/A

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.71	0.64	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	9.6%	9.7%	9.2%	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	8.03	5.48	5.28	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	45.8‰	61.5‰	129.2‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.31	0.57	0.62	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	2.9‰	4.6‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
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 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

Medicines management	Y/N/Partial
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 PHE guidance to ensure they remained safe and effective.	Y
<p>At our last inspection we found that a number of patients prescribed high risks medicines or medicine that required periodic checks were either not being appropriately monitored. We also found that the practice did not have a supply of one emergency medicine or children's defibrillator pads; although these were purchased following our visit.</p> <p>At this inspection we found that the practice had all recommended emergency medicines and children's defibrillator pads. We also found that concerns related to the high-risk medicines we reviewed at our last inspection had mostly been addressed. However, we found that a small number of patients where next test due dates for warfarin were not 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. Following our inspection visit, the practice told us that they were receiving support from a PCN pharmacist to address these issues.</p> <p>The practice had completed a single cycle audit of prescribing of antibiotics for non-complicated urinary tract infections on 5 March 2022 and found that in 50% of cases (5 patients) appropriate urine tests had not been completed in line with guidance. The practice planned to discuss the findings in a clinical meeting and remind staff of the relevant guidance to follow prior to prescribing these medicines.</p>	

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

**The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	19
Number of events that required action:	19
At our last inspection we found that there were two members of staff who were unable to outline a recent significant event. At this inspection we found that all staff were able to provide an example of a recent significant event.	

We were provided with the notes of a clinical meeting from 7 December 2021 and a staff and clinical meeting from 14 December 2021 which refer to an incident with a patient. Reference was made in the 7 December 2021 meeting about an incident with a prescription that was treated as a complaint.

There was no reference to either matter on either the significant event or complaints spreadsheets that the practice provided. However, the practice manager outlined discussion and action taken to address this concern.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Patient identified as being prescribed two medicines that should not be taken together	Patient stopped having these medicines prescribed together and pharmacist to include a search for patient on both medicines in regular reviews of medicines.
Fire alarm sounded in error	Premises evacuated within a minute and fire alarm repaired.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>At our previous inspection we reviewed patients taking a medicine that had been the subject of a high-risk medicines alert and found that appropriate action had not been taken; though the provider told us these patients had been followed up after our assessment.</p>	
<p>At this inspection we ran a search of patients who were prescribed 40 mg of simvastatin and amlodipine. This combination was the subject of a medicine's safety alert issued in 2014. The search highlighted the records of 13 patients prescribed this combination. We reviewed the records of five patients and found that all of these patients had their medication recently updated to address the concern highlighted in the safety alert. However, the last prescription for this combination was issued for all five patients between January 2022 and March 2022. This indicated that the system for responding to safety alerts was not effective as action was not taken in 2014 to either change the prescriptions of those prescribed this combination or to undertake periodic reviews of the clinical system to ensure that this combination was not prescribed in the future.</p>	
<p>The practice told us of action taken following our inspection to ensure that safety alerts were appropriately actioned including creating a folder of alerts and using this to run periodic searches.</p>	

## Effective

## Rating: Inadequate

The practice is rated 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.

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment were delivered in line with current legislation and standards but systems to identify patients with undiagnosed medical conditions were not always effective.**

	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.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
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
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. For example, we saw that patient safety alerts were not actioned in a timely manner and that a small number of patients prescribed medicines that required regular monitoring were overdue.

## 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.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- We ran a search to identify patients who had a possible missed diagnosis of diabetes. The search identified three patients whose records we reviewed. The patients had been incorrectly coded as having suspected diabetes when they were diabetic. Lack of proper coding meant that these patients were not informed of their condition and had not been referred for appropriate assessment or given appropriate treatment. We also found that one of these patients was prescribed a medicine that could cause a spike in insulin levels and another had undiagnosed chronic kidney disease (CKD). The practice told us that they had implemented a system following our inspection to link medications on their clinical system to possible diagnosis which would flag possible diagnosis to clinicians so that these could be considered and records coded where appropriate.
- We ran a search for patients with a potential missed diagnosis of CKD. The search highlighted 131 patients. We looked at five of the records and all five patients had undiagnosed CKD. One patient had also been prescribed a medicine for many years which was contraindicated for long

term use in patients with CKD. The practice told us that after the inspection they coded all patients and followed up those patients who required monitoring or other follow up.

- We ran a search of patients who had been prescribed 12 or more SABA inhalers in the last 12 months and found six patients who had been issued more than 12 inhalers. Four of these patients had no diagnosis of COPD. One of these patients had not received an asthma review since 2019 and another patient was not coded as asthmatic. Again, the practice hoped that linking medications to possible diagnosis would ensure that patient conditions would be easily identifiable. We were also told that the nurse was undertaking an audit of patients prescribed this medicine with the support of the PCN pharmacist prior to our visit and the practice provided us with a review of patients completed as part of the audit after our inspection.
- Aside from the concerns above we found that generally patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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)	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)	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 Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England)	48	65	73.8%	Below 80% uptake

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)	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)	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 found that the practice had not met any of the five childhood immunisation targets.

At this inspection we found that one target had been met though the other four had slightly declined. Unverified data provided by the practice was in line with the figures above.

The practice primary care network (PCN) had employed a care coordinator who worked in several practices in the locality. This staff member would call patients and encourage them to attend screening programmes either provided by the practice or other local health services. The care coordinator told us that their job had, since September 2021, involved ensuring that children were being recalled and immunised at the correct time as previously the practice was immunising children outside of the recommended schedule. They could book appointments with a nurse or doctor who could counsel patients on the benefits of immunising their children. The practice disputed the assertion that children were previously not being recalled for immunisations during the recommended schedule.

Practice staff told us of other ways in which they were trying to improve uptake including holding a mother and baby clinic, getting administrative staff to support efforts and delegating long-term condition management tasks to the practice healthcare assistant to allow the practice nurse to focus on immunisation targets. While staff at the practice told us that provision of childhood immunisations continued throughout the pandemic they said that parents were reluctant to bring children into the surgery and that there was continued vaccine hesitancy which staff found difficult to overcome due to cultural barriers.

Reference will also be made to the cultural resistance, the mother and baby clinic and the administrative support staff.

The practice provided unverified data from their clinical system which indicated that performance against targets in March 2022 was

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) – 90%

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) – 91%

The percentage of children aged 2 yearsmonths who have received immunisation for measles, mumps and rubella (one dose of MMR) – 85%

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) – 88%

The practice provided unverified data from their clinical system which indicated that performance against targets in April 2022 was

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) – 91%

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) – 73%

The percentage of children aged 12 – 18 months who have received immunisation for measles, mumps and rubella (one dose of MMR) – 77%

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/09/2021) (Public Health England)	69.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	68.0%	52.4%	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) (PHE)	60.0%	63.5%	66.8%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) <sup>(PHE)</sup>	83.3%	52.8%	55.4%	No statistical variation
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### Any additional evidence or comments

At our last inspection we found that the practice had not met targets for cervical screening. Although performance had improved slightly since our previous inspection, the practice was still below target. The PCN care coordinator was also focused on trying to encourage women to attend for screening and the practice nurse that they would opportunistically engage women who were overdue for screening when they attended other appointments. Patients could also book appointments at extended access hubs outside of working hours and there was provision of specialised clinics for patients who were nervous about the cervical screening process.

The practice had completed a two-cycle audit looking at the uptake of cervical screening. Through the use of a new systems that allowed for better data capture and recall the practice increased the proportion of women aged 25 to 49 who had received cervical screening from 75% in December 2021 to 88% in March 2022 and those aged 50 – 64 from 78% to 82% in the same period. The data within this audit was unverified. After our inspection we were provided with unverified data from the practice's system for May 2022 which indicated that 88% of women aged 25 to 49 had an adequate screening test recorded in the previous 3.5 years and 83% of women aged 50 to 64 had an adequate screening test recorded in the previous 5.5 years.

The practice provided further verified data from NHS digital screening coverage which showed that between March and December 2021 68.1% of women aged 25 to 49 had an adequate screening test recorded in the previous 3.5 years and 74.8% of women aged 50 to 64 had an adequate screening test recorded in the previous 5.5 years.

Performance against targets for bowel screening had increased since our previous inspection (previously 53%) and the proportion of new cancer cases detected using the two week wait pathway had increased from 45.5% at our last inspection.

### Monitoring care and treatment

#### The practice had a comprehensive programme of quality improvement activity.

	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 previous inspection we found that the practice had not demonstrated improvements based on clinical audits or other quality improvement activities, though they had completed some single cycle audits.

At this inspection we found quality improvement activity had been completed.

In addition to the two-cycle audit focusing on cervical screening (see above) the practice had completed a two-cycle audit of their learning disability review procedure. The audit aimed to ensure all relevant monitoring tests had been requested/recorded and assessment had been undertaken to determine whether patients on medications had appropriate reviews for completed for these and/or other health conditions. The outcome of the first cycle of the audit in August 2021 showed that although most patients had their learning disability review, 86% had not been done using the correct recording template and 47% of patients had not received appropriate blood monitoring. The second cycle completed in November 2021 showed that 100% of patient eligible for review had been reviewed using the correct template and had appropriate monitoring completed.

The practice had completed a single-cycle controlled drug prescribing audit, cancer and urinary tract infection audit.

### Effective staffing

**Although staff had received the appropriate clinical training to enable them to provide effective care and treatment, some staff whose files we reviewed had not completed all mandatory training.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
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.	Partial
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.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

There were some gaps in staff training. For example, we found that one staff member had not completed fire safety training, two had not completed sepsis training and one had not basic life support training on file.

Two members of staff had no record of induction on file.

At our last inspection we found that a clinical member of staff had not received an appraisal. At this inspection we found that all staff whose files we reviewed had received an appraisal within the last 12 months.

## 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

## 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

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y



## Caring

**Rating: Good**

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Most of the 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

Patient feedback	
Source	Feedback
Patient interviews	Patients we spoke with during the inspection told us that most, particularly clinical, staff were kind and treated them with respect. Some patients did say that reception staff could be rude, and this coincided with difficulties getting appointments since the beginning of the pandemic.
Feedback to CQC & Google reviews	Some patient feedback indicated that patients found the approach of reception staff to be rude.

### National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	91.9%	90.1%	89.4%	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 (01/01/2021 to 31/03/2021)	93.4%	88.5%	88.4%	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 (01/01/2021 to 31/03/2021)	96.3%	96.0%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	87.0%	85.2%	83.0%	No statistical variation

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

Any additional evidence
<p>The practice told us that they would send patients text messages after appointments that allowed patients to respond with feedback. However, they had not collated or reviewed this.</p> <p>Although the practice had not undertaken their own patient survey, they had analysed feedback from the national GP patient survey and developed action plan for scores where the practice had scored below local and national averages which predominantly related to access and appointments.</p>

### 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.	Staff we spoke with indicated that the practice made efforts to involve them in decision about their care and treatment and spoke highly of the quality of care provided by clinical staff.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their	94.8%	93.2%	92.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)				

	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.	3.3% - 219 carers
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: 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

Practice Opening Times	
Day	Time
Opening times:	
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
<ul style="list-style-type: none"><li>• Patients had a named GP who supported them in whatever setting they lived.</li><li>• 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.</li><li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li><li>• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</li><li>• 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.</li><li>• The practice held a register of patients living in vulnerable circumstances including those with a learning disability.</li><li>• People in vulnerable circumstances were easily able to register with the practice.</li></ul>

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

### Feedback from patients indicated that people were not able to access care and treatment in a timely way.

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	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

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	55.4%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	65.4%	74.8%	70.6%	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 (01/01/2021 to 31/03/2021)	59.7%	71.4%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	80.3%	82.1%	81.7%	No statistical variation

### Any additional evidence or comments

The practice had reviewed the national patient survey scores and developed an action plan to address possible concerns which had resulted in below average scores including:

- Changing the telephone provider to obtain more lines.
- Recruited additional reception staff.
- Encouraging more patients to use electronic prescribing in order to reduce the number of patients requesting prescriptions over the telephone.
- Starting video group consultations for patients with long term conditions to better utilise doctor appointments and provide better support for patients.
- Training the healthcare assistant to support housebound patients.
- Offering double appointments for patients with complex needs.
- Obtaining support from staff employed by the Primary Care Network including physicians associate, social prescriber and pharmacist.

The practice manager told us there were initially problems with the new telephone system, but these issues seemed to have reduced. They told us that the pandemic had highlighted deficiencies in the phone system as previously people would typically make appointments by attending the surgery in person. We were also told of difficulties in recruiting staff to the reception team, that some staff had been absent for long periods of time and that staff had left during the pandemic. The practice told us that they were still looking for additional reception staff.

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Source	Feedback
Patient interviews	Some patients we spoke with during the inspection said that it was difficult to get through on the phone and that since the pandemic it had become harder to get an appointment.
Feedback to CQC & search engine reviews	Patient feedback to CQC highlighted difficulties both in accessing appointments and difficulties getting through on the telephone. However, complaints about phone access lessened after July 2021. A key element of the feedback from unverified online reviews related to access to appointments and difficulties with the telephone system.
Staff feedback	Feedback from staff was mixed with some staff saying that the appointment system had improved as a result of the new phone system. Other staff said that more staff were needed to improve access and meet patient demand.

### 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.	9
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>We were provided with the notes of a clinical meeting from 7 December 2021 and a staff and clinical meeting from 14 December 2021 which refer to an incident with a patient. Reference was made in the 7 December 2021 meeting about an incident with a prescription that was treated as a complaint.</p> <p>There was no reference to either matter on either the significant event or complaints spreadsheets that the practice provided. However, the practice manager outlined discussion and action taken to address this concern.</p>	

Examples of learning from complaints.

Complaint	Specific action taken
Delay with prescription being provided	Investigated issue with requesting pharmacist and discovered that delay was the result of lack of communication from the local pharmacy. Action to resolve the issue and provide patient with medicine requested.
Issue with telephone system	The practice changed telephone provider



## Well-led

## Rating: Inadequate

The practice is rated inadequate for providing a well led service as governance and risk management systems and processes had not sufficiently improved and additional risks and concerns were identified at this inspection.

### Leadership capacity and capability

**There was compassionate and inclusive 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
At our last inspection we were told that one of the managing partners was acting as practice manager on a temporary basis. We were told during this inspection that the managing partner, who previously worked as a paediatric consultant and had clinical managerial experience, was now the full-time practice manager. They told us that they undertook a single clinical session once a week related to paediatric care.	

### Vision and strategy

**The practice had a clear vision and credible strategy aimed at providing 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 and supportive culture.**

	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
At our last inspection we found that staff did not have access to a Freedom to speak up guardian. We reviewed the practice's updated whistleblowing policy at this inspection which included details of the external freedom to speak up guardian.	

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

Source	Feedback
Staff interviews	Staff told us that they were happy working at the service. They said that there was an open culture and they felt well supported in their role.

## Governance arrangements

**The overall governance arrangements were ineffective in some areas.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
At our last inspection we found that governance arrangements were not effective at identifying and mitigating risks.	
At this inspection we found that systems and processes had improved in several areas including in relation to systems related to safeguarding and whistleblowing. However, there were several governance areas that required further improvement including systems related to medicines safety alerts and those which identify and respond to patients with undiagnosed long-term conditions.	

## Managing risks, issues and performance

**Although there had been some improvement since our previous inspection, the practice still did not have clear and effective processes for managing some risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
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 that the risks in relation to safeguarding, recruitment records, safety systems and records, health and safety and medicines management had either not been identified or adequately addressed. At this inspection systems related to safeguarding had improved. However, there were still gaps in recruitment records, risks identified related to legionella had not been addressed and systems for responding to safety alerts did not ensure that timely action was taken.</p> <p>At previous assessment found that the provider had not effectively demonstrated improvements based on clinical audits or other quality improvement activity in the last two years. At this inspection we found that the practice had undertaken two cycle audits which had resulted in improvement in care for patients.</p>	

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

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

### **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

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

### The practice involved patients, 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
At our last inspection we found that the PPG had not met since the beginning of the pandemic and that the practice was trying to encourage more patients to join. At this inspection we found that there had been three PPG meetings. Minutes showed discussion with patients about the appointment system and the process for obtaining prescriptions.	

## Continuous improvement and innovation

### There were some systems and processes for learning and continuous improvement although further improvement was required.

	Y/N/Partial

There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
At our last inspection we found that some staff were not aware of any significant events. Staff we spoke with at this inspection were able to outline significant events.	
Although the practice had made some improvements since our last inspection; the concerns that we identified at our last inspection indicated a reactive approach to learning and quality improvement; for example a number of patient records reviewed indicated that action had been taken to try and address areas of concern or risk immediately prior to our visit.	

#### 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 CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.

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