Care Quality Commission

Inspection Evidence Table

Canberra Old Oak Surgery (1-2781330404)

Inspection date: 2 November 2022

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

Explanation of any answers and additional evidence:

- The practice had comprehensive policies governing their approach to safeguarding. These were reviewed annually and records showed safeguarding was regularly discussed at practice meetings. All staff signed a register to confirm they had read the policy. Staff gave an example of a safeguarding concern they had reported and demonstrated understanding of their responsibilities in that regard.
- Training was delivered by the group safeguarding lead on a quarterly basis. Staff across all five sites in the group shared experiences of and learning from safeguarding incidents.
- Records showed the practice maintained registers of children at risk and vulnerable adults. Patients with safeguarding concerns were flagged on the records system. Searches were run regularly to ensure the registers were up to date and where relevant, care plans for these patients were reviewed to ensure they continued to be appropriate.

Safeguarding	Y/N/Partial
• Requests for reports from local safeguarding teams were responded to by the practice's safeguarding lead, with support from the administrative team. Where input was required in person at case conferences, the doctor on-call was responsible for attending. • Out of hours services were able to access patients' summary care records from the practice's clinical records system. This would include any safeguarding flags. Out of hours services could add notes or alerts which were followed up on by the doctor on-call. • It was the service's policy for all staff to undergo DBS checks prior to employment and at three-yearly intervals. • Multi-disciplinary Team (MDT) meetings took place fortnightly. Attendees included GPs, community matrons, link workers, palliative care team members, district nurses and health visitors. Patients with safeguarding concerns were discussed and care plans were made/reviewed. Safeguarding cases were also discussed at bi-monthly primary care network (PCN) meetings to ensure learning was shared.	

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
Explanation of any answers and additional evidence: • The practice had a recruitment policy in place. We saw this was followed in practice. Records showed recruitment checks and records retained included DBS checks, interview notes, CVs, right to work in the UK and two references. Doctor and nursing staff were required to provide proof of qualification and registration with professional regulators. • Staff were asked to provide proof of vaccination. Where any vaccinations were missing, staff were referred to Occupational Health or to their GP to be vaccinated. If staff declined to be vaccinated, a risk assessment was carried out to decide if they could still carry out their role safely without being vaccinated.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18/2/22	Y
There was a fire procedure.	Y
Date of fire risk assessment: 17/2/22 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: • The provider and/or the landlord carried out a number of risk assessments including health and safety, manual handling, fire, legionella and infection control. • The most recent fire risk assessment had been carried out by an external company, instructed by the landlord. This risk assessment covered the whole health centre. Fifteen actions had been identified. There was an action plan in place to address areas of concern. We saw evidence of fire alarms checks, most recently on 10/10/22. • A health and safety inspection had been carried out on 18 February 2022 by an external company. We saw an action plan to address the areas of concern had been completed. The provider also	

carried out their own risk assessment on 17/10/22. This included an assessment of workplace hazards such as ventilation and temperature, lighting, waste management and cleanliness. No actions had been identified.

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: 26/10/22	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
Explanation of any answers and additional evidence: • The practice had an infection control policy in place. Minutes showed infection control was discussed at team meetings and daily team "huddles". • Infection control audits were carried out every six months by the lead nurse. We saw actions had been completed or were underway. •	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: • Staff were able to work across the five practices in the group. Therefore staff absences and additional staff requirements could be managed without requiring temporary reception staff. Phone lines could be diverted to one of the other practices if required. • The practice mainly used long term locums. There was a locum GP pack which was sent in advance and copies were available on site. This pack contained all the information they would need about the practice. Audits of locum consultations were carried out by the lead GP on a regular basis. • The practice had a defibrillator, oxygen and emergency medicines to respond to medical emergencies. Records showed these were checked regularly to ensure they were available and in working order. At the previous inspection in June 2017 we found emergency medicines were	

stored in two locations which were both kept locked. We told the provider they should review the efficiency of this in the event of an emergency. At this inspection we found emergency medicines were now kept in one location in an unlocked cupboard (although the trolley they were contained in was kept locked), in an area which was inaccessible to patients without a staff escort.

- There was also an emergency response policy in place and a panic alarm. Staff knew where these were located and how to use the alarm. Emergency drills were run regularly where staff practiced responding to a simulated emergency.
- Staff had undergone basic life support and sepsis awareness training. Guidance on how to identify and manage suspected sepsis was on display.
- Staff we spoke with told us there was sufficient staff and this was supported by the staff rotas.

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. [1]	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

- A review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.
- New patients' notes were largely received electronically. Those which were not were received electronically were summarised manually.
- Summary care records were used to share information with other agencies such as out of hours services.
- We saw referrals were made and followed up on. The practice had a referral lead who was responsible for overseeing referrals and ensuring they were monitored. There was a tracker to monitor "two week wait" cancer referrals which was updated daily. If the practice was not made aware of an appointment booked within the two weeks, there was a process to ensure this was followed up on.
- Test results were received into the practice's global inbox of their clinical records system. This was checked at least twice a day. Any abnormal results were assigned to the duty GP to review if the requesting clinician was unavailable. We checked the global inbox and found the oldest test results had been received three days prior. All had been reviewed by a GP.

- Prior to this inspection we received information that pharmacists at the practice had been expected to work beyond the scope of their role and without adequate support and oversight. Staff we spoke with told us non-clinical staff did not review test results. Pharmacists only reviewed the blood tests they had requested. If they felt the matter was beyond their scope, they could request the result be assigned to the duty doctor.
- Staff dealing with triaging patients worked as a hub, sitting in close proximity to each other. Hubs consisted of the on-call doctor (who was responsible for triaging), a pharmacist, physician's associate and administrative support. None of them worked in isolation apart from where the patient's needs required it. GPs and pharmacists we spoke with told us they found this a supportive and safe way to work as they could discuss cases and advise and learn from each other easily.

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.52	0.59	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	6.3%	8.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.97	5.57	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	46.1‰	57.7‰	128.0‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.40	0.46	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.1‰	4.8‰	6.8‰	No statistical variation

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 structured 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 high risk medicines (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

Explanation of any answers and additional evidence, including from clinical searches.

- We reviewed a sample of clinical records to review how patients taking specific categories of medicines considered to be high-risk medicines were monitored. We found these patients were being monitored accordingly.
- Medicines safety meetings were held regularly where clinicians reviewed the prescribing of high-risk medicines across the practice and ensured patients prescribed these medicines were being reviewed accordingly. Clinical pharmacists carried out structured medicines reviews and there were guidelines in place to support them. If any changes needed to be made to patients'

Medicines management	Y/N/Partial
medicines, this was discussed with the patient before any changes were made. Where patients did not respond to invitations for a medicines review, they could be given prescriptions for a reduced period of time to encourage them to have blood tests completed. • Medicines safety audits were carried out annually. There was a standard list of audits to be carried out to enable the impact of any resulting changes to be monitored. This also enabled any learning points to be identified and shared. Prescribing audits were carried out by the lead pharmacist and discussed with the clinical team. • Prescriptions were only printed at reception. When the practice was closed, blank prescription pads were stored in a locked room. There was a process in place for monitoring the use of prescription pads. • At the inspection in June 2017 we found there was no process in place to manage uncollected prescriptions. At this inspection in November 2022 we found there was now a process in place for checking the prescription box regularly. All prescriptions over a month old were reviewed by the duty doctor for any action to be taken. A log was kept of any prescriptions destroyed. • Records showed emergency medicines, defibrillator and oxygen were checked regularly and replenished. The practice held appropriate emergency medicines for their type of service. They did not hold any opiates and we saw evidence of a comprehensive risk assessment which was reviewed regularly. This included consideration of the likelihood of opioids being required in an emergency situation and the measures in place to mitigate any risk of not holding opiates.	

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.	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:	10
Number of events that required action:	10
Explanation of any answers and additional evidence: • The practice has a policy in place for the identification and management of significant events. • We saw significant events were logged on a central register, which was accessible to all staff. Safety updates were received from across the group's practices in England. Staff we spoke with understood what a significant event was and knew how to report and escalate them. • Significant events were discussed at weekly team meetings and monthly regional meetings where learning was shared.	

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

Event	Specific action taken
A medicines safety audit picked up a patient prescribed medicines which were not safe to take together.	Patient contacted to attend the practice for blood tests. Patient received an explanation and apology. Incident was investigated to ascertain how this had occurred. It was emphasised to clinicians the need for vigilance when signing patient prescriptions to first check the medicines patient is already prescribed and not to sign in bulk but to check each patient individually. Incident discussed with relevant clinician and asked to reflect. Incident discussed at regional meeting and shared on the incident reporting system.
Patient at the practice experienced an attack of palpitations and high blood pressure.	Duty GP attended. Review of incident found all appropriate steps were followed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

- The practice subscribed to all relevant sources to receive safety alerts including the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS). These were shared amongst all necessary staff members through various internal communication channels and were logged centrally where they could be accessed by all staff.
- Named staff were assigned to carry out the searches of the clinical records system to ensure all affected patients were identified, contacted and attended the practice for appropriate action to be taken.
- We saw examples of actions taken on recent alerts, for example, concerning risks to patients prescribed teratogenic drugs (medicines which can cause affect the development of unborn babies). Records showed affected patients were contacted and advised appropriately around the use of contraception.

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 prioritised care for their most clinically vulnerable patients.	Y

Explanation of any answers and additional evidence:

- Clinical staff were aware of and followed evidence based guidance and standards such as National Institute for Health and Care Excellence (NICE) best practice guidelines. These were discussed at weekly practice meetings where care needs of complex and vulnerable patients were also assessed. Latest guidance was also discussed and shared across all the organisations practices.
- The practice was aware of the issues affecting its patient population and planned and prioritised care accordingly. For example, they had arranged a learning day for patients around female genital mutilation (FGM) led by a midwife who specialised in FGM. This was combined with a walk-in cervical screening clinic. Staff told us this had been well attended and feedback from patients was positive.

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. 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.
- 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

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.
- Patients experiencing poor mental health could be referred to a psychological therapies service

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	93	106	87.7%	Below 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	62	85.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	56	62	90.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	62	85.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	10	14	71.4%	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

- The provider was aware the uptake of childhood immunisations was below target. They told us there was a high level of vaccine hesitancy amongst their patient population. To try and address this they had a dedicated childhood immunisation team (nurse and administrator) that was responsible for contacting patients and monitoring uptake. Additionally, all staff, including administrators and receptionists had received basic training to enable them to answer routine questions about immunisation.
- The practice staff was diverse and many were able to speak the languages used by a majority of their patients. This meant they were able to answer some concerns patients might have without having to arrange an appointment with a nurse or GP. They also made educational material available for patients to take away.
- Patients were routinely contacted by the practice when their children's vaccinations were due and staff opportunistically offered vaccinations when patients attended to practice for other reasons.
- Where patients continued to be reluctant, they were offered an appointment with a nurse to discuss any other concerns they might have. Some patients received their vaccinations abroad but did not provide the necessary documentation for their records at the practice to be updated.
- The practice had increased the number of appointments available for childhood immunisations available outside of working hours, including at weekends, through its primary care network (PCN) to accommodate working parents.
- The practice had a tracker which they used to monitor uptake of vaccinations. Performance was monitored and discussed at practice meetings where best practice and learning was shared.
- The practice provided data from their clinical records system which showed that for the period July to September 2022, 93% of eligible one year olds had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b and

Hepatitis B. the data showed 79% of 2 year olds had received their booster immunisation for Pneumococcal infection, 75% had received their immunisation for Haemophilus influenza type b and Meningitis C and 71% had received their first dose of immunisation for measles, mumps and rubella. 50% of five year olds had received their second dose of immunisation for measles, mumps and rubella. This was unverified data at the time of this inspection. We have told the provider they should continue to monitor and improve performance in this area.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	57.5%	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) (UKHSA)	50.6%	48.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	48.9%	57.1%	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) (UKHSA)	45.5%	55.9%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

- The provider was aware its performance in cervical screening was below target. They told us this was due to similar challenges as those around childhood vaccination, including having a high immigrant population and 'hard to reach' groups and general screening hesitancy.
- We saw examples of efforts made by the practice to raise awareness and inform the community about cervical screening. For example they had held women's health events which had speakers with different languages, informing and advising about cervical screening.
- The practice had a task force assigned to raise cervical screening performance. Recall monitoring took place on a continuous basis and performance was discussed at weekly meetings. Administrators had received training from a leading cervical cancer charity to support them when speaking with patients about cervical screening. The administration lead for cervical screening had received training from the lead nurse to equip them to answer patients' questions and encourage them to be screened.
- Text messages were sent to patients with leaflets attached providing information about cervical screening in their first language.
- The provider had recognised that patients may feel more comfortable receiving information about cervical screening from someone they knew. Therefore, they practice had created a video where

nurse and healthcare assistant spoke about cervical screening. The link to this video was sent to patients by text message.

- The practice had increased the number of nurse appointments available in the evenings and weekends to support access for working patients.
- The practice had discussed their performance with the cancer charity and received advice on how they could improve performance, specifically in view of the socio-economic factors impacting many of their population.
- The provider's data taken from their clinical records system showed in November 2022, 55% of their eligible cohort of patients were up to date with cervical screening (53% of 25-49 year olds and 71% of 50-64 year olds). This was unvalidated data at the time of this inspection. We have told the provider they should continue to monitor and improve performance in this area.

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

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

- The practice had a structured, comprehensive programme of audits and quality improvement activity. Examples of audits included uptake of bowel cancer screening, patients prescribed high-risk medicines, audits to ensure patients with long term conditions had been coded correctly and those carried out in response to medicines alerts, to ensure affected patients had been identified and managed appropriately. Results of audits were discussed at monthly meetings and benchmarked across all of the practices in the group. Examples of audits carried out in 2022 included:
    - An improvement project focussed on diabetes. This was carried out across all of the practices in the regional group. They had chosen diabetes because they recognised this was a large and growing challenge for their patients and for the NHS nationally. The aim of the programme was to improve their attainment in specified diabetic care processes and improve diabetes control. Pharmacist and organisational interventions were planned. Over the period of the programme, achievement in 'triple target' treatment targets (blood sugar level (Hba1c), blood pressure and cholesterol) had improved from 33% to 50% from May to November 2022.
    - An audit to identify patients whose HbA1c (blood sugar level) was above average (≥48mmol/mol) and those who were not recorded as diabetic was carried out in 2022. This two-cycle audit identified 11 patients with high blood sugar levels and five patients not recorded as diabetic. Of the five, four had nondiabetic hyperglycaemia and were referred to the National Diabetes Prevention Programme and one had Type 2 diabetes and was referred for Structured Education Programme and initiated therapy.

Effective staffing

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

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

Explanation of any answers and additional evidence:

- Prior to this inspection we were made aware of allegations that patients were booked in with pharmacists who had not been adequately trained or provided with sufficient protected time to enable them to carry out their role. Staff we spoke with, including pharmacy staff, told us this was not their experience of working at the practice. Pharmacists told us only the GPs triaged patients; deciding which patients were appropriate to be seen by a pharmacist. There was an on-call doctor available daily and that doctor was not booked any appointments that day. There was a protocol in place which set out the type of patient suitable for each practitioner. The duty doctor decided which patients could be seen by which practitioner (physician's associate, pharmacist, nurse or GP). Before the consultation, the GP discussed the patient with the practitioner first to ascertain if they were able to deal with that patient competently. Appointment lengths could be varied depending on the patient's needs and the practitioner's experience.
- We spoke with a range of staff including GPs, nurses, pharmacists and physician's associates. The pharmacists told us they started training initially by observing only and were then allocated patients based on their competency level. There were regular opportunities to review and discuss patients with senior clinicians. Reviews took place every three and six months which were recorded and reports were given. Reports included an analysis of the practitioner's competencies and where additional support was required.
- Initially pharmacists started working as part of a hub which included a GP, physician's associate and practice nurse. They sat in close proximity to each other. This was done to allow for support and oversight. We saw slots were allocated for debriefs where more complex cases could be discussed.
- We saw there were processes in place to support regular clinical oversight of consultations. As well as designated slots for debriefs, annual tests called Objective Structured Clinical Examinations (OSCE) took place. This included a simulation of various consultations and observation of how the member of staff would respond. Staff told us this allowed any knowledge gaps to be identified and additional training provided.

- The group's medical director reviewed consultations quarterly. Any significant events, complaints or incorrect referrals involving that member of staff were discussed as well as any training needs. The nursing lead carried out these reviews for nurses. There was a performance management process in place to be followed where staff were underperforming.
- Prior to this inspection we were made aware of an allegation that staff were not provided with sufficient time to undergo training. We raised this with the provider and spoke with various members of staff with different roles at the practice. Staff told us they were provided with sufficient time to undertake training within working time. They were provided with five study days a year and were paid overtime or given time off in lieu for any training done at home.
- We saw annual appraisals took place for all staff. At appraisals leaders set out the organisational priorities for the year and reviewed how these priorities had been achieved. Regular one to one meetings took place throughout the year with each staff member where their progress against a set training programme was discussed. Staff were encouraged at appraisals and one to ones to talk about their career goals and plans were made to support them to achieve them.

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
Explanation of any answers and additional evidence: • Multidisciplinary team meetings took place fortnightly. Attendees included GPs, community matrons, link workers, palliative care team members, district nurses and health visitors. Information about vulnerable patients or those with complex needs was shared and plans agreed to meet their health and care needs.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	

- The practice held lifestyle events were patients were invited to have their height, weight and BMI checked. Where appropriate, referrals were made to weight management services and patients were advised about exercise and healthy eating. The practice's social prescriber signposted patients to local support. Any vulnerable patients identified were discussed at multidisciplinary team meetings.
- The provider reviewed their palliative care patient list regularly.
- Patients were able to make some self-referrals directly, for example for musculoskeletal issues or through the practice website which also had some self-help guides. Patient educational information was sent to patients as well as being available on the website.
- The practice's online consultation platform provided patients with information about different patient care pathways. This supported patients to access this information on demand.

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. [1]	Y
Explanation of any answers and additional evidence • Records showed there were seven patients with an active DNACPR decision in place. We saw all of these decisions had been reviewed with the last year. • A review of clinical records did not reveal any concerns about DNACPR decisions. We found these decisions were clearly discussed, recorded and reviewed accordingly.	

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

Explanation of any answers and additional evidence:

- The provider told us their main challenge was around having a rapidly increasing patient list and sourcing the additional space required. Negotiations around that were underway. They also told us there were a number of social issues faced by its patients such as poverty, poor health (including mental health) and lifestyle. They had a number of patients who had fled disasters in their country of origin, who consequently had additional needs. The provider had adapted the practice to meet these particular challenges. For example flexibility around appointment times and intentionally recruiting from within the local community so patients could feel more comfortable discussing their needs.
- At the inspection in June 2017 we told the provider they should consider ways to inform patients about the range of languages spoken by practice staff. At this inspection in November 2022 we found this information was now available on the practice website, displayed at the practice and on staff name badges.
- Staff we spoke with told us the leadership were very supportive and visible. They felt no hesitation in speaking with leadership about any concerns and found them to be welcoming and understanding.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

- Staff we spoke with told us the provider informed and involved them in future plans for the practice and its aims. For example, staff told us they were focussed on connecting more with patients by putting on more community outreach initiatives and targeting their population's health needs.

- The practices' vision included working more closely as a primary care network (PCN), sharing experiences and improve practice across the PCN.

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

Explanation of any answers and additional evidence:

- Staff we spoke with were aware of how to report and escalate concerns. They told us they did not feel hesitant about raising concerns and felt they would be supported by the leadership should the situation arise.
- Due to the nature of the organisation there were several layers of management, both within the practice and at regional and executive leadership level where concerns could be raised. Contact details for all staff were available on the practice's system. Staff also had access to a third party advice line.
- Details of the practice's Freedom to Speak Up Guardian were available on the practice's system.

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

Source	Feedback
Staff interviews (including receptionists, administrators, nurse and secretaries)	Staff told us: • They were well supported with training and given support and encouragement to advance in their careers. • There was an open culture at the practice, they felt comfortable and supported to ask questions and try new things. They felt comfortable to speak up if something had gone wrong. • There were open discussions about the organisation's strategic aims and all staff are involved. • Staff felt their values were reflected by the organisation. • Staff often met together and the team was friendly and helpful.

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 were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: • The practice was part of a large organisation providing primary care services across a large geographical area. Governance was overseen centrally with several layers of management and oversight involved. We found there were robust governance and oversight processes in place providing consistency and stability. Where appropriate, these processes were tailored to the specific needs or features of the practice. • All policies and protocols governing the operation of the practice were stored on the shared computer drive and on a cloud based system which staff could access on and off site. • Staff we spoke with understood their roles and responsibilities and knew where to find information about how the practice operated.	

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
Explanation of any answers and additional evidence:	

- The practice had a business continuity plan in place. Practices within the group were able to share staff and resources and they had collaboration agreements with other practices in the health centre if necessary.
- Practice performance was benchmarked against national standards and local achievement. Performance across all of the practices in the group was monitored and compared at regional level to support the identification of any challenges to performance.
- The practice had processes for regular quality improvement activity including a regular cycle of audits. Audits were repeated to monitor improvement.
- We found regular risk assessments took place, including infection control, health and safety and fire. Any actions identified by these risk assessments were assigned and completed (or were underway).
- There was a business continuity plan in place. Staff knew where this was located. It could be accessed on and off site.

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

Explanation of any answers and additional evidence:

- The provider used regional and national internal and external data to benchmark achievement and monitor performance. Examples included data about performance in the management of patients with long-term conditions, childhood immunisation and cervical screening achievement.
- Staff we spoke with told us the practice's performance was shared and discussed at practice meetings and daily team "huddles". They were involved in discussions about how to make improvements.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y

The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Explanation of any answers and additional evidence:

- Initial contact with the practice was mainly through an online consultation platform. We found staff at all levels knew how the platform worked and were able to advise and help patients to use it.
- The provider ensured patients were made aware of any potential for breaches of privacy when using digital services and how to protect their personal data. There was also guidance on the practice's website and on the digital application.

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:

- At the inspection in June 2017 we told the provider they should continue to monitor and act in response to patient feedback to drive improvements. At this inspection in November 2022 we found the provider carried out regular patient surveys, most recently in 2022 and an action plan had been devised. This survey had been discussed with the PPG.
- We saw the action plan devised following the 2022 survey. Examples of actions taken in response to feedback included recruiting more GPs and using long-terms locums to support patients in getting appointments and getting to see their preferred GP. The provider had also worked with their patient participation group (PPG) and held a community events at the practice to explain to patients how their appointment system worked, provided mental health training to improve staff awareness and put a link worker in place to help signpost patients to local services who could assist patients with long term condition management.
- We saw minutes of the most recent PPG meeting (October 2022). We also spoke with the chair of the PPG. We found the practice worked collaboratively with the PPG to improve the care they provided for patients and their experience of using the practice. We saw the leadership shared their vision for the practice with the PPG and responded to any issues or comments raised by PPG members.

Feedback from Patient Participation Group.

Feedback
We spoke with the chair of the PPG who told us: • Following the lifting of COVID-19 restrictions, some patients were dissatisfied with the online triage system. The PPG worked with the practice to educate and inform patients about how the system worked and highlighted ways in which those who did not have online access or smart phones were still supported to access the practice. • The leadership of the practice was very supportive of the PPG and demonstrated this by always attending the quarterly meetings and meeting with the PPG chair before each meeting to agree the agenda. Suggestions made by the PPG were always considered and where possible, taken on board. For example community events and educational sessions. • The PPG was involved in patient information and education initiatives such as informing patients about where to get vaccination boosters and training patients on how to use the online consultation tool. They had recently run a training event on a Saturday morning which was attended by over 35 patients. • Future plans for the PPG included looking at how the practice could work even better with the wider community, for example inviting local food banks, mental health teams and other community groups to hold information events at the health centre.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

- The provider showed a commitment to supporting its patients and the local community in tackling the social and health related challenges they faced. For example the practice had put on and/or been involved in a number of community events such as women's health and cervical screening awareness events, events aimed at connecting with older patients and those from ethnic minority groups and diabetes awareness events. They had connected with several local community groups and worked collaboratively with them.
- Staff had identified many patients were at risk of isolation or represented "hard to reach" groups. To encourage these patients as well as local residents to engage with the local community and to help them with advice about diet, exercise and socialising they started a weekly park walk at the park adjacent to the health centre. We were told several locals made friendships through this group and patients could be signposted to support services.
- The organisation had developed an online consultation platform, which was managed by an in-house technology team. Forty percent of the practice's patients had registered to use the platform. This platform was intuitive, following pathways depending on the data inputted by the user, to help patients identify and access the support they needed. The outcome of each online

consultation was always reviewed by a doctor to ensure it was correct. This application was accessible from anywhere on any digital device and enabled live, two-way conversations with patients.

- The provider had designed a training package for allied health professionals (AHPs) (trained health care professionals including physiotherapists, occupational therapists, podiatrists, dieticians and paramedics). This was a bespoke programme aimed at supporting these professionals to be used more widely, within the scope of their practice, to support patients in having their care needs met quickly and by the most appropriate person.
- The provider had undertaken projects targeting long term condition management, for example diabetes and cancer screening projects. Their aim was to ensure health checks were carried out and to improve the uptake of screening. Staff at all levels received specific training to enable them to answer patients' questions when they contacted them to invite them for reviews and screening.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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