

Care Quality Commission

Inspection Evidence Table

City Health Centre (1-8501998035)

Inspection date: 1st August 2022

Date of data download: 25 July 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
<ul style="list-style-type: none">• Safeguarding training was delivered by gtd Healthcare academy and records showed all staff had been trained to the appropriate levels.• There was a safeguarding lead within the practice, who was supported by the gtd Healthcare Child and Adult safeguarding leads at head office. All safeguarding concerns were reported through a central system.• All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. Staff we spoke with were familiar with what they should do if they had safeguarding concerns and were able to give examples.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<ul style="list-style-type: none"> Recruitment was centralised and managed by a human resource team at the head office, with clear recruitment policies and procedures in place, including details of the checks required for locum staff. We reviewed four staff files and found recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body, references and the appropriate checks through the DBS. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:12/21	Partial
There was a fire procedure. Date of fire risk assessment:12/21	Yes
Actions from fire risk assessment were identified and completed.	Partial
<ul style="list-style-type: none"> The building was managed by an external company who were the landlords and responsible for some of the maintenance and health and safety measures of the building. There were areas of concern identified during the inspection, which were also rectified during the inspection. For example: We were told that the tap water in the building was not suitable to drink and staff informed us there had been times where no drinking water had been available onsite. We were told there had been times during clinical consultations where the GP was unable to offer a patient a drink of water. By the end of the inspection senior managers had recorded a risk assessment and action plan to address this. All clinical rooms had a sealed bottle of drinking water and disposable cups available, staff had accessible water cylinders, posters had been developed and placed in all clinical rooms and staff were emailed to inform them of the new process. The baby changing area in the waiting area had a waste drainage problem. This was escalated to the property management for review. The provider immediately closed the area to patients until the issue had been fully resolved. 	

- There had been no risk assessment or process in place for the shared use of the EVAC chair (a chair used for wheelchair patients in an emergency) used in case of a fire evacuation. Staff were not aware what to do in an emergency. We spoke directly to the lease holder on the inspection day, who explained that their customers, rather than the practice's patients would take priority over the use of the two evac chairs available within the building if an emergency did ever arise.

During the inspection the senior managers took action and developed a risk assessment, reviewing the immediate risk and mitigating this by: asking the lease holder if one of their two evac chairs could be placed at the top of the second floor, training for staff in the use of the evac chair being sourced and the purchase of the providers own evac chair had been discussed before the end of the inspection.

Any risk identified during the inspection was mitigated by the end of the inspection day and further supporting evidence was submitted after the inspection.

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 (IPC).	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 06/22	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

- Legionella testing was provided by the landlords of the building. However, no evidence to state these had been taking place regularly with assurances at the time of the inspection was available.

During the inspection we spoke directly with the landlord who confirmed that the legionella testing was done on a regular basis and the results uploaded into an online portal. However, access to the portal was not available to view on the day of inspection. After the inspection, we were provided with a copy of the legionella testing records which had taken place on the 24 June 2022. Access to the online portal for audit purposes had been requested.

- We reviewed the latest 'Infection Control Annual Assurance Statement' dated April 2021- March 2022. The practice achieved 75% in their last IPC audit dated March 2022, most of the actions identified in the plan had already been resolved. However, the legionella issue identified was listed as a follow up action in the audit.
- There was an organisation wide IPC lead who supported the practice and carried out regular audits and spot checks. Key infection prevention and control measures included information such as an IPC framework for practice staff to follow and a monthly clinical newsletter including changes to COVID-19 related guidance.
- Appropriate standards of cleanliness and hygiene were met, and guidance was updated to reflect the latest COVID-19 guidance.

- We observed most of the premises to be clean and tidy and personal protective equipment and hand sanitiser was readily available for staff and patients.
- Staff had received up to date training in the form of online and face to face support from the head office.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<ul style="list-style-type: none"> • There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. Staff worked flexibly across this and another site to ensure skill mixes and basic staff numbers remained safe. • There was an effective induction system for temporary staff tailored to their role. • Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. • In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. • The practice had introduced a Monkey Pox policy (newly circulated infectious virus) in June 2022 and decision tree to support staff in the potential symptoms, treatment, management of this. National signposting guidance was also available to support staff and patients with a suspected diagnosis. 	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<ul style="list-style-type: none"> Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. 	

Appropriate and safe use of medicines

The practice had 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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.48	0.88	0.79	Significant Variation (negative)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	4.8%	8.5%	8.8%	Variation (positive)
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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.05	4.99	5.29	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	20.0‰	167.7‰	128.2‰	Significant Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>	0.13	0.86	0.60	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	2.0‰	7.7‰	6.8‰	Significant 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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N/A
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes

Medicines management	Y/N/Partial
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> • The practice provided the local walk in service and worked closely with the local medicines management team in monitoring antibacterial prescribing in this area. Weekly prescribing figures were monitored and submitted to NHS Greater Manchester Integrated Care. • As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. The records we examined provided evidence that the majority of patients prescribed high risk medicines had been monitored appropriately and in a timely manner. Where our searches identified gaps in monitoring, the practice was able to provide evidence that patients had been recalled for monitoring and there was a clear plan in place to follow up those patients who had not attended. • There were clear medicine management and prescribing policies and procedures in place including a home visiting policy and a protocol for those patients prescribed lithium. • During the COVID -19 pandemic, the practice in line with guidance, had prioritised monitoring of those patients prescribed the most high-risk medicines. Working with the central data team they were in the process of identifying those patients who were due monitoring and systematically scheduling appointments with patients. • The organisation employed a medicines management team, which included pharmacists and pharmacy technicians who supported the practice, carrying out regular medicine audits to ensure prescribing was in line with best practice guidelines for safe prescribing. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	8
Number of events that required action:	8
<ul style="list-style-type: none"> • There were good systems for reviewing and investigating when things went wrong. The service used a secure web-based incident management system to record and monitor incidents. • Incidents were reviewed for significance and those identified as moderate or above were managed in conjunction with the provider's central governance team who support the investigation process. • City Health Centre had recorded eight low level incidents in the previous 12 months. However, we noted GPs were not recording incidents with only one clinical incident reported by the pharmacist. • The organisation learned and shared lessons, identified themes and acted to improve safety in the service. Feedback regarding events and findings were discussed during governance meetings and clinical service quality performance meetings. • The organisation produced a monthly governance newsletter for all staff where they shared lessons learnt from across the whole organisation and highlighted the changes introduced as a result of incidents 	

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

Event	Specific action taken
Prescribing error noticed by pharmacist before issued to patient.	Reported incident via the reporting system. Error noticed prior to issuing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<ul style="list-style-type: none"> • The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. • Where action was required as a result of a safety alert the central data team would run searches of clinical records to identify patients who may be affected. • Clinicians would then review patients and make changes to care and treatment where required. 	

- Details of safety alerts were also included in the monthly clinical newsletter where a summary of new National Institute for Clinical Excellence (NICE) guidance and safety alert information was produced.
- From a sample of patients' records we reviewed, we found action had been taken on the most recent alerts, and a system had been introduced to ensure they continued to audit medicines previously subject to safety alerts to ensure prescribing continued to be in line with up to date guidance.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
<ul style="list-style-type: none"> • There were organisation wide clinical leads in post, including medical and non-medical clinic leads, palliative care and safeguarding leads. The leads were available to provided support, advice and guidance to staff within the practice. 	

Effective care for the practice population

Findings

The practice had designed and was delivering two government schemes . The Afghan Relocation Assisted Programme (ARAP) and the Asylum Seekers Contingency (ASC) both supported families placed in temporary accommodation in the City centre. service did not differentiate between permanent and temporary/transient patients

The Afghan Relocation Assisted Programme (ARAP) and Asylum Seekers Contingency (ASC) provide a full range of primary examinations, screening for families within their hotel rooms, which to date has seen:

- 880 patients screened over the last six months
 - 98% uptake rate for cervical screening
 - 71 positive for an infectious virus patients were referred to the relevant secondary care specialist by an agreed pathway of care with the trust
 - All patients received pre and post screening counselling offered in the patient's first language including Dari, Fassi and Pashtu resulting in an 98% uptake of care.
 - Positive outcomes included changes to NICE guidance to reduce radiological Xray exposure to young children.
 - The provider had been nominated for three collaborative Heath Service Journal (HSJ) awards 2022, for their service delivery of these unique programmes.
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- The number of registered patients over age of 65 equated to 1% of the patient population.
 - The proportion of patients signed up to online access via the NHS application was 67%. NHS England contacted the provider to use them as a case study to highlight the high uptake, which is above the national average.
 - The practice had systems to inform eligible patients of annual review and for those before attending university for the first time.
 - The practice worked collaboratively with the primary care network (PCN) and another inner-city practice to support the homeless population in the city, by providing a no barrier approach to accessing healthcare. For example, if the homeless person had no access to a phone.
 - 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
 - Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
 - Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
 - All patients with a learning disability were offered an annual health check.
 - The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
 - Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required assessment and reviews were taking place. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately.
- All diabetic patients received access to an online resource which provided advice and support to help manage their diabetes. The online resource allowed patients to see their recent diabetic bloods results and blood pressure readings to enable them to have more autonomy in managing their diabetic care.
- 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.
- 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	58	60	96.7%	Met 95% WHO based target
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)	49	66	74.2%	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	49	66	74.2%	Below 80% uptake

Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	66	77.3%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	22	37	59.5%	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

- Practice leaders were aware of the lower uptake levels for children receiving immunisation. The practice supported a high number of transient patients, refugees and families placed in temporary accommodation within the City Centre. For example: The Afghan Relocation Assisted Programme (ARAP) and the Asylum Seekers Contingency (ASC) supported patients in temporary accommodation in the city. The service provided screening of childhood immunisation and further infectious screening. Due to uncertainty around any previous immunisation status of the children, the immunisation program had to be restarted.
- The service's clinical IT system logged all patients in the same way and there was no way to differentiate between patients' home circumstances. The practice had some solutions on how to resolve these problems. However, currently all patients were logged as a permanent patient. Action to remove historic patient data did take place, but the rate of families joining and leaving the service was significantly high.
- Demographics of the patient population showed children registered at the practice under the age of five equated to just 4% of the patient population.

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: 31/12/2021) (UK Health and Security Agency)	52.3%	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)	45.7%	51.5%	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)	49.0%	54.8%	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)	50.0%	55.7%	55.4%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> The provider explained how the demographic of the patients affected the uptake of cervical screening in the inner city centre area and pre inspection information provided to us by the practice did include a cervical screening ongoing action plan. We observed there was a dedicated cervical screening information board in the waiting area. The practice held a Women's Health weekend in collaboration with their local primary care network (PCN) where women could be booked in for screening, contraception advice or a fitted contraceptive device. This was so successful this service was now a monthly event. Additional smear appointments in the evening and at weekends for the working patient had been introduced. All patients overdue a screening were sent a video link by text message, informing patients about their overdue cervical screening and the importance of this screening. The provider hosted two services to newly arriving refugees and Afghan relocation programmes. Families were offered temporary residence in a hotel within the City. Due to the patient's circumstances, care was provided directly onsite to the patient in the hotel room. The service provided a GP and nurse onsite to deliver a one stop clinic and included dedicated smear clinics. Translators were part of the team and this approach had seen a smear uptake rate of 94%.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<p>We saw there was a range of quality improvement work carried out within the practice, supported by the central data and medicines management team. For example:</p> <ul style="list-style-type: none"> • Early cancer • Dementia face to face review • Diabetes Case Finding • Standard monthly clinical searches <p>The central data team monitored practice performance and provided reports to the practice, including performance against the Quality Outcomes Framework, National Screening Programme and childhood immunisation uptake.</p>
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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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<ul style="list-style-type: none"> The organisation had a head office based learning academy which co-ordinated and managed all learning and development activities. They produced a weekly summary of internal and external training and development opportunities. For example, one of the GPs was currently in the Ukraine and had been supported by the organisation to travel and volunteer their services for one year. Staff were encouraged to develop and were actively supported by the practice to gain additional skills and qualifications to enhance their roles. For example, during the practice's first inspection in 2016 we were told by a health care assistant, how they were being supported to start the journey to become a nurse. On the day of the inspection, the same staff member was a registered full-time nurse and had successfully been supported to achieve their degree. Staff had access to corporate and onsite induction. The organisation had launched a new appraisal process, with managers undertaking training and a schedule of new appraisal had been developed for 2022/23. 	

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<ul style="list-style-type: none">• The five key principles of the Mental Capacity Act were displayed, and guidance was available for staff in relation to the management of patients lacking capacity or refusing treatment.• During the inspection we saw the practice had a clear protocol in place in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).• Due to the demographics of the service no patients had any DNACPR in place.	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
NHS Choices	<p>Due to the location hosting the NHS walk in centre, some reviewed comments were left for this part of the service.</p> <p>The last three reviews left for the practice, two out of the three were positive about the service. Patients stated the service was fast at responding, staff were nice and various options of appointment styles available.</p>

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)	88.1%	89.4%	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)	84.6%	87.6%	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	91.1%	95.0%	95.6%	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)				
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)	77.5%	82.7%	83.0%	No statistical variation

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

Involvement 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

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 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)	94.2%	92.2%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice identified 414 carers, 3% of the patient population
How the practice supported carers (including young carers).	All new patients registering with the practice were asked about their carer status and the details would be incorporated into their patient records with details of reasonable adjustments where required.
How the practice supported recently bereaved patients.	For patients and families who had suffered bereavement, their usual GP contacted them where appropriate.

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times: Monday to Friday	8.00 am – 8.00 pm
Appointments available:	Monday to Friday appointments, including home visits.
	Evening and weekends Patients can access appointments with GPs and nurses at a local hub as part of the extended access scheme. Access to the seven day walk in service was available, seven days a week between 8am-8pm.

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • Due to the demographics of the patient population there were relatively fewer children registered at the practice. Patients aged 5 years and under equated to just 4% of the patient population. • A qualified mental health practitioner who carried out reviews of patients presenting with mental health needs was available and they were supported by two specialised health care assistants. • The practice offered contraception clinics, patient education and advice on women's health. • Patients had a named GP who supported them in whatever setting they lived.

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and refugees. For example, the practice had many homeless patients on their list.
- The practice held a register of patients living in vulnerable circumstances including homeless people, refugees and homeless.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Access to the service

People were 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 and Improvement 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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

- The practice monitored and analysed patient call waiting times.
- The practice offered patients a choice of telephone triage or face to face appointments where preferred.
- The practice offered a range of appointments which could be pre booked in advance online, booked on the telephone or in person.
- Appointments with GPs were flexible throughout the day to meet the needs of individual patients.
- At the time of the inspection there were urgent appointments available the same day, and the next available routine appointment was for the following working day.

The Walk In Centre service access information indicated:

- The practice was flexible in the way they made appointments.
- Patients could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure people had timely access to treatment, support and care.

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)	72.0%	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)	72.3%	71.5%	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)	67.9%	69.7%	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)	78.4%	80.9%	81.7%	No statistical variation

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.	48
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<ul style="list-style-type: none"> • During the period April 2021-March 2022, the practice received 48 complaints for both the GP and walk in service, 40 of these were formal complaints and eight were informal. • All complaints were directed to a central team with a central telephone number and email address. Any complaints that could be resolved within 48 hours were passed to the practice manager for them to investigate and provide their findings to the complaints team. Clinical complaints were sent to the governance team for clinical independent review. • All complaints were logged centrally and were categorised, risk rated, and outcomes documented to enable themes and trends to be analysed. Complaints were reviewed and incorporated into the annual review. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy that their printed prescription has not been sent to the pharmacy.	On investigation no delays or issues related to the prescription process could be identified.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<ul style="list-style-type: none">The practice was part of gtd Healthcare (a not for profit organisation) and benefited from support from central teams. For example, human resources, the training academy and clinical leadership for guidance and support.Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<ul style="list-style-type: none">The mission statement read: "We care for people, families and communities, in order to improve their health and wider wellbeing."The service developed its vision, values and strategy jointly with patients, staff and external partners, which read: "gtd healthcare is a values driven organisation and we are passionate about providing the best possible healthcare for our patients".	

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none"> • Staff had access to a confidential employee assistance programme, which also provided a range of wellbeing advice and guidance via the practice's website. • In 2021 there had been an organisation wide 'Year of wellbeing' with a range of monthly events for staff to participate in. 	

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<ul style="list-style-type: none"> • Structures, processes and systems to support good governance and management were clearly set out, understood and effective. • The practice had a number of pathways to support staff, for example a detailed referral pathway for incoming and outgoing data and a COVID support pathway for staff who became isolated. • An understanding of the performance of the practice was maintained with support from the gtd Healthcare data and medicines teams. • The organisation had an academy which co-ordinated and managed all learning and development activities. They produced a weekly summary of internal and external training and development opportunities. • Staff understood local health needs and worked to meet those needs. • Staff had access to corporate and onsite induction. Staff were encouraged to develop and were actively supported to gain additional skills and qualifications to enhance their roles. 	

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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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none"> • A programme of quality improvement, clinical and internal audits were used to monitor quality and to make improvements. • The service used a secure web-based incident management system to record and monitor incidents. Incidents were reviewed for significance and those identified as moderate or above were managed in conjunction with the central governance team who supported the investigation process. • The organisation learned and shared lessons, identified themes and acted to improve safety in the service. Feedback regarding events and findings were discussed during governance meetings and clinical service quality performance meetings. A monthly governance newsletter was produced for all staff to reference where the provider shared lessons learnt from across the whole organisation and highlighted the changes introduced as a result of incidents. 	

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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes

The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<ul style="list-style-type: none"> Following the COVID-19 pandemic the practice carried out a review to identify areas of recovery to meet the needs of the patient population and staff. This was produced as a Covid-19 recovery plan. 	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<ul style="list-style-type: none"> Quality was overseen by a dedicated governance and data team who were also instrumental in supporting the organisation to achieve the goals set out in the organisational strategy. The information used to monitor performance and the delivery of quality care was accurate and useful. The data team analysed data and presented it via a red/amber/green (RAG) rated dashboard to the practice team which highlight areas that required action. 	

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<ul style="list-style-type: none"> The patient participation group stopped meeting over the period of the COVID-19 pandemic. Plans were in place to re-establish the group and recruit new members. The practice produced a regular patient newsletter to communicate with and update patients. The practice worked closely with other local practices as part of the Primary Care Network and other practices within the gtd Healthcare network. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>There was a focus on continuous learning and improvement at all levels within the practice. The practice team were forward thinking and looked to develop in ways which supported the patient population. For example, the two services set up in response to the government refugee crisis, saw the provider deliver a unique mobile clinical provision, carrying out a primary care service where patients were accommodated. This resulted in positive outcomes in children's uptake in immunisations and women's cervical screening.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.