

Care Quality Commission

Inspection Evidence Table

Clarendon Medical Centre (1-562997712)

Inspection date: 02 November 2022

Date of data download: 03 October 2022

Overall rating: Good

The overall rating for this practice is good. We inspected three key questions; safe, effective and well-led. We rated safe as requires improvement, effective and well-led as good.

We also reviewed prompts in relation to access to treatment under key question Responsive. The rating for the key questions, responsive and caring, remain good.

Safe

Rating: Requires improvement

Following this inspection, we have rated the practice requires improvement for providing safe services. Whilst we found no breaches of regulations, the provider should:

- Complete the infection prevention and control action plan and embed systems to ensure improvements are maintained.
- Ensure the new processes put in place for monitoring patients prescribed high risk medicines are embedded.
- Continue to monitor prescribing multiple psychotropics for patients is in line with guidance.
- Ensure the new processes put in place regarding safety alerts are maintained.
- Continue to monitor that Patient Group Directions (PGDs) are signed.

Safety systems and processes

The practice had 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: <ul style="list-style-type: none"> All staff had received safeguarding training to appropriate levels in line with guidance. There was a risk register in place for vulnerable patients which was monitored and kept up to date. 	

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: <ul style="list-style-type: none"> There were clear recruitment policies and procedures in place, including details of the checks required for locum staff. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 08.07.2022	Y
There was a fire procedure. Date of fire risk assessment: 02.09.2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used outside providers to carry out an annual PAT testing and calibration of equipment. We saw evidence which showed these had both been completed. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 16.08.2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The IPC audit was completed by Tameside and Glossop integrated care foundation trust. The IPC audit gave the practice a score of 86% compliance and made a number of recommendations. Following this the practice developed an action plan, and we noted some actions had been completed and where equipment needed replacing this was being arranged. However, during the site visit we noted in one clinical room dust remained on shelving and a nail brush was on the sink in another clinical room, we also noted not all sharps bins had been signed and dated. Following the inspection, the practice told us they had taken action to resolve the issues we highlighted.• Not all staff had completed infection control training, including clinicians.• Although there was an infection control lead in place not all staff were aware of who this was, and some staff feedback indicated concerns that the outcomes of the recent audit and actions being taken had not been shared with staff.	

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: <ul style="list-style-type: none">• There was a clear procedure in place for staff to follow should they encounter acutely unwell patients either on the telephone or within the practice.• Staff told us they worked together to cover staff absences and that there were enough staff to provide appointments, however some staff told us the practice would benefit from additional administrative and reception staff.	

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

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England 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)	1.16	0.87	0.82	Tending towards 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). (01/07/2021 to 30/06/2022) (NHSBSA)	10.0%	7.4%	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)	3.85	4.09	5.31	Variation (positive)

Indicator	Practice	SICBL average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	268.3‰	200.6‰	128.0‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.98	0.74	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	19.6‰	8.5‰	6.8‰	Significant Variation (negative)

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).	N
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. ¹	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> 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. These searches were visible to the practice. The records we examined showed for some high-risk medicines monitoring was not always carried out in line with guidance. However immediately following the inspection the provider submitted details of actions taken, for example: <ul style="list-style-type: none"> Our clinical search identified 18 out of 65 patients prescribed Potassium sparing diuretic had potentially not had the required monitoring. Following the inspection, the provider planned to implement monthly clinical searches and contact patients requiring monitoring. Clinical searches identified 42 out of 254 patients prescribed gabapentinoids had potentially not had a medication review in the last 12 months. Of the five records we reviewed in detail we noted 3 out of the 5 were overdue their medication review. Following the inspection, the provider confirmed medication reviews had either taken place or had been booked. Going forward the provider will establish a new system whereby patients will be contacted 1 month before their review date, and if the patients fails to respond following reminders, the practice, where safe to do so will reduce the quantities of medicines prescribed. The practice had a higher than average number of unique patients (145 individual patients) prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA). This is where patients are prescribed a combination of at least one antidepressant and at least one antipsychotic. Whilst this can often be clinically necessary, prescribing of multiple psychotropics carried increased risks and patients should be closely monitored. This was discussed with the provider who was aware of the prescribing outlier. This was in the main due to the high number of older patients with complex care needs and reviews regularly took place. During the clinical searches the GP specialist advisor also reviewed a sample of five consultations which included a medication review. They found although all had a medication review documented, three of the five did not give any details. We reviewed the Patient Group Directions (PGDs) and found that seven had not been signed by relevant staff and others had not been signed by all relevant staff. PGDs allow a specified medication to be administered to a particular group of patients by non-prescribing health professional such as a practice nurse. We asked the practice to review this immediately following the inspection and they provided information which assured us that the PGDs had now been signed by the relevant staff and a new governance system has been established to ensure all PGDs are signed. 	

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
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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:	8
Number of events that required action:	8
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff reported they were familiar with the system and were encouraged to report incidents. We saw they were discussed in practice meetings with partners and manager, and learning was shared with relevant staff. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a system in place to review and action safety alerts as appropriate and these were discussed during practice meetings, however there was no formal process in place to ensure actions taken were monitored and information from historic alerts was not continually audited. For example, the GP specialist advisor reviewed a sample of patients prescribed a combination of medicines which were subject to a Medicines and Healthcare products Regulatory Agency (MHRA). An MHRA Drug Safety update in December 2014 advised that it was undesirable to prescribe a combination of clopidogrel and omeprazole/esomeprazole, as this can decrease the effectiveness of clopidogrel and increase the risk of heart attack or stroke. The search identified 22 patients prescribed this combination and a detailed review of five records showed patients continued to be prescribed the combination despite the alert. Following the inspection, the provider told us they planned to review all patients prescribed Clopidogrel and Omeprazole/Esomeprazole and amend the medication where appropriate. They also planned to introduce monthly clinical searches linked to safety alerts and that alerts would become a standard agenda item for practice meetings. 	

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. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	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

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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.• The practice employed a part-time nurse dedicated to the vulnerable, elderly population. The role enabled the nurse to provide holistic reviews and included referrals to social care and mental health services.• 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, including referral to the primary care network mental health nurse.

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. These searches were visible to the practice. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately. However, we noted for those patients who had received treatment for an acute exacerbation of asthma that they were not consistently followed up by a clinician. This was discussed with the provider and they shared an updated protocol whereby, a follow up call with a clinician would be automatically booked to review patients within a week.
- Clinical searches were also carried out to identify patients who may have had a missed diagnosis of Chronic Kidney Disease (CKD) stage 3, 4 or 5. In line with National Institute of Health and Care Excellence (NICE) clinical knowledge summary guidance relating to CKD. Our search identifies 84 patients whose test results identify reduced kidney function and a potential missed diagnosis of CKD stage 3-5. Following the inspection, the provider assured us they would review all of the patients and update coding where required, they had also invited patients for blood monitoring where required.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The clinical team worked in a coordinated way to arrange and manage chronic disease reviews such as Diabetes and Hypertension.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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)	75	78	96.2%	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)	84	85	98.8%	Met 95% WHO based target
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)	84	85	98.8%	Met 95% WHO based target
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)	84	85	98.8%	Met 95% WHO based target
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)	79	83	95.2%	Met 95% WHO based target

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>

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	69.1%	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)	74.6%	57.2%	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)	62.7%	64.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	45.8%	56.6%	55.4%	No statistical variation

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

Any additional evidence or comments

The practice had a clear procedure in place for two week wait referrals and checks were in place to ensure patients had received and attended appointments.

The practice team monitored cervical screening uptake and were aware of they were below target. One of the practice nurses recently appointed had now completed the relevant training as was able to provide additional capacity to improve uptake.

Monitoring care and treatment

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

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

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

- The practice regularly audited achievements and prescribing data using local and national data, supported by the primary care network clinical pharmacist working within the practice.
- We saw there was a range of quality improvement work carried out within the practice. For example:
 - Quality improvement programme to improve the triage process for emergency presentations with reception staff.
 - HRT audit to ensure adherence to current NICE guidelines in the practice, resulting in the recommendation of a standard protocol whereby when HRT was initiated a task was sent to reception to book a follow-up appt with a nursing within 3 months.
 - Optimising Osteoporosis Management and Fracture Prevention.

Effective staffing

The practice was able 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.	Partial
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:	
The practice had a training plan in place and staff were provided with time to complete training, when the practice closed one afternoon a month. We noted however not all staff had completed some mandatory training including infection control. Following the inspection, we were assured time would be set aside to ensure staff had completed all required training and that training would be incorporated into the new IT system to provide the practice manager with a clearer overview.	
We noted all staff had been scheduled for an appraisal or had a recent appraisal carried out, however we noted that some staff, including clinical staff had not had an appraisal for up to five years.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<ul style="list-style-type: none"> Working collaboratively with seven other local practices under the Healthy Hyde banner, the practice are involved in a number of health and wellbeing initiatives, including: <ul style="list-style-type: none"> Health and well-being coaches promoting good physical and mental health with drop-in sessions covering weight management, mindfulness and wellbeing. Social prescribing signposting patients to appropriate services to meet their individual needs. Programmes were in place to reduce health inequalities in the local population, for example, asylum seekers, Isolated black, Asian and minority ethnic (BAME) patients who needed a translator, and adults who required support with drug and alcohol problems. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Our clinical review of notes where a DNACPR decision had been recorded, showed where possible the patients views had been sought and respected, and where a patient did not have capacity the views of family were sought. We saw that information had been shared with relevant agencies. 	

Responsive

Rating: Good

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	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice was open from 8am until 6.30pm Monday to Friday. The practice also offered pre-booked nurse appointments from 7am on a Wednesday. Patients could also access evening and weekend appointments available as part of the local extended hours scheme.• The practice provided flexibility in their offered appointments which included, telephone appointments and face to face appointments including pre-bookable face to face appointments with GPs and nurses.• The practice website provided patients with a range of information on how they could access care and treatment in hours and out of hours. The website could be translated into a range of languages.• The most recent results from the National GP survey carried out (01/01/2022 to 30/04/2022) showed no statistical variation when compared to local and national averages. For example, the percentage of respondents to the GP patient survey who were satisfied with the appointment they were offered was 71% in line with the national average of 72%.	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate 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.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a clear mission and vision and were developing a business plan to the changing needs of the practice.• Staff feedback we received was mixed with regards to visibility of leaders and opportunity to give feedback. Staff feedback that they felt supported and valued by colleagues and department leads, and found value in the weekly huddle meetings. However, some felt there were limited opportunities to meet with leaders to share ideas and have their views listened to.• Plans were in place to introduce a structured meeting schedule at department level to give staff more opportunities to meet with leaders, as well as opportunities for the whole practice team to meet.	

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: <ul style="list-style-type: none">• Majority of staff feedback that thought the provider had a clear vision for the future. Some staff reported they would like more opportunities to be involved in future planning.• The partners and senior manager met regularly to review the strategy and had recently been successful in reviewing and expanding the clinical team to include paramedics.	

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

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had a number of governance system in place to manage risk and monitor quality, including a range of audits and quality improvement programmes. However, we found during the clinical searches there were gaps in the systems and process in place relating to the management of patients prescribed high risk medicines. Immediately following the inspection, the provider submitted plans to address the concerns raised during the clinical searches, including plans to improve the governance systems and ensure patients were monitored and reviewed within the required timeframes.	

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: <ul style="list-style-type: none"> A programme of quality improvement, clinical and internal audits were used to monitor quality and to make improvements. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<ul style="list-style-type: none"> The practice had a range of management meetings scheduled to monitor performance and plans were in place to schedule departmental meetings to involve and keep staff up to date. There was an audit programme in place and results discussed during meetings. The practice took action immediately following the inspection on the information shared as part of the clinical search and provided CQC with management plans. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Partial
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: <ul style="list-style-type: none"> The practice worked alongside the Hyde Primary Care Network and the Tameside locality of the Greater Manchester Integrated Care Board (ICB) to collaboratively identify ways in which they can meet the needs of patients. The practice continually gathered patients view using the friends and family test (FFT). Recent results showed majority of patients who provided feedback, said that their overall experience of the service received was good or very good. For example, in September 2022 of 169 patients 94% said their experience was good of which 76% stated very good. The practice did not currently have a patient participation group (PPG), but they were looking at ways to engage patients and re-establish a PPG. 	

- Staff feedback as part of the inspection process highlighted staff desired to be more involved in the planning and delivery of services and would welcome more opportunities to meet as a team with the partners and managers.

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: <ul style="list-style-type: none"> • The practice worked closely with the PCN and were able to accommodate a number of services within the practice for patients. • The practice took part in a range of quality improvement projects. • The practice was a training practice and had a range of GP trainees currently working within the practice. 	

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

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

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

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

Glossary of terms used in the data.

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