

# Care Quality Commission

## Inspection Evidence Table

### Beech Hill Medical Practice (1-567944468)

Inspection date: 9 November 2022

**Overall rating: Good**

**Safe**

**Rating: Good**

**Safety systems and processes**

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff had access to safeguarding e-learning modules and all clinical staff members had completed safeguarding training to the appropriate level for their role.</li><li>• There were safeguarding policies and procedures in place for both children and adults and protocols were in place for patients who did not attend appointments.</li><li>• The safeguarding lead in the practice attended local adult safeguarding and child protection meetings when required</li></ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 27 July 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 28 October 2022 Actions from fire risk assessment were identified and completed.	Yes
<ul style="list-style-type: none"> <li>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.</li> </ul> <p>An external private company were the property managers and provided a range of facilities management services to keep the building in good order and repaired. The services included:</p> <ul style="list-style-type: none"> <li>Repairs and maintenance of the building fabric.</li> <li>Repairs and maintenance of the external areas of the building.</li> <li>Maintenance of the electrical and mechanical installations.</li> <li>Ensuring premises compliance to statutory requirements.</li> <li>Maintenance of any fixtures provided and fitted.</li> </ul>	

## 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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 17 October 2022	Yes
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>All the staff we spoke with demonstrated an awareness of appropriate infection prevention and control (IPC) standards.</li> <li>There were cleaning schedules in place that were monitored by the practice.</li> <li>The practice had protocols in place which were regularly updated, following the latest government advice in relation to COVID-19.</li> <li>There was evidence to show action had been taken following the last IPC audit and regular hand hygiene audits were carried out.</li> <li>Risk assessments and audits had been carried out to ensure services such as flu vaccinations, were carried out in a safe space and followed IPC good practice guidance.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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

## 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. <sup>1</sup>	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.</li><li>• The practice had established referral systems and processes.</li><li>• All test results were reviewed and actioned by a GP.</li></ul>	

## Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England 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)	1.03	0.95	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	11.6%	9.2%	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)	5.70	5.96	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	155.5‰	187.7‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.60	0.62	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	8.0‰	9.2‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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 effective medicines reviews for patients on repeat medicines. <sup>1</sup>	Yes

Medicines management	Y/N/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.	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. <sup>2</sup>	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p data-bbox="57 1202 1540 1247">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul data-bbox="121 1292 1511 1957" style="list-style-type: none"> <li data-bbox="121 1292 1511 1404">• The practice continually reviewed their systems and processes for the administration and supply of medicines, and regular reviews for repeat prescribing for the benefit of the patient population.</li> <li data-bbox="121 1404 1511 1482">• There were medicine management and prescribing policies and procedures in place including a home visit policy.</li> <li data-bbox="121 1482 1511 1628">• As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. 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.</li> <li data-bbox="121 1628 1511 1957">• The records we examined provided evidence that most patients prescribed high risk medicines had been monitored appropriately. Of those where monitoring was overdue, we saw the plan in place to arrange the required checks for patients. We saw evidence that the practice carried out regular audits on high risk medicine monitoring. The practice had a system in place to note the prescriptions of patients prescribed high risk medicines to highlight they must have blood tests at the required intervals, and repeat prescriptions would only be issued if the required tests had taken place. We noted that the recording of patient medicine reviews provided consistent and comprehensive information regarding the patient and their prescribed medicines.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>We reviewed patients taking medicines for hypothyroidism to assure they were being monitored appropriately. We looked at five patients and found that two of those appeared to be overdue. We highlighted these to the practice who assured us they would take appropriate action.</li> <li>During the pandemic the practice, in line with guidance, postponed routine medication reviews and phlebotomy unless considered necessary. The practice took a decision to protect high risk patients as the risk of COVID-19 to these patients was greater than delaying recommended blood tests.</li> </ul>	

### 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>All significant and learning events were reviewed, discussed at meetings, and all actions carried out.</li> <li>If learning points were identified these were cascaded to appropriate staff to prevent recurrence.</li> <li>The significant events we reviewed indicated that the practice was responsive to the needs of vulnerable patients and identified the need for improved communication between internal staff and other health and social care professionals if required.</li> </ul>	

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

Event	Specific action taken
Patient blood sample incorrectly stored	Change of procedure
Clinical communication by email outside of the clinical system	Change of procedure
Duplicate medications left on repeat prescription	Discussed with clinicians and resolved

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts. <sup>1</sup>	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had a clear and timely process in place to ensure safety alerts were reviewed and a record was maintained of the action taken in response to alerts where appropriate. Safety alerts were circulated to the GPs. They decided if action was required and ensured that any actions were cascaded to the appropriate staff member.</li> <li>We reviewed a number of safety alerts. This included Mirabegron, Mirabegron is a medicine that eases the symptoms of overactive bladder. We noted that 13 of 15 patients on this medicine were overdue monitoring (blood pressure check). The five we reviewed were overdue monitoring and two were booked in for blood pressure checks. However, we were reassured on the site visit that these patients had all now been contacted for the required monitoring.</li> </ul>	

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. <sup>1</sup>	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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 prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	

- Practice staff were aware of the benefits of social prescribing and had links to community groups and support networks.
- Records we reviewed demonstrated the use of best practice guidance.
- The practice worked with the community link worker (CLW). The CLW took referrals for patients who need extra help, but not necessarily medical help. It varied from advice on benefits to social issues such as loneliness and not knowing which services were available and how they could be accessed. This service worked in co-operation with Age UK so that patients over 65 would be linked to the services available through them.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The Practice had an open list which placed no barriers for a person from any of the key population groups to register.
- The practice identified patients who were at high risk of complications because of COVID-19. After the practice identified those patients, patients aged over 65 to contact were prioritised and invited to complete a welfare check and advise patients of additional help or direct them to the correct agency.
- The practice offered appointments for parents and/or guardians to attend with babies for immunisations at an appointment time of their choice rather than a set clinic.

## Management of people with long term conditions

### Findings

- The practice had a recall system to invite patients at their birth month annually for review. The invite was tailored to meet the needs of the patient. For example, patients on the learning disability register received a call rather than a letter to support stronger engagement and reassurance. Patients would be invited more frequently subject to their needs.



- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- All potential missed diabetes diagnoses had been followed up.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- The practice nursing team ensured patients with long term health conditions or housebound were invited for annual review or home visit attendance if required. The practice worked closely with the Primary care Network (PCN) and care home leads.
- Wigan locality of the Integrated Care Board (ICB) and the Primary Care Network (PCN) recognised their continued commitment to the diabetes nine care processes. The nine key processes of care measurements are: Weight and body mass index, blood pressure, HbA1c (diabetes monitoring), retinopathy screening, foot risk stratification, urinary albumin test, –serum creatinine, smoking status and cholesterol level. The practice were top in their PCN for patient compliance.

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)	116	122	95.1%	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)	101	107	94.4%	Met 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	101	107	94.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	102	107	95.3%	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)	122	133	91.7%	Met 90% minimum

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: 30/06/2022) (UK Health and Security Agency)	76.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.9%	61.7%	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)	66.6%	65.2%	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%	49.6%	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
<ul style="list-style-type: none"> <li>There was a system in place to offer appointments for cervical screening at any of their local network practices. This was to allow flexibility and encourage uptake by offering a more flexible time of attendance for this population group.</li> </ul>

## 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

**Any additional evidence or comments**

- The practice regularly audited achievements and prescribing data using local and national data, supported by the clinical pharmacist working within the practice.
- The practice routinely reviewed the effectiveness and appropriateness of the care provided.
- The practice used information about care and treatment to make improvements.
- The practice had a programme of quality improvement which included audits and searches, both clinical and non-clinical.
- The practice worked within the Greater Manchester Primary Care Standards and we saw evidence their performance had demonstrated compliance with these standards. The practice regularly submitted a data return for the Wigan Borough quality and engagement scheme to support these standards.
- The practice utilised Arden clinical template. The latest versions were downloaded at each consultation to ensure the latest template was being used. This ensured consistent care across the clinical team. Ardens searches were used proactively. In particular with the case finder searches which were used to support the management of chronic disease registers.

**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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice ensured staff were competent for their roles and provided specialist training.</li> <li>• Managers appraised staff's work performance and held supervision meetings with them to provide support and development.</li> <li>• The service supported staff to access continuing professional development opportunities.</li> <li>• We saw the practice manager had a system in place to monitor the training completed by staff. Staff told us they were aware of what training they needed to complete, and they were given the time to complete this.</li> </ul>	

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice was an active member of their Primary Care Network and worked closely with the other practices to ensure that effective care and treatment was delivered.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice embraced social prescribing and used resources within the practice to support this important workstream and also resources from the primary care network. The practice worked</li> </ul>	

with the community link worker (CLW). The CLW took referrals for patients who needed extra help, but not necessarily medical help. It varied from advice on benefits to social issues such as loneliness and not knowing which services were available and how they could be accessed.

- The practice actively promoted the national flu vaccination campaign and the rollout of COVID-19 vaccinations.
- Patients had access to community services such as healthy routes and smoking cessation. Healthy routes was a service provided by Wigan Council to support healthier lifestyles for the patient population, including wellbeing, alcohol support, weight loss and physical activity.
- The practice signed up to a local enhanced service to refer into the weight management service.

## 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. <sup>1</sup>	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• During the inspection we saw the practice had a clear protocol in place in relation to do not attempt cardiopulmonary resuscitation (DNACPR) and we noted from a review of records they were appropriate and completed in line with good practice.</li> <li>• We saw evidence that staff had undertaken Mental Capacity Act (MCA) and consent training.</li> </ul>	

## Responsive

Rating: Good

### Access to the service

#### People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to 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 (including those who might be digitally excluded).	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• 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. This could be through text messaging and video conferencing.</li><li>• The practice provided flexibility in their offered appointments which included: online booking, electronic consultation, in-person booking at the reception desk, and telephone appointments at a time that best suited the patient, if needed.</li><li>• Patients requesting an appointment were offered either a telephone consultation or face to face appointment, and they could choose which they wanted.</li><li>• We saw that routine appointments could be offered on the same day, in many instances.</li><li>• The practice told us they listened to patients who described the need for an urgent appointment, and accommodated their needs if necessary.</li><li>• Searches were run regularly to identify the number of missed appointments, and to encourage attendance.</li><li>• Longer appointments were available with the practice nurse. These helped patients who were on multiple disease registers to have a holistic review. Patients and carers found this convenient as it reduced the need to have multiple appointments.</li><li>• Home visits were offered to housebound patients.</li></ul>	

- The practice used AskmyGP, an online GP consultation platform with the aim of improving patient access and reduce unnecessary appointments. This enabled patients to communicate with the practice directly, requesting a clinician of their choice. They responded to patients the same day, via their preferred choice of contact. For example, telephone, face to face where safe to do so and necessary, keeping both the patient and clinician safe.

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.</li> <li>The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.</li> <li>The practice was proactively engaged with the local Primary Care Network and Greater Manchester Integrated Care Board by having attendance at meetings and forums to ensure services met the local population needs.</li> <li>All the staff we spoke with told us that the GPs were approachable.</li> </ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.</li> <li>There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.</li> <li>Plans were consistently implemented, and had a positive impact on quality and sustainability of services.</li> </ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>There was clinical and management oversight of the service quality and performance. Quality improvement initiatives were evident.</li> </ul>	

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

Source	Feedback
CQC Questionnaires Staff	We received 33 completed staff questionnaires. All the responses indicated the practice was a good place to work and that they felt supported by the management team and colleagues.

## 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.</li> <li>• The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.</li> <li>• Reception staff had access to policies in relation to patient medical emergencies.</li> <li>• Staff were trained to recognise the symptoms of sepsis and to act on them.</li> <li>• A range of health and safety risk assessments were undertaken and regularly reviewed. Actions were taken where needed.</li> </ul>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	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
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## 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
Staff are supported to work remotely where applicable.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice worked collaboratively with the PCN. This included the introduction of an alternative appointment system for cervical screening. There was a system in place to offer appointments for screening at any of their local network practices. This was to encourage uptake by offering a more flexible time of attendance for this population group.</li> </ul>	

Feedback from Patient Participation Group.

## Feedback

- There were regular patient participant group (PPG) meetings. The last one was in August 2022. They discussed national patient survey results. They also received a briefing from the local Healthwatch team and were updated on the developments of the Integrated Care Board (ICB).

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff had dedicated learning and development time.</li> <li>• There was a strong focus on education and training for practice staff and for medical students. The trainees were undergraduate and postgraduate from Manchester University.</li> </ul>	

## Examples of continuous learning and improvement

- The practice had a 12-monthly meeting schedule in place. This included internal clinical meetings and business meetings. This also included quarterly palliative care and child protection meetings where representatives from external agencies attended.
- The practice was working towards LGBTQ+ accreditation.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$

Significant variation (negative)

≥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.
- ‰ = per thousand.