

Care Quality Commission

Inspection Evidence Table

Donneybrook Medical Centre (1-502711427)

Inspection date: 7 December 2022

Date of data download: 10 November 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|---|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: <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: | |

- 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: 22/11/2022 | Y |
| There was a fire procedure. Date of fire risk assessment: 15/2/2022 | 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 met.

| | Y/N/Partial |
|---|-------------|
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: May 2022 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| 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 in May 2022. The IPC audit gave the practice a score of 87% compliance and made a number of recommendations. Following this the practice developed an action plan, and we noted the immediate actions had been completed and all other were in progress. | |

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 | Partial |
| Explanation of any answers and additional evidence: | |

- 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.
- There was a well-established clinical team and they had extended the team to include a part time pharmacist and they were recruiting an additional salaried GP for 6 sessions a week. They had experienced a high turnover of reception staff and had approximately 2 full time equivalent vacant posts. We were told staff worked together to cover the shortfall. The partners acknowledged the challenge this presented and the additional pressure this placed on current staff and they were actively recruiting to the posts.

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. | Partial |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • During the inspection we reviewed the workflow management system, whereby in-coming clinical tasks, test results, clinical correspondence are received to be reviewed and actioned by staff. We found there was some lack of management oversight of the system. Although we noted laboratory results had been viewed and actioned, it was unclear how the large number of tasks remaining in the system were being managed. We raised this during the inspection and immediately following the inspection they completed a workflow audit and identified areas for improvement, including: <ul style="list-style-type: none"> ○ Some staff were generating additional test request tasks, duplicating the original task. This has now been rectified and discussed with the relevant staff to prevent further duplication of tasks. ○ They identified outstanding tasks within the registration workflow and have discussed with staff responsible for this area. Managers will complete regular audits to ensure the workflow is kept up to date. | |

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) | 1.10 | 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) | 7.4% | 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) | 3.81 | 4.09 | 5.31 | Variation (positive) |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 236.7‰ | 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) (NHSBSA) | 1.19 | 0.74 | 0.59 | Tending towards variation (negative) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 9.3‰ | 8.5‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |

| Medicines management | Y/N/Partial |
|---|-------------|
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹ | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ² | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Y |
| <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 consistently 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"> 11 patients were prescribed Azathioprine, 2 were highlighted as not having had required monitoring. Review of the 2 records were overall good, however renal function was missed for one patient. The provider took action to contact those patients where monitoring was overdue. They told us all DMARDs will have a maximum authorisation of 3 months, and will be reviewed by a clinician and action taken if patients have not attended for monitoring, which may include printing prescriptions so patients have to come into practice to collect, or reducing the amount prescribed. The medicines lead also created a flow chart for all DMARDs and medication requiring monitoring to support the nurses and health care assistants to carry out the required monitoring. There were 8 patients prescribed Lithium of which 2 patients had not had monitoring and 4 not had U+E/Calcium/TFT levels checked. Review of records showed 4 of the 8 patients who were prescribed lithium had not been monitored appropriately. One of them had not | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <p>had Lithium levels tested for over one year. Prior to the inspection the provider audited Lithium monitoring and invites for appointments had been sent to patients. Of 2 patients yet to respond to the invites the practice removed the prescriptions from the electronic system, requiring patients to come into practice to collect the prescription, enabling them to discuss directly with patients the need for monitoring. They planned to re-audit in 6 months' time to check actions taken improved compliance.</p> <ul style="list-style-type: none"> ○ A review of 5 patient consultation records with medication reviews found although all had a medication review documented, not all medicines had been reviewed, including some medicines subject to MHRA alerts and for some there were no detail only coded as having a review. We discussed this with the practice, who had already identified an issue with the quality of medication reviews and was one of the reasons for the recruitment of a practice pharmacist. The prescribing lead met with the prescriptions team and the clinicians and agreed to use Ardens medication review template to improve quality and consistency of medication reviews. • The practice had in place a quality improvement programme linked to the management of patients prescribed high risk medicines, in particular those prescribed hypnotics and multiple analgesics and those prescribed Pregabalin or Gabapentin. They had support from the local medicines management team and have appointed a clinical pharmacist to support them to improve the management and monitoring of patients prescribed high risk and controlled medicines. We noted they had RAG rated patients based on risk and we saw that all those at the highest risk had been reviewed and some had had a second review. They had reviewed approximately half of those identified as at medium risk (including patients prescribed gabapentinoids) and those at low risk would be reviewed by the incoming clinical pharmacist. The project was continually monitored by the partners as part of the weekly clinical meetings. • Data showed the practice prescribed a higher than average number of antibacterial medicines. We discussed this with the practice who told us they regularly audited prescribing to ensure they prescribed within the Greater Manchester Medicines Management Group protocols and reviewed where prescribing was outside of guidance. The practice had a higher number of older patients, prone to Urinary tract infections (UTIs) which contributed to the higher than average prescribing, they also had a higher prevalence of patients with Asthma and COPD. | |

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. | 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: | 6 |

| | |
|---|---|
| Number of events that required action: | 6 |
| 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. There was a system in place to record and monitor actions taken following incidents, and these were reviewed regularly. | |

| 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 12 patients prescribed this combination and a detailed review of 5 records showed patients continued to be prescribed the combination, however there was no evidence the potential harm had been discussed with the patient. Immediately following the inspection, the prescribing lead reviewed patients identified in the search and took action to prescribe, where appropriate, alternative medicines after discussing the risks and interactions with patients. Where they had been unable to make contact by telephone they had written to patients. They also planned to introduce monthly clinical searches linked to safety alerts and 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.• 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 majority of patients with long term conditions had been monitored and reviewed appropriately and where risks were identified these were addressed immediately following the inspection, for example,
 - Patients with hypothyroidism who have not had thyroid function test monitoring for 18 months. The searches identified 20 out of 315, a review of 5 records showed 4 had not had monitoring for a long time. We discussed this with the practice who immediately following the inspection shared a plan of action, including sending invites to those patients identified from the searches. They would then be followed up by the practice pharmacist and clinicians for a medication review before their next prescription was due. Those not responding to invites would be written to in the new year informing them that their prescription would go to 2 weekly until they had had the required monitoring.
 - 13 patients were identified by search as having a potential missed diagnosis of diabetes. Review of 5 records identified, 2 patients with abnormal HbA1C were filed as stable, but not coded correctly. The other 2 patients need repeat HbA1c as their last readings were high. One patient had been coded appropriately. The diabetic lead planned to review all patients highlighted in the search. They also planned to hold a diabetes refresher teaching session for all the clinicians, nurses, and HCA. They have established clinical searches to be run every 6 months to ensure all patients have been correctly coded, diagnosed, reviewed, and managed as per guidelines. They have also arranged a meeting with a diabetic system representative with a view to implement the program PARM (Proactive Register Management) furthering the practices ability to monitor diabetic patients and their diabetic control.
 - 8 Patients with Chronic Kidney Disease (CKD) Stages 4 or 5 who have potentially not had U+E monitored in the last 9 months. A review of records showed appropriate management. Going forward they planned to hold monthly CKD monitoring clinic to ensure regular monitoring and checks continued.
- The practice told us they recognised the importance of long-term condition management, and have recruited additional clinicians, including a salaried GP and paramedic. This will allow the partners to have more capacity to care for those with complex need.
- There were lead GPs for each long term condition who supported the clinical team with complex cases and monitored outcomes in line with the Quality Outcome Framework (QoF).
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. They had established a new call and recall system to ensure patients requiring annual reviews, for example were recalled in a timely manner.

- 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) | 79 | 88 | 89.8% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 71 | 77 | 92.2% | Met 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 71 | 77 | 92.2% | 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) | 71 | 77 | 92.2% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 99 | 116 | 85.3% | Below 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>

Any additional evidence or comments

- The childhood immunisation data was discussed with the practice. They were aware the data showed they were below target; however, they had identified a coding error, whereby patients who had been immunised had not been correctly coded and therefore not showing in the data. Administrative staff were in the process of checking all patients had the correct code added to their record.

| 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) | 73.6% | 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) | 67.0% | 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) | 62.3% | 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) | 49.1% | 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 they were below target. They told us, especially among the younger age group there was a resistance to the screening programme. This was reflected in unverified QoF data shared by the practice which showed those aged 25 to 49 was currently at 76%, whereas those aged 50 to 64 was 81%. They told us clinicians took every opportunity to promote and educate patients on the benefits of cervical screening. They would also provide opportunistic screening and the nurses were able to provide appointments up until 6:30pm for those unable to attend during core hours. Patient could also access appointments on evenings or a Saturday as part of the extended hours scheme.

Monitoring care and treatment

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

Y/N/Partial

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

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

| |
|--|
| <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ A cancer care review was completed in September 2022 by a GP Registrar. The aim was to identify if cancer care reviews were being completed as per guideline and how to improve these reviews. 60% of reviews were being done in 3 months as per guideline and the use of different codes was identified as the main problem for reviews not being completed within the time frame. As a result, the practice set up monthly clinics where all cancer care reviews would be automatically booked, and they arranged additional coding training. They have also agreed on a standard template for reviews to ensure a consistent approach. ○ One of the GPs put together guidance for emollient prescribing as they identified a wide variation of products prescribed locally, with a large proportion being premium priced products. For new patients presenting to the surgery, it is now recommended prescribing a single range of emollient to avoid confusion, maintain quality and be cost efficient. ○ A prescription audit was conducted in the practice to check appropriate prescribing and risk assessment for benzodiazepine (diazepam). The recommendation from the audit included: <ul style="list-style-type: none"> ▪ Writing to patient outlining dependency issues with long-term diazepam use. ▪ Developing a patient information leaflet outlining patient dependency issues with long-term, diazepam use. ▪ Document patient review when getting repeat prescription. ▪ Document phased dispensing of benzodiazepines if there were patient safety concerns ▪ Re-audit in 6 months. |
|--|

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. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |

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 |
| Explanation of any answers and additional evidence: <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. Staff in the practice had special interest in weight management. Social prescribing signposting patients to appropriate services to meet their individual needs. Patients at Donneybrook medical centre could access a range of PCN initiatives, including, a monthly Healthy Memory Café for Dementia patients and a Healthy Hub Club for parents and young Children who play together, with visitors from health services, MIND, Citizens Advice Bureau, Active Tameside, nutritionists and Fuel for Fun. | |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹ | Y |
| Explanation of any answers and additional evidence <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, although the details of who was involved in the discussion was not always recorded. 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 has had an online consultation system in place since 2021, and in November 2022 introduced a new system providing more flexibility and capacity. The system was open for patients to use from 7:30am and remained open until the system reached capacity. On average they were able to accept between 70 and 100 requests via the system each day. Initial feedback on the new system was positive from both patients and staff.• 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 out of 115 patients who responded to the survey, 33% responded positively to how easy it was to get through to someone at their GP practice on the phone. The practice had taken | |

action to address this, including establishing a new online system. Data shared by the practice, following analysis of the telephone system showed a significant reduction in the number of calls for appointment in the telephone que had halved since 2020.

- The practice continued to gather feedback on access via the Friends and Family test (FFT) and the Patient Participation group. We noted results from the FFT in September, October and November 2022, 90% of respondents would recommend the surgery.

Well-led

Rating: Good

Leadership capacity and capability

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

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | 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.• The partners acknowledge the impact staff retention and recruitment had had, particularly on the reception team, and hoped they had responded to this compassionately. Leading up to the inspection, some staff told us there was an inconsistent approach from managers. We discussed this with the provider who told us they tried to create an environment where staff felt able to discuss concerns with managers. They had also introduced a new role within the team to bridge the gap between staff and managers. They sent an email earlier in the year to all staff with the updated whistleblowing policy and details of the local 'Freedom to Speak up' guardian. They also added mandatory training modules for all staff on 'Whistleblowing' and 'Freedom to Speak up'. | |

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">• The majority of staff fed back that they 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 an 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. | Partial |
| 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 some 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.• Leading up to the inspection some staff told us they were unsure of which manager they should approach for certain issues, and that responses varied from one manger to another. The partners were aware that work was needed to ensure clear and consistent roles within the management team and work was already underway. | |

Managing risks, issues and performance

There were 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 |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had a range of management and clinical meetings scheduled to monitor performance.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 searched 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. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| Explanation of any answers and additional evidence: <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 the majority of patients who provided feedback, said that they would recommend the service. The practice Patient Participation Group (PPG) restarted face to face meetings following the Covid pandemic. They promoted the PPG and received a good level of interest and recently appointing a new Chair. The PPG had been involved in the rollout of the new on online | |

consultation system, and during the first week, some members spent time in the waiting area, promoting the services and helping patients to sign up and use the system.

- They continue to work as a group to encourage other patients to join and have a more diverse representation.
- 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. We discussed this with the provider who told us that now the new partners had been appointed and additional clinicians were being recruited, the partner were looking to review the practice strategy and would be involving staff in this work, to reflect the changing needs of the practice population and how they worked together as a PCN.

Continuous improvement and innovation

There were evidence of 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. | |

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a 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.