Care Quality Commission

Inspection Evidence Table

Ashton Medical Group (1-547522539)

Inspection date: 29 October 2019

Date of data download: 28 October 2019

Overall rating: requires improvement

We rated the practice as requires improvement in effective and well led as the systems and process to monitor patient outcomes was inconsistent and there was no system in place to monitor the uptake of screening programmes or childhood immunisations. We fond however the practice to be good in safe, caring and responsive.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Effective Rating: requires improvement

We have rated effective as requires improvement as the systems in place for monitoring care and treatment delivered were inconsistent.

Effective needs assessment, care and treatment

Patients' needs were not consistently assessed, and care and treatment was not always 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Explanation of any answers and additional evidence:

- The recall system for patients with long term conditions or those requiring reviews was ad-hoc and quality outcome framework (QoF) indicators were below average for diabetes, dementia and mental health. The practice was aware of this and one of their objectives for the next 12 months was to develop a QoF quality improvement programme and they had appointed a GP partner to lead on this work.
- Incoming pathology results were shared among the GPs to review and action. We noted however the buddy system established to monitor incoming results of GPs who were on leave was not adequately monitored and some results were not been reviewed or actioned in a timely manner. We were assured by the practice the system would be reviewed and a fail-safe put in place to ensure all results were reviewed and actioned appropriately.
- Practice staff were aware of the benefits of social prescribing and referral templates were embedded into the clinical system. We noted the practice was one of the highest refers to social prescribing services locally. They also had numerous links to community groups and support networks which continued to develop following the introduction of patient champion volunteers (patient champions are trained volunteers from the local community working with the practice to support them to improve people's health and wellbeing).
- Clinician offering home visits had secure access to patients records to enable them to carry out full assessments and reviews.
- The practice employed a paramedic who was able to respond to requests for home visits and provide visits to residential and nursing home patients throughout the day, enabling them to respond to urgent requests as well as provide proactive care and treatment in the community.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	1.16	0.96	0.75	No statistical variation

Older people — Population group rating: good

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.

People with long-term conditions

Population group rating: requires improvement

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, the system was ad-hoc. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice results linked to the quality outcome framework (QoF) were mixed for patients for patients with long term conditions, for example outcomes for patients with COPD and asthma were in line England averages. However, results for patients with diabetes and hypertension were below average. Unverified data provided by the practice for 2019/20 showed results were improving, for example, in year 74% (target is 80%) of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less.
- The practice had been involved with local initiatives, whereby specialist clinicians supported the practice to improve their prevalence rates for patients with respiratory conditions and review patients with chronic COPD and asthma.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Clinicians 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	69.8%	77.6%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.0% (28)	10.1%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure	66.8%	78.9%	78.1%	Tending towards variation (negative)

reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	2.5% (34)	5.8%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	72.5%	79.1%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.5% (76)	12.3%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	72.0%	74.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	5.1% (66)	6.2%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	91.3%	90.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	22.2% (137)	11.1%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	74.1%	82.3%	83.0%	Variation (negative)
Exception rate (number of exceptions).	1.7% (53)	2.6%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	90.7%	91.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.5% (5)	5.2%	5.9%	N/A

Families, children and young people Population group rating: good

Findings

- The practice had not met the minimum 90% target for three of four childhood immunisation uptake indicators between April 2018 and March 2019. Unverified in year 2019 data provided by the practice showed they met their target and systems were in place to ensure patients were aware of when immunisations were due and those who failed to attend were followed up.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2018 to 31/03/2019) (NHS England)	138	151	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	157	185	84.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	157	185	84.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	156	185	84.3%	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

Working age people (including those recently retired and students)

Population group rating: good

Findings

- 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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had not met the minimum 80% target for cervical screening uptake indicators between April 2017 and March 2018. We noted from published quality outcomes framework data in 2018/19 the practice had improved screening uptake to 78% and unverified data provided by the practice for April 2019 to Oct 2019 showed they were on track to meet the 80% target.
- The percentage of patients with cancer diagnosed within the preceding 15 months, and had had a review recorded in their records within six months was below average (39% compared to 69% England average)

Cancer Indicators	Practice	CCG average	England average	England comparison
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) (01/04/2017 to 31/03/2018) (Public Health England)	68.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	67.6%	69.8%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	50.7%	55.0%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	38.7%	72.6%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	47.4%	47.1%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: good

Findings

- Same day appointments and longer appointments were offered when required.
- 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 utilised social prescribing and promoted the monthly walking group organised by the health champion volunteers to support patients who maybe socially isolated or benefit from support within the community.

People experiencing poor mental health (including people with dementia)

Population group rating: requires improvement

Findings

- The practice assessed and monitored the physical health of people with mental illness and dementia. However, the recall system for reviews was ad-hoc and we found not all patients had been reviewed or reviews had not been accurately coded as taking place within patients records. The practice was aware of the lower than average results and had scheduled additional clinics to carry out holistic reviews and ensure care plans were recorded. As part of the overall QoF quality improvement programme they were looking to improve the recall system going forward.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive,	41.9%	88.4%	89.4%	Significant Variation (negative)

agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	3.7% (5)	7.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	66.4%	89.7%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	2.2% (3)	6.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	54.5%	81.2%	83.6%	Significant Variation (negative)
Exception rate (number of exceptions).	4.3% (8)	5.4%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	463.1	535.0	537.5
Overall QOF score (as a percentage of maximum)	82.8%	95.7%	96.2%
Overall QOF exception reporting (all domains)	2.9%	4.7%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
Explanation of any answers and additional evidence: The system to monitor the quality outcomes framework (QoF) was not robust and the recall system was ad-hoc. As a result, the practice has now appointed a clinical QoF lead and have developed a quality improvement plan in year to ensure they are achieving the targets set out as part of QoF.	

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

- A programme of quality improvement had been established.
- Medicine related audits were completed monthly to monitor prescribing and results were routinely shared with managers and leads.
- The pharmacist completed audits and responded to MHRA alert with actions and outcomes shared during clinical meetings.
- We noted two full cycle audits had been completed and learning shared at clinical meetings.
- The practice engaged in local quality improvement initiatives and recently engaged in a COPD improvement programme, looking at improving outcomes for patients with COPD.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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:

- The new practice manager had completed a training audit and identified significant gaps in staff training records. As a result, they have developed a training programme which incorporated mandatory and role specific training. All training was due to be completed by March 2020. We also noted the record of GPs completing level three safeguarding training was incomplete. Speaking with the practice manager they told us they would priorities this and ensure all GPs had the required level of safeguarding training and where this had not been completed this would be highlighted with individual GPs.

- Feedback from staff was mixed in relation to continuing professional development, some staff told us they had been provided with a range of opportunities to develop and progress, whilst other felt training had not a priority previously. However, all welcomed the new structured approach to training, supervision and appraisal.
- The new practice manager had completed a human resources audit and had one to ones with all staff. As a result, they identified, inductions had either not been completed or records had not maintained. Staff we spoke with told us of mixed experience at induction. For all new staff a formal documented induction process had been established.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Helping patients to live healthier lives

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

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

highlight the benefits of screening programmes. Dedicated information for carers was also available.

In partnership with Community Wellbeing Tameside and Glossop the practice had recruited a team of patient champion volunteers, who were actively involved with the practice and signposted patient's local community support groups and active lifestyle initiative taking place in the community.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.8%	95.3%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.3% (16)	0.5%	0.8%	N/A

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
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes

Responsive Rating: good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

The practice valued being part of the local community and were conscious of the impact the three practices merging had had on patients and staff. As a result, they were striving to improve services offered in house but also understand the range of services locally they could link with, for example:

- In partnership with Community Wellbeing Tameside and Glossop the practice had recruited a team of 13 volunteer patient champions who started in the practice in January 2019. To date they have been offering waiting room support, directing patients to the right location, helping them check in. They have also set up a monthly walking group, for patients of all abilities. There are now on average 20 to 40 people taking part each month. The volunteers have also held an open day at the practice following the completion of the refurbishments and to gather the views from patients.
- As part of the practice renovations the practice also made improvements to accessibility including widening doors for wheel chair access.
- The practice has been awarded dementia friendly and homeless friendly status and they have also achieved gold in the pride in practice scheme.

Practice Opening Times	
Day	**Time**
Opening times: Monday to Friday 8:00am to 6:30pm	
Appointments available: Monday to Friday 8:00am to 5:30pm	
Additionally, patients could also access GP services in the evening and on Saturdays and Sundays at a local extended hours hub.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
19002.0	332.0	102.0	30.7%	0.54%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	86.3%	95.1%	94.5%	Tending towards variation (negative)

Any additional evidence or comments

The practice was very conscious of the impact the practice merger and renovation work had had on patients over the past 18 months and had detailed, quality improvement plans in place and an engagement strategy to work with patients to ensure patient experience improved.

The practice revised the reception staff rota to ensure there were enough staff available to answer the telephone at peak times and they had revised the appointment system to have more appointments available to book on the day or within 3 weeks. This was in response to patient feedback but also the high percentage of patient who failed to attended appointments booked more than 4 weeks in advance.

They had also appointed a skill mix of clinician's including a paramedic to respond to diverse patient needs and the higher percentage of patients 65 years and older.

Since the system changes were implemented in September 2019, the practice has seen a reduction in the number of complaints and received positive comments from patients.

Older people — Population group rating: good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice employed a paramedic who was able to respond to home visit request throughout the day.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions — Population group rating: good

Findings

- Patients with multiple conditions had their needs reviewed where possible in one appointment.

- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: good

Findings

- Appointments were available outside of core school times so that children did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students) — Population group rating: good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6:30pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as part of the local extended hours scheme. Appointments were available evenings and weekends.

People whose circumstances make them vulnerable — Population group rating: good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers. The practice had been awarded homeless friendly status.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: good

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

Explanation of any answers and additional evidence:

- The practice had a duty doctor available throughout the day to respond to urgent needs. Working alongside the paramedic they were also able to respond to home visit requests quickly and priorities those with the most urgent need.
- The practice promoted online appointment booking, with 90% of appointments now bookable online, including on the day appointments.
- The practice has increased the clinical skills mix to provide a wider variety of appointment times and availability of appointments. We saw from data provided by the practice they had more appointments with a clinician available each week than the minimum recommended for example guidance suggests 70:1000 patients and the practice were now offering 112:1000.
- In response to the challenges faced by patients getting through to the practice by telephone and accessing appointments the practice implemented a quality improvement plan. This included:
    - Employing 4.5 full time equivalent receptionists to ensure there were enough staff to meet demand. They had also changed staff rotas to ensure the maximum number of staff were available to take calls at peak times.
    - Changes to the telephone system had enabled the practice to monitor performance in real time. Since the changes the average time patients waited for the telephone to be answered has decreased with the average now 5 minutes or under every day compared to previously 20 minutes or more.

- Early indications following the improvements have been positive with a significant reduction in the number of complaints received.
- The practice monitor patients' experience of accessing the service via the friends and family test, complaints and feedback from the patient participation group and patient champions. The practice manager also had plans in place to hold engagement events with patients.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	36.7%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	39.3%	62.4%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	47.7%	60.9%	64.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	57.3%	69.9%	73.6%	Tending towards variation (negative)

Source	Feedback
Healthwatch: Summary of views gathered by Healthwatch shared with CQC monthly.	Three patients provided mixed feedback to Healthwatch in September 2019 about their experience, describing positive experience when seeing clinicians, but reported difficulties accessing appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	14
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

Explanation of any answers and additional evidence:

Following a review of the complaints process by one of the partners at the beginning of 2019, they identified a backlog of complaints which had not been actioned by the previous practice manager. As a result, a full investigation took place and a lead partner was appointed to manage all outstanding complaints. We noted during the inspection all outstanding complaints had been investigated and action taken.

Working with the new practice manager a new complaints process has been developed and we noted all recent complaints were appropriately investigated in a timely manner and learning shared with staff and the wider organisations as appropriate. The practice manager also had a tracking system in place to monitor action and outcomes following complaints. The system also allowed the practice manager to identify any trends.

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Well-led Rating: requires improvement

We have rated well-led as requires improvement as the processes for managing risks, issues and performance were inconsistent.

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.	Partial
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:

- Since 2017 the practice had seen significant changes, merging with two other practices with a combined patient list of 19500. Although the merger was planned there were unexpected challenges including the IT and telephone systems which had a significant impact on staff and patients accessing the service. At the same time the practice underwent a large renovation programme. All of this and a turnover of managers had an impact of patient experience and staff morale.
- Since September 2019 the practice had appointed a new management team, appointing a new practice manager and reviewed other managers roles to have a core team to take the practice forward and focus on quality improvement. The have also appointed quality lead roles across the partnership team.
- The new management team have established lead roles within the practice and established new governance arrangements and were in the process of reviewing system and process to make them more efficient and establish robust monitoring systems. Work had already started with the introduction of a team intranet system which had embedded within it process for managing significant events, audits, learning from complaints, document meetings and individual or team tasks.
- The practice needed to further develop their systems to ensure patients with long term conditions were attending for reviews or accessing monitoring in line with the Quality Outcomes Framework and review the recall system to ensure patients with poor mental health and dementia have access to reviews and care plans are recorded within their records.
- The practice acted to address the challenges faced by patients when trying to access the service by telephone and reviewed the appointment system.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
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: • The practice had scheduled time when the practice was closed for all staff to come together and review the practice vision and to agree a shared set of values. • Partner meeting routinely reviewed risk, quality improvement schedule and review strategy following the merger.	

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: Equality and diversity training was included in the new mandatory training programme which all staff were expected to have completed by March 2020.	

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

Source	Feedback
Staff	We spoke with a range of clinical and non-clinical staff during the inspection and received mixed feedback about the changes which have taken place following the merger. Some staff were positive about opportunities to develop and valued the innovation and support they received within the team. However, some staff said they did not feel supported and communication following the changes was inconsistent. All staff however were optimistic about the new management structure and felt since the appointment of the new practice manager the practice was more organised, and they valued the introduction of formal meetings and the team intranet had already improved communication. All staff valued the opportunity to have a one to one meeting with the new practice manager and were able to share their views and opinions.
Staff survey	The partners and new management team were conscious of low staff morale and to understand the issues more clearly, they conducted an anonymous staff survey which was completed by 20 members staff. The survey highlighted the need for improved communication and clear, supportive management and leadership. The management team had developed an action plan including more formalised opportunities to meet as teams, protected time for learning and social activities. The new practice manager plans to be more visible and accessible going forward. The practice plan to repeat the survey in 2020 to identify if improvement made have had a positive impact on the staff team

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

Explanation of any answers and additional evidence:

There was now a clear system in place for investigating, reviewing and learning from complaints and significant events. The practice manager monitored actions identified to ensure that they had been completed and reviewed.

There was a clear system in place to manage health and safety and monitor cleanliness and infection control to ensure standards were being met.

The new practice manager has carried out an audit of human resource records and created a risk register where gaps were identified. We noted from the risk register there were gaps in staff records, for example not all staff records, where appropriate, had disclosure and barring checks recorded. This was immediately actioned. Working with an external HR company the practice was reviewing all systems

and process to bring them in line with current good practice. We noted for all staff recently recruited all appropriate checks had been carried out.

There was now a clear management and leadership structure in place and leads had been appointed to improve the governance and lead on key quality improvement initiatives, for example there was now a dedicated reception, administration and estates managers in post. The partners had taken lead roles including, quality improvement, QoF and complaints and significant events and staffing.

There were opportunities for staff to develop, and there was now a clear training programme in place. Clinical staff had been supported to gain additional qualifications and training to develop their role.

A new programme of meetings had been developed to improve communication and shared learning. These included, weekly partner/manger meetings, monthly department meetings and monthly clinical meetings. The nursing team were also looking to establish regular meetings now they had a full team.

There were a range of both clinical and administrative policies, that were easily accessible for all staff, that supported the delivery of good quality and sustainable care.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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.	Partial

Explanation of any answers and additional evidence:

There were no formal governance arrangements in place to ensure the practice achieved clinical targets or indicators such as the Quality outcomes framework, screening programmes such as cervical screening or uptake childhood immunisations.

A programme of quality improvement programme was being developed to formalise the process for monitoring performance and respond to risks. This included appointing a lead for QoF and quality.

There was a clear audit programme in place to monitor prescribing, respond to MHRA and safety alerts. Results and learning form audits were shared during clinical meetings and published within the team intranet, with staff encouraged to comment and discuss outcomes.

The merger of three practices was planned overtime and in consultation with patients. However, the

impact on systems such as telephones was not anticipated and impacted on patient access. In response to complaints and patient feedback the practice updated the telephone system and invested in additional administration/reception staff to meet demand, as well as increasing the skills mix within the clinical team to be able to offer additional appointments.

The partners also acknowledged that undertaking renovation work at the same time as the merger put additional pressures on the service, further impacting on staff and patients experience.

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 adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

The practice did not have an overview of performance relating to the screening and immunisation targets or achievements in line with QoF indicators.

The practice had acted to address performance in response patient feedback and the results of the national GP survey. This included establishing a new call centre approach to answering the telephone and making changes to the appointment system and increasing the number of appointments available each week. Performance was continually monitored and initial feedback to the changes was positive, although a formal evaluation had yet to take place.

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:

- The patient participation group was an amalgamation of patients from the three practice and they

met with the practice 4 to 6 times a year.

- The practice had a patient engagement plan in place, which included open engagement sessions with the practice manager and they planned to re-establish pages on social media networks and role out the friends and family test to gather on-going feedback from patients.
- The practice invited Tameside Healthwatch to gather independent feedback from patients.
- The new practice manager had met with all staff to gather feedback and identify issues and concerns and identify solutions.
- A staff survey had been carried out in October 2019, with plans in place to repeat the survey early 2020.
- The volunteer patient champion hosted a practice open day in June 2019 to show patients around the practice after the renovations had been completed, but also to gather patients views on what they would like to see from the patient champions going forward.

Continuous improvement and innovation

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

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

Explanation of any answers and additional evidence:

- The practice had developed a quality improvement programme to make improvements.
- The role of the paramedic continued to develop and enabled the practice to be more responsive to requests for home visits and support patients living in residential and nursing homes.
- Plans were in place to improve access through care navigation and offering online and group consultations.
- A new website was being developed which would also include an improved symptom checker
- The patient champions planned to expand on work already started, including a dementia café, hosting a waiting area hub to help patient with checking in and signpost patients to community events/groups. They also had plans to setup a gardening club and a young carers support group.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **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.