

# Care Quality Commission

## Inspection Evidence Table

### St Andrews House Medical Centre (1-1309587927)

Inspection date: 21 July 2022

Date of data download: 13 July 2022

## Overall rating: Good

The overall rating for this practice is good. We inspected three key questions; safe, effective and well-led. We rated safe as requires improvement, effective and well-led as good. We found breach one Regulations: 12 Safe care and Treatment

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

## Safe

## Rating: Requires improvement

Following this inspection, we have rated the practice requires improvement for providing safe services. We identified the practice did not have robust systems in place for the appropriate and safe use of medicines and infection prevention and control.

### 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

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>All clinical staff were trained to level three safeguarding which is in line with guidance.</li> <li>Multidisciplinary meeting were held to monitor and review safeguarding concerns and co-ordinate responses where required.</li> <li>Safeguarding is a standing agenda item for weekly clinical meetings.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We reviewed a sample of four staff files and found in the main recruitment checks had been carried out in accordance with regulations. However, we noted for two recently recruited staff, reference had either not been obtained or where reference had been requested where these had not been provided there was no system in place to follow these up.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: November 2021 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice completed weekly health and safety checks.</li> <li>The practice used an external company to carry out PAT testing and calibrate medical equipment.</li> <li>The practice had two fire marshals and they carried out practice fire drills every six months, in addition to weekly fire alarm tests.</li> <li>Staff received health and safety and fire safety training.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	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:	

- During the site visit, we observed clinical areas to be clean and well maintained and the clinical rooms observed were set up in line with good infection prevention guidance. A full IPC audit was completed in 2019 by an external provider. Following this the cleaning staff completed weekly environmental audits, and these were used to monitor IPC compliance. Plans were in place for a full external infection control audit to be completed in addition to the internal checks taking place.
- Staff feedback from the CQC staff survey sent as part of the inspection process, was that overall, they felt, as a result of COVID-19, enough changes were in place to ensure infection control arrangements were sufficient to protect staff and patients. We observed personal protective equipment (PPE) was readily available for staff and hand sanitiser was available for staff and patients throughout the building.
- Staff training records showed GPs had completed IPC training, however not all other clinical and non-clinical staff had completed training, including one of the named IPC leads. Immediately following the inspection evidence was provided showing all the IPC lead staff had now completed training.

## Risks to patients

**There were gaps in 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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Nine members of staff completed and returned the CQC staff survey. Of the nine, three colleagues stated that although a GP was always contactable by telephone, there was not always a GP onsite to provide support and guidance. We discussed this with the provider and in response to feedback from staff before the inspection, they told us from the beginning of July a GP would be onsite every day, wherever possible from 9:30am at the latest, and that a GP was available by telephone for any staff queries from 7:30am.</li> <li>• One staff member told us they regularly worked over their contracted hours to complete tasks, working on average an additional hour each day. Following the inspection, the provider shared additional data and additional information from staff which showed staff were not working over contracted hours without agreement and the provider was flexible with staff, including enabling home working and amending working hours to accommodate personal circumstances.</li> </ul>	

## Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment.**

	Y/N/Partial
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Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The was a central system monitor all test results to ensure results were reviewed and actioned by an appropriate clinician in a timely manner. Checks were in place at the end of each day to ensure no actions were outstanding.</li> </ul>	

### Appropriate and safe use of medicines

**The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.18	0.84	0.79	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	8.4%	7.6%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.40	4.06	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	212.8‰	200.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>	0.68	0.75	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	9.1‰	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
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Lead GPs were available each day for non-medical prescribers to liaise with and ad-hoc audits were completed to monitor competencies of competence of non-medical prescribers.</li> <li>• 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 are visible to the practice. The records we examined showed there was a lack of processes in place to ensure monitoring was carried out in line with guidance, and where patients were being monitored in secondary care, the results were not being reviewed routinely prior to prescribing. For example: <ul style="list-style-type: none"> <li>○ Clinical searches identified 729 patients prescribed ACE inhibitor or Angiotensin II receptor blocker of which 94 patients had not had the required monitoring.</li> <li>○ A review of five patients prescribed Benzodiazepine and Z drugs found an inconsistent approach to reviews and monitoring, with four out of five patients not having a review recorded in the last 12 months.</li> </ul> </li> <li>• Immediately following the inspection, the provider submitted management plans to address the concerns raised during the clinical searches, including initial actions to recall patients overdue monitoring and longer-term plans to embed audits to ensure patients were monitored and reviewed within the required timeframes.</li> <li>• During the clinical searches the GP specialist advisor also reviewed a sample of five consultations which included a medication review. They found in most cases detailed medication reviews had been completed.</li> <li>• Processes were in place to monitor prescribing competence of non-medical prescribers, and ad hoc audits were carried out by GPs. However, following the inspection concerns were raised that clinical staff were being asked to work outside of their clinical competencies. They told us this had been raised with managers, and that training had been requested, but we were told some clinical staff still felt pressured to see patients with conditions they were not fully trained or confident in treating.</li> <li>• We raised these concerns with the provider who told us that none of their staff worked outside their clinical competencies. They told us they did not expect staff to see patients with conditions where they felt they were not competent they encouraged staff to discuss with their manager if they needed additional training to keep up to date. We were provided with evidence of notes from meetings with staff in which actions were agreed should patients present with conditions they were not comfortable in assessing. Systems were also implemented at receptions to guide staff to book patients in with specific complaints to the appropriate clinician. Details were also provided of a range of professional training courses attended by staff to support the development of clinical competencies identified during the appraisal process.</li> <li>• The practice and local Integrated Care System (Tameside) monitored antimicrobial prescribing. Where antibiotics were prescribed, rational was noted in clinical records, and where concerns were raised the practice engaged in prescribing reviews and completed a root cause analysis.</li> </ul>	



## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A significant event policy and procedure was in place and there was a standard form in place to help investigate and record outcomes and learning.</li> <li>Staff were familiar with the system and staff were encouraged to report incidents. We saw they were discussed in practice meetings.</li> </ul>	

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

Event	Specific action taken
Letter filed in wrong patients records	Investigation carried out and error was made by patients previous GP. Additional checks put in place to ensure new patients records were checked for accuracy.
Patient informed clinician of positive pregnancy test, during telephone consultation. Patients prescribed topiramate medication, and therefore increased risk of cleft lip.	GP contacted on-call gynaecologist and patients referred to gynaecology and remained under hospital care during pregnancy.  Review of all patients prescribed topiramate or similar drugs to ensure up to date pregnancy prevention programme was in place.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a system in place to review and action safety alerts as appropriate and these were discussed during clinical meetings.</li> <li>The GP specialist advisor reviewed a sample of patients on teratogenic medications to ensure action had been taken following alerts issues by the action taken following Medicines and Healthcare products Regulatory Agency (MHRA) alerts and found appropriate action had been taken.</li> </ul>	

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

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

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

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>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 and advanced care plans were developed. For those patients identified with mild and moderate frailty they could be referred to social prescribing link worker provided by Action Together team who offered advice on health and well-being. They could also access to a Health and Well Being coordinator.</li><li>The practice provided a weekly ward round in a local care home. The care home has a high number of residents who are receiving palliative care, and the practice work together as a team</li></ul>



to ensure, clinical staff have quick access to patients previous clinical notes and history to enable them to assess and meet the needs of patients.

- The practice identified a gap locally for patients who required ear syringing service. As a result, they set up an ear suction clinic in house. The service is now open to other patients within the primary care network.
- 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.
- The practice offered a contraceptive service and from August 2022 will also be able to offer a contraceptive coil and implant fitting. The practice nurse also taught patients how to use self-administered long acting reversible contraceptive where appropriate.
- 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.

## 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 are visible to the practice. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	49	49	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	44	46	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	44	46	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	44	46	95.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	50	53	94.3%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	72.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	51.1%	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)	66.2%	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)	43.8%	56.6%	55.4%	No statistical variation

#### Any additional evidence or comments

A quality improvement project was carried out to increase the uptake of cervical screening for eligible patient. The practice invited all eligible patients by text, phone call, letter and utilised the Saturday morning clinics for those patients unable to attend during the week. Unverified data shared by the practice showed by March 2022 74% for patients aged 25 to 49, and 78% for those aged 50 to 64.

The practice continued to promote the benefits of screening with patients. They provided a range of appointment options for patients. They continued to monitor up take.

#### 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

The practice carried out a range of audits and quality improvement activities, for example:

- Quality improvement work was undertaken for patients with a learning disability. This included scheduling 30-minute appointments (15 minutes with the nurse and 15 minutes with a GP). Staff training was arranged.
- Quality improvement to increase the uptake of cervical screening.
- Improving access to wax clearing services by creating a Micro-suction of the Ear service for their own patients and patients across the PCN.

## 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.	Partial
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
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Nine staff returned staff surveys to CQC, with three staff reporting they did not have enough time to complete training, and although they were allocated protected time for training, they had been unable to take time out, due to demand to complete training. We raised these concerns with the provider who told us that all staff have protected time one afternoon a month when the practice is closed, and those who do not work, those afternoons, if they choose to work additional hours to complete training they would be paid for their time. Following the inspection in response to feedback the practice has introduced additional protected learning afternoons every six months.</li> <li>• There was a training plan in place, which included mandatory training and updates, however this was not closely monitored, and we noted gaps in training records. We were told the practice was introducing a new IT system which would enable them to monitor compliance with training more closely going forward and additional protected time had been set up, giving more time for staff to complete training.</li> </ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff at the practice worked closely with the primary care network (PCN) complex care team.</li> <li>• The practice provided a weekly ward round in a local care home and had regular contact with care home staff and other health and social care professional to coordinate care, especially at those receiving palliative care.</li> <li>• The practice ensured where required special patients' notes were shared with out of hour and ambulance services.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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
<p>Explanation of any answers and additional evidence:</p> <p>Patients at the practice were able to access additional services as part of the local primary care network (PCN), including access to social prescribers, a musculoskeletal (MSK) practitioner and a mental health nurse. The practice could directly book patients (children and adults) an appointment with the mental health nurse, within three to four days, significantly reducing the time it would take for a patient referral into secondary care.</p>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
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## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• The practice aimed to provide 72 appointment per 1000 patients with either a GP or advanced nurse practitioner each week.</li><li>• The practice operated a hybrid appointment system, with a mix of on the day urgent and pre bookable appointments.</li><li>• Patients could request either a telephone or face to face appointment at any time throughout the day. If all urgent on the day appointments had been booked for the day, staff were able to book patients into urgent slots the following day, preventing them having to call back the following day. Reception staff were trained to seek support from the GP on call should think a patient may need to be seen sooner.</li></ul> <p>The practice shared recently published data from the latest GP National Survey (Jan to March 2022) which showed:</p> <ul style="list-style-type: none"><li>• 76% were offered a choice of appointment when they last tried to make a general practice appointment (ICS Average 59% and National Average 59%)</li><li>• 82% were satisfied with the appointment they were offered (ICS Average 71%; National Average 72%)</li></ul>	



## Well-led

## Rating: Good

### Leadership capacity and capability

**There was compassionate, leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a clear mission and vision and supporting business plans which reflected the vision and values.</li><li>• The practice did not have a formal leadership plan in place, as there were no plans in the near future whereby the partners planned to leave or retire from the practice.</li><li>• Staff feedback we received was mixed as to how involved and how supported they felt by leaders. Six of the nine staff stated they felt supported and managers were approachable and available when needed. However, three staff members reported that they felt they were not listened to, felt unsupported by leaders and were not provided with the time required to complete training required for their role. The provider took onboard the feedback received from the staff surveys and provided details of how they planned to work with staff to improve communication and work with staff to address concerns raised.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a long-standing mission statement and vision in place, with staff involved in the initial development. This was shared with new staff during the induction process, including induction for GP registrars. However, some staff reported that they were not clear the provider had a clear vision for the future.</li><li>• The practice monitored and reported on how they were continued to achieve their vision and values.</li></ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns.	Partial
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Majority of staff told us they felt supported, there was a friendly and kind atmosphere and that they were supported. However, some staff told us that they did not feel that their concerns were listened to or acted upon.</li> <li>The provider told us it was practice culture that staff were encouraged to share formally or informally any areas of needs and that they try to support them to achieve the need. They provided examples of where staff had attended substantial training programmes to develop skills and competencies to fulfil their role. They also provided evidence of responding to staff feedback, including amending staff work patterns around childcare, and GPs amending their sessions to allow for more GPs to be physically onsite throughout the day.</li> <li>The provider shared details of how they supported staff to adapt work patterns to support individual staff wellbeing and personal circumstances.</li> </ul>	

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

Source	Feedback
CQC staff feedback forms	We received feedback from nine members of staff. All staff reported leaders were nice and friendly, with six reporting they were supported, listened to and felt the practice had a clear vision for the future. However, three members of staff raised concerns that they felt unappreciated and unsupported by leaders, and there was insufficient time for training.

## Governance arrangements

### There were roles and systems of accountability to support good governance and management.

	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a number of governance system in place to manage risk and monitor quality, including a range of audits and quality improvement programmes. However, we found during the clinical searches there were gaps in the systems and process in place relating to the management of patients prescribed high risk medicines. Immediately following the inspection, the provider submitted management plans to address the concerns raised during the clinical searches, including initial actions to recall patients and longer-term plans to improve the governance systems and ensure patients were monitored and reviewed within the required timeframes.</li> <li>There was a clear management and leadership structure in place and leads in post for key areas.</li> <li>Not all staff were clear about their roles and responsibilities. We received information following the inspection that some staff were given additional tasks/roles without being involved and others raising concerns they were being asked to work outside of their competencies, and on occasions without a GP onsite to provide support. We raised these concerns with the provider after the inspection and they provided a detailed response, including details of discussions with staff and training programmes staff have attended to develop skills and competencies. They told us they did not expect any staff to work beyond their clinical competencies, and work with staff as part of the appraisal process to identify skill gaps and identify training.</li> </ul>	

## 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.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We noted from the clinical searches we carried out as part of the inspection, that there were gaps in the medicines management assurance systems put in place for patients prescribed high risk medicines. However, immediately following the inspection, the provider submitted management plans to address the concerns raised, including initial actions to recall patients for monitoring and reviews where these were overdue and longer-term plans to embed audits ensuring patients were monitored and reviewed within the required timeframes.</li> <li>The practice had recently invested and installed some additional computer software to improve the monitoring and clinical governance systems and the medicines management lead had developed a series of clinical searched which were run monthly.</li> </ul>	

## The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice made physical changes to the building to improve ventilation, and adapted windows at the height of the pandemic, to enable patients and staff communicate safely without patients having to enter the building.</li> <li>The practice updated their Covid risk assessment in June 2022 using a risk assessment tool provided by the British Medical Association.</li> <li>Changes had been made to infection control arrangements. We observed measure remained in place where appropriate.</li> </ul>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	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"> <li>The practice had a range of meetings scheduled to monitor performance and keep staff up to date. These included quarterly full staff meetings and protected time for learning and development.</li> <li>There was an audit programme in place and results discussed during clinical meetings.</li> </ul>	

- 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

## Engagement with patients, the public, staff and external partners

**The practice involved the public, external partners to sustain high quality and sustainable care, however some staff reported their views were not acted upon.**

	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.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had an active patient participation group (PPG) prior to the COVID-19 pandemic. The practice has been proactively in recruiting new patients to the PPG and now have ten patients involved with meetings scheduled.</li> <li>• The practice worked alongside the Primary Care Network and Integrated Care Systems (ICS) Tameside to work together and identify ways in which they can meet the needs of patients.</li> <li>• The practice has not conducted a recent internal patient survey in the last 12 months, but have continued to listen to feedback, including adapting the appointment system now the acute phase of the pandemic has ended, after patients requested having the choice of face to face or</li> </ul>	

telephone consultation at the point of booking an appointment, rather than staff triaging. Plans were in place, working alongside the PPG to carry out a patient's survey towards the end of 2022.

- Feedback staff provided as part of the CQC staff survey was mixed. Majority of staff stated that they were involved and felt supported by leaders, however some staff reported they did not feel involved and their views were not listened to. We shared the themes from the staff surveys with the provider and they told us going forward in team meetings they will ask staff how communication could be made better and seek suggestions as to how staff can be more involved in decision making.

## Continuous improvement and innovation

### There were 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"> <li>• The practice worked closely with the PCN and were able to accommodate a number of services within the practice for patients, including setting up an ear suction clinic after identifying a gap locally.</li> <li>• The practice took part in a range of quality improvement projects, including improving uptake of cervical screening.</li> </ul>	

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

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

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

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

#### **Glossary of terms used in the data.**

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