

Care Quality Commission

Inspection Evidence Table

Pennine Medical Centre (1-572207424)

Inspection date: 11 November 2022

Date of data download: 20 October 2022

Overall rating: Good

The overall rating for this practice is good. We inspected all key questions, rating safe as requires improvement, effective, caring, responsive and well-led as good.

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice appointed two safeguarding leads, one for children and one for adults. The practice matron also took a lead on supporting and safeguarding vulnerable and elderly patients.All staff had received safeguarding training to appropriate levels in line with guidance.There is a risk register in place for vulnerable patients which was monitored and kept up to date. There was a process in place to review children on the risk register transitioning into adult services and assess if there were any ongoing concerns.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> There was a clear 'did not attend' system in place to ensure children or vulnerable patients would be followed up where appropriate, If they had either failed to attend an appointment including within secondary care, or attended out of hours services or A&E. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were clear recruitment policies and procedures in place, including details of the checks required for self-employed and locum staff. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
There was a fire procedure.	Y
Date of fire risk assessment: 26/10/2022	Y
Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a risk assessment policy in place, and they carried out a range of health and safety risk assessments including, Legionella assessment, COSHH Risk Assessment forms for cleaning products, an emergency lights survey and asbestos survey. The practice used outside providers to carry out an annual PAT testing and calibration of equipment. We saw evidence which showed these had both been completed. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 06.07.2021	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a clear infection prevention control (IPC) policy in place. Following the most recent IPC audit the provider was rated as compliant with an overall score of 93 out of 100. The practice developed an action plan and we noted all actions had been completed. The practice also carried out regular hand hygiene audits and audited annually for post-operative minor surgery infections. We noted from the latest audit in July 2022 that no patients developed post-operative infections. 	

- All staff had completed IPC training to appropriate levels.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

- A review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.
- There was a robust system in place when referring patients to specialist services and processes were in place to monitor two week wait referrals.
- There was a clear system in place for the management of test results and incoming clinical correspondence, these were managed in a timely manner. There were safeguards in place to ensure all urgent results or clinical correspondence had been actioned by the end of the day, and one of the GP partners checked the pathology inbox at the end of the week to ensure no urgent actions would be left over the weekend.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.96	0.94	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	6.7%	7.0%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.35	4.46	5.31	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	162.5‰	185.7‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.78	0.84	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.1‰	7.1‰	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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches are visible to the practice. All the records we examined were discussed with the practice and actions taken demonstrated there were no risks or risks were low where monitoring had not been recorded. For those patients who failed to respond to reminders for monitoring, there was a robust non-responder policy in place, whereby, after an initial non-response to 3 reminders the non-response is escalated to the named GP for action. Actions included amending medications from repeat to acute with a notification to the patient for the reasons. For those patients where risks were higher, or they continued to not respond they would be discussed as part of the practice clinical MDT meetings and an action plan would be agreed. We identified from the clinical searches: There were 35 patients prescribed Methotrexate, of which 6 had potentially not had the required monitoring. We reviewed 5 records in detail and found all patients had annual medication reviews 4 patients had been sent reminder, but had not attended for monitoring, another was being monitored in secondary care. Those who failed to respond to reminders the practice would follow the non-responder policy. The practice had also in the summer of 2022 written to all patients 	

Medicines management	Y/N/Partial
<p>prescribed Disease-modifying antirheumatic drugs (DMARDs) reminding them of obligations to attend our practice under the shared care protocols.</p> <ul style="list-style-type: none"> • There were 13 patients prescribed Lithium, of which 8 had not had all the required monitoring. We reviewed 5 records in details and found 2 patients were overdue monitoring, and 3 required calcium levels monitoring, this was deemed to be low risk by the GP specialist advisor and it was noted that the patients had had a medication review documented in the records. As with all other high-risk medicines prescribed the non-responder policy was in place. • There were 1474 prescribed ACE inhibitor or Angiotensin II receptor blocker, of which 131 (9%) had potentially not had the required monitoring. Of the 5 records we reviewed in detail we noted 4 had been sent reminders, and one patient had an appointment booked for monitoring. This risk to these patients was deemed low by the CQC GP specialist advisor. Additionally, all these patients had been reviewed by medicines management team and CCG pharmacy technician as part of a quality Improvement programme (QIP) and they will be recalled as part of the ongoing QIP. • There were 36 patients prescribed Warfarin of which 16 had potentially not had monitoring in the last 56 days. Of the 5 records we reviewed in detail. All 5 appeared to be overdue monitoring, however details were provided of the local Warfarin shared care protocols which were in place, whereby clinicians had the ability to see the patients INR test results (INR tests shows the time it takes for the blood to clot) in real time, demonstrating patients were being monitored. The practice worked with 2 anticoagulant community warfarin services offering both clinic, remote and home visits. These services provided the practice with a weekly update and the results were then coded into patients' records, or real time INRs were available to clinicians electronically prior to prescriptions being authorised. The practice also worked with the anticoagulant services to review patients where they identified any INR which were outside of clinical levels. The practice was alerted if any patients did not attend appointments with the anticoagulant service so they can immediately follow this up with the patient. Additional safety measures were also in place with 2 local pharmacies who dispensed majority of the prescriptions, whereby they would check the patient's warfarin anticoagulant record upon dispensing. • The practice employed two clinical pharmacists who undertook medication reviews for elderly patients who were discharged from hospital. They also completed annual medication reviews, especially for those patients prescribed multiple medications. • The practice carried out a range of regular audits to monitor prescribing of medicines and recall patients who required monitoring. • The practice held a monthly meeting with the ICB Oldham medicines management team to review prescribing practices. 	

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:	7
Number of events that required action:	7
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used an IT system 'Teamnet' to record and monitor significant or critical incidents. This enabled the practice to monitor whether any actions required had been completed and reviewed. Significant events were a standard agenda item at practice meetings, and they were discussed for learning. We reviewed the records of the 7 significant events and noted actions proposed had been completed. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a system in place to review and action safety alerts as appropriate and these were discussed during practice meetings. The GP specialist advisor reviewed a sample of records for patients of childbearing age who were prescribed teratogenic medicines which had been subject to a Medicines and Healthcare products Regulatory Agency (MHRA) alert. We noted appropriate action had been taken. They also reviewed a sample of 4 records of patients prescribed a combination of clopidogrel and omeprazole/esomeprazole, where it was not clearly documented during medication reviews if the risk of the combination of medicines had been discussed with the patients. Following the inspection, the provider reviewed the records to confirm the risk had been discussed and this was to be documented more clearly as part of the medication review. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There were staff in lead clinical roles, including palliative care and safeguarding leads. They were available to provide support, advice and guidance to staff within the practice.• The practice matron took a lead in developing care plans and ensuring the needs of vulnerable patients and those patients needing end of life care had their needs fully assessed on a regular basis.	

Effective care for the practice population

Findings
<ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.• Health checks, including frailty assessments, were offered to patients over 75 years of age.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. The practice was working with others to review the register to ensure all patients who had a learning disability had access to a holistic review.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. One of the partners was the palliative care lead and they had developed a dashboard, visible to the health care team, which was updated daily where necessary.
- 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 were visible to the practice. The records we examined showed an inconsistent approach in relation to monitoring patients with long term conditions for example:
 - The clinic searches identified 6 out of 24 Patients with Chronic Kidney Disease Stages 4 or 5 who had potentially not had U+E monitored in the last 9 months. We reviewed 5 records in detail and found that monitoring was taking place in secondary care or patients had been prompted by the practice to attend for monitoring.
 - We reviewed a sample of patient records with diabetic retinopathy who's latest HbA1c was >74mmol/l and found the practice recognised raised HbA1c and acted, reviewing patients and referring to the diabetic clinic.
 - Our clinical searches identified 504 patient who had hypothyroidism and found 24 had potentially not had a thyroid function test (TFT) for 18 months in line with guidance and 6 of them had abnormal test results. From the 5 records we reviewed in detail we noted 4 out of 5 patients had had a medication review, 2 patients were being monitored in secondary care, however 3 patients were overdue a TFT, of which 2 patients had been sent reminders. This was discussed with the practice during the clinical interview and actions taken by the practice demonstrated low risk. As with high risk medicines, patients who repeatedly failed to respond to requests for monitoring the practice would follow the non-responder policy.
 - The clinical searches identified 92 out of 854 patients with Asthma who have had 2 or more courses of rescue steroids in the last 12 months. In line with NOC guidance patients who have been prescribed a course of rescue steroids should be followed up within 48 hours. We reviewed 5 records and noted, 4 had had an asthma review completed. It was also noted that all 5 patients had been assessed at the time of prescribing rescue steroids. This was discussed with the practice and following the inspection they provided details of the acute exacerbations protocol whereby patients would be reviewed post discharge and reviewed post steroid use. Following the inspection, the practice also shared again with all clinicians the importance of this acute asthma protocol.
- For patients with long term conditions the practice provided a range of services, including annual reviews. The practice had a quality improvement programme in place known as the 'Every Contact

Counts' (ECC). This meant that every patient, who had a long-term condition combined with other conditions, such as dementia, were offered, on their birth month, a full medical, long term conditions review, bloods and investigations. Where required a medication review with a clinical pharmacist would also take place.

- The practice worked closely 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.
- 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 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)	209	218	95.9%	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)	235	249	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	235	249	94.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	235	249	94.4%	Met 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	228	241	94.6%	Met 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice had a clear immunisation strategy in place and worked as a team to ensure good access to baby clinics and encouraged uptake of childhood immunisations.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	79.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.5%	58.3%	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)	69.7%	58.7%	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)	41.7%	50.6%	55.4%	No statistical variation

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

Any additional evidence or comments

During the pandemic and continuously from then the whole practice team had monitored cytology uptake and continued to work with patients to encourage uptake of screening.

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

<p>All staff were actively engaged in activities to monitor and improve quality and outcomes (including, where appropriate, monitoring outcomes for people once they have transferred to other services). Opportunities to participate in benchmarking and peer review were proactively pursued. Outcomes for people who use services were positive, consistent and regularly exceeded expectations.</p> <ul style="list-style-type: none"> • The practice worked closely with local commissioner and sought opportunities to benchmark outcomes. For example, they met with the local medicines management team to review prescribing and look at opportunities to improve. They also worked with other to share learning and good practice. • There was a culture of high performance and quality improvement was embedded throughout the practice. All staff were on some level engaged in activities to monitor and improve quality and outcomes for patients. The practice provided details of a wide range of recent audits and quality improvement projects carried out, for example: <ul style="list-style-type: none"> ○ The practice identified an increased number of patients seeking advice around the menopause and hormone replacement therapy (HRT). In response to this increase they conducted a quality improvement project, initially to ensure that all those patients prescribe HRT were receiving the optimal treatment in line with the latest guidance. They also developed a standard HRT template for all clinicians to use. Secondly, they improved the information available on the practice website with a specific section dedicated to the menopause. ○ A quality improvement programme took place to develop a patient action plan for diabetic patients as it was identified there had been a fall in the number of patients attending reviews following the Covid-19 pandemic. They aimed to optimise the care of patients with diabetes to ensure all patients were being reviewed annually and that there was a clear plan for their management going forwards. As a result, they set up a monthly meeting to review diabetic patients and they developed a standardised clinical template and action plan. In addition, a new pathway was developed for processing HbA1c results, which included a flowchart for clinicians to use when reviewing results, for example depending on the results they would be logged within patients records as 'target/keep up the good work', optimise treatment at pharmacist/GP review or to be discussed at diabetic MDT. Receptionists would then be tasked to inform the patient, book a follow up appointment or add patients onto the diabetic MDT register for closer monitoring. ○ The practice reviewed and improved the workflow for patient related, non-urgent, same day queries. They developed a standardised approach with a clinical template for inputting clinical information and actions required. These would be tasked to GPs or clinical pharmacists to action, with time set aside each day to complete this task. Outcomes would be sent to reception who would then inform patients. ○ A post-operative minor surgery infections audit was conducted annually. ○ A Valproate Pregnancy Prevention Programme Audit was carried out annually to ensure patients of childbearing age on sodium valproate were on appropriate contraception where

required and that there was an annual risk acknowledgement form recorded in line with good practice.

Effective staffing

The practice was able demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice ensured staff were competent for their roles and provided specialist training. They encouraged and supported staff to develop skills and acquire additional qualifications. All non-medical prescribers had a named clinical mentor, for support, advice and guidance. Alongside annual appraisals, clinical staff also had access to monthly supervision. There was a system in place to monitor required training had been completed by staff and there was protected time for staff to complete training 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
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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> <ul style="list-style-type: none"> The practice worked in a multidisciplinary way with colleagues across health and social care to ensure coordinated care was in place for vulnerable patients and to support patients and their families at the end of life. The practice had developed and provided links to local and nationally recognised organisations to help patients manage their own health. The practice had access to a range of links to self-help information and organisations. They could text or email patients following consultations where this would benefit the patient in understanding their condition or where additional healthy lifestyle information would be helpful. The practice had developed an information pack for patients who had been diagnosed with diabetes, which included information about what that meant and how the practice would work together with the patients to help them manage their condition. Where patients may require additional support, they were able to refer them to the social prescribing team. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> Our clinical review of notes where a DNACPR decision had been recorded, showed where possible the patients views had been sought and respected, and where a patient did not have capacity the views of family were sought. We saw that information had been shared with relevant agencies. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a strong, visible person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.• Patient's emotional and social needs were seen as being as important as their physical needs.• The practice used the Friends and Family test to gather ongoing feedback from patients. Results for September 2022 showed that of 509 patients who gave feedback 89% said the service was very good and 6% said it was good. The results were similar in October 2022 with 85% of respondents rating the service as very good.• As part of one GP partners appraisal they sought feedback from patients, of the 32 patients who provided feedback we noted 30 strongly agreed that the doctor was honest and trustworthy and 2 agreed. Comments showed patients felt listened to and that the doctor was kind and caring.	

Patient feedback	
Source	Feedback
Friends and Family test	There was a wide range of positive feedback from the September and October 2022 friends and family test, with praise for individual staff, and several comments mentioned how lovely staff were, that the service was efficient and friendly and patients felt they were looked after and staff made them feel at ease.

National GP Patient Survey results

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

Indicator	Practice		SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	83.6%		80.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	84.1%		80.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	87.8%		90.9%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	77.7%		63.2%	72.4%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Explanation of any answers and additional evidence:

- Staff saw patients as active partners in their care and treatment and understood the challenge many patients experienced, and they would work with patients to provide flexible appointments, and wherever possible where patients required ongoing care they aimed for this to be provided by the same clinician for continuity. With consent staff would work with patients' relatives and advocates to facilitate attendance.
- Staff recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this, referring patients to the social prescribing team for additional support where required.
- Easy read patient information leaflets were available.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	90.0%	87.6%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 596 carers, 5% of the patient population group.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • All new patients registering with the practice were asked about their carer status and the details would be incorporated into their clinical record with details of reasonable adjustments where required. Carers physical and emotional needs were assessed and appropriate referrals, including safeguarding referrals were made where appropriate. This was reviewed yearly, and all carers were offered an annual health check regardless of their current health status or chronic disease status.

	<ul style="list-style-type: none"> The practice recently ran a text message campaign to encourage patients not already registered as carers to share detail with the practice, so they could be signposted and offered support where required.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> For patients and families who had suffered bereavement, where appropriate, a member of the team would contact them. A note would also be added into patients records alerting staff, and appointments were offered, giving additional time to offer support where required. The practice prepared information which they shared with patients following a bereavement which had the details of community support groups in the local area.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a patient centred culture whereby the focus was on meeting people's individual needs and tailoring their approach to meet the needs of vulnerable patients. They had developed innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for older and vulnerable patients. The services they provided were flexible, provided informed choice and continuity of care. For example:</p> <ul style="list-style-type: none"> • The practice organised their systems to prioritise continuity of care wherever possible and the new digital triage system supported this to work in practice. For example, where patients put forward requests via the digital triage system, this was reviewed by clinicians and if the patient was known to a specific clinician, they would either be booked an appointment with the specific clinician or the details shared with specific clinicians for them to review and make a decision on the most appropriate action based on their knowledge of the patient. • The practice had a higher than average number of older patients (886 patients over the age of 75). There were 21% of older patients registered at the practice compared to 15.5% local average and 18% England average. The practice had developed the clinical team to meet the needs of this population group by employing a full time practice matron. The practice matron developed holistic care plans and engaged with other health and social care providers to coordinate care especially for those receiving end of life care. We were provided with a range of examples where the care and support provided by the practice matron was valued by patients and their families, and also where input had improved the outcomes for patients. • The practice had identified from patient survey data, digital triage audit and feedback from the Patient Participation Group, that many older patients were not using or were unable to use technology such as online services. As a result, the practice set up a specific GP lead clinic for patients over 80 years of age, where staff could book patients directly into this specialised clinic. • One of the quality improvement programmes within the practice was to improve services for those patients with learning disabilities, not only improving uptake of learning disability reviews but also identifying patients who may not have been included on the learning disability register as they had not previously met the criteria. Alongside work to reconcile the register the practice introduced a new clinically approved template to ensure a holistic annual review was completed. They also 	

worked with third party organisations, such as Action Together, to increase and promote access to social prescribing, as they wanted to reach more patients who may not be in regular contact with health services but may have unmet health or social needs.

Practice Opening Times

Opening times:

Mossley Surgery: Monday to Friday 8am to 6:30pm

Greenfield Surgery: Monday to Wednesday 8am to 6:30pm, Thursday and Friday 8am to 5pm

Appointments available: Appointments are available throughout the day, including home visits.

Evenings and weekends: Patients can access appointments with GPs and nurses at a local hub as part of the primary care network extended access scheme. Appointments were available from Monday to Friday from 6.30pm to 9pm and Saturdays 9am to 4pm

Further information about how the practice is responding to the needs of their population

The practice used patient demographic information, audit data and feedback from patients and other health and social care providers to develop and adapt services offered to meet patient's needs. The practice was located in a semi-rural area, and overall had a lower level of deprivation, however the practice was aware of the pockets of deprivation in the local area, and the issues associated with isolation being in a rural area and having a higher than average number of older patients.

As a result, the practice were responsive to the diverse needs of the population, for example:

- For older patients the practice employed a practice matron, who took a lead on care planning, reviewing and support patients living in care homes alongside the clinical pharmacist. The practice offered a range of home visit services, including phlebotomy, ECGs, diabetic foot checks, and blood pressure monitoring. The practice had also introduced an over 80s clinic in recognition of the complex care needs of this age group and provided patients with continuity of care wherever possible.
- Lead clinicians held weekly residential care home meetings via Teams with senior carers at a residential care homes where they had patients to proactively monitor patient's wellbeing.
- The practice employed two clinical pharmacists, who provided a range of enhanced services within the practice, this included a minor ailments scheme. They provided face to face and telephone consultations, for ailments such as hayfever, allergies, coughs and colds and emergency contraception. This freed up GP time to focus on patients with more complex care needs. They also led on medication reviews for elderly patients who are discharged from hospital, elderly patients who had medication queries and annual medication reviews, especially for those that were on multiple medications. They also provided remote and on-line consultations. We were provided with a range of positive outcomes for patients having accessed a clinical pharmacist.
- Following an audit of diabetic care, the practice identified there had been a reduction in the number of patients attending for a diabetic review, who prior to Covid would have normally attended. They had also identified that a percentage of patients' HBA1c results had declined. The practice developed a task and finish group and as a result, all diabetic patients had an annual 'Every Contact Counts' review and where appropriate were then followed up by a practice nurse or clinical pharmacist, or for those with more complex needs were reviewed weekly by a clinician to get the patients diabetes back under control.

- The practice offered an in-house contraception service including contraceptive coil and implant fitting. They were also able to support patients with the use of Sanyana contraception, a self-administered long acting injectable contraception.
- The practice provided minor surgery in house, meaning patients did not have to travel or be referred into secondary care for joint and soft tissue injections or minor surgery involving removal of small lumps or skin tags.
- The practice had seen an increase in the number of patients seeking support with mental health issues, via the digital triage service, particularly among the working age population. In response the practice tried to ensure patients were triaged to the same clinician for continuity of care. The triage system also enabled clinicians to take immediate action if a patient shared information which suggested the patient or others may be at risk. The practice also offered a weekly counselling services in house, provided by MIND. They also actively sign posted patients to self-referral, talking therapies, through the Healthy Minds website. As part of the Primary care network they could also refer patients to a mental health practitioner.
- 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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child under 5 years of age were offered a same day appointment when necessary.
- 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.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	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 (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence: Patients were able to access a range of services and appointments in a way and at a time that suits them. The practice used technology innovatively to ensure people had timely access to treatment, support and care.	

- In October 2021 the practice introduced an online GP triage system for urgent on the day requests. The new system allowed patients to complete an online form detailing their issues or concern. Each morning two GPs would triage the forms replying to the patient either by email, text or telephone call. Where required they allocated appointments with an appropriate clinician, either a face to face or telephone consultation depending on patient choice or clinical need or referred to the pharmacy first scheme. Where a patient had ongoing needs, wherever possible they would be allocated an appointment with the same clinician for continuity of care. Initial feedback has been positive from patients and meant they did not have to call the practice at 8am for an appointment. Audits of the new system showed increased patient access and had enabled clinicians to handle at least double the requests on the day compared to previous systems. The practice ensured equitable access for those patients who are unable, or do not wish to use the online triage system. They could still call the practice and staff would complete the triage form, or book appointments with an appropriate clinician. The system also provided data which the practice used to improve services and analyse the nature of requests and adapt services as a result, for example introducing an over 80s clinic as it was identified this age group were not using the digital triage. They also found a number of requests from patients relating to menopause and as a result they added a section onto the practice website giving patients more access to self help and advice.
- Patients were able to pre-book routine appointments up to six weeks in advance.
- Following feedback from patients and considering the results from patient surveys the practice introduced a new telephone system in October 2022. The new system enabled callers to easily navigate to the correct department, and patients had the option of being in a virtual queue where they would receive a call back. Initial findings showed the waiting time for calls being answered had reduced.
- The practice provided same day appointments where clinically necessary for children under 5 years of age and older vulnerable patients.
- The practice website was set up in line with accessibility standards and provided patients with a wide range of healthy lifestyle advice and self-help information.
- Patients who required a translator the practice provided an interpretation service by a recognised translation service.

National GP Patient Survey results

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Indicator	Practice	SICBL 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 (01/01/2022 to 30/04/2022)	60.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	60.5%	45.5%	56.2%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	47.5%	48.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.3%	63.9%	71.9%	No statistical variation

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.	15
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a complaints policy, which was accessible and written in line with recognised guidance. The practice recorded all complaints received whether verbal or written complaints and maintained a log to enable them to identify any pattern or trend. The practice also monitored and responded to feedback from NHS choices, Healthwatch and from the Friends and Family test where appropriate. Learning from complaints was shared and used to improve quality. We observed that the practice investigated complaints in a timely manner. 	

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a comprehensive and successful leadership strategy in place and there was a high-performance culture among the partners and management team. Leaders had a deep understanding of issues, challenges and priorities in their service, and within the local community. One of the partners was the Clinical Director for the Primary Care Network (PCN) and another was the pharmacy lead for the ICB Oldham locality.• The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. They had an embedded system of leadership development and succession planning and had recently reviewed the lead roles for partners and introduced a new reception manager role to bridge the gap between staff and managers.• The practice was proactively engaged with the local PCN and Greater Manchester Integrated Care Board by attending meetings and forums to ensure services met the local population needs. Where possible managers invited staff to be involved in external meetings as development opportunities, but also to have input in the development of local services and to share learning.• Feedback from staff was positive and staff stated they felt the partners and managers were approachable and visible.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice aimed to 'provide high quality healthcare backed by an efficient, friendly and effective service.'• The practice strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the	

wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

- The strategy was regularly reviewed, and leaders held regular meetings with staff, the patient participation group and external partners to gather views and share ideas. They wanted staff to be 'on the journey' with them.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.
- Plans were consistently implemented and had a positive impact on quality and sustainability of services. One recent key objective to become a training practice was achieved, as was the desire to utilise technology to improve services for patients. Staff at all levels were involved in developing these.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We experienced that leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. We saw evidence of this leadership and there was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. • There was clinical and management oversight of the service quality and performance. Quality improvement initiatives were evident, we found a range of responsive and proactive quality improvement projects had taken place which led to improved outcomes and services for patients. • Staff feedback demonstrated that they were proud of the organisation as a place to work and spoke highly of the culture and strong leadership. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. • There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. • The practice carried out an Equality Impact Assessment in January 2022 to ensure that Pennine Medical Centre were following equality and diversity policies with regards to recruitment of new staff. • All staff had completed equality and diversity training. 	

- One of the practice partners was the freedom to Speak up Guardian and there was an external Guardian should staff wish to raise concerns externally.

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

Source	Feedback
CQC staff feedback forms	Feedback received from the staff feedback forms was positive. They told us they had been involved in strategic planning, they stated they felt their views were listened to and acted upon. They commented that there was good teamwork across the organisation and a positive culture within the practice. They also commented that practice supported training and professional development.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had established policies, procedures and activities to ensure safety. There was a system in place to monitor and review policies according to guidance, legislation and practice needs. • Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. • There was a system in place for reporting, recording and learning from significant events. Staff confirmed, and we saw evidence, that findings were discussed at meetings (or sooner if required). 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a demonstrated commitment to best practice performance and risk management systems and processes. The practice reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly. • Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. • The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. • Reception staff had access to policies in relation to patient medical emergencies. • A range of health and safety risk assessments were undertaken and regularly reviewed, with actions taken where needed. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice invested in embedding best practice systems and process, regularly reviewing and improving systems for both staff and patients. • The information used in reporting, performance management and delivering quality care was valid, reliable, timely and relevant. They had a range of regular audits in place and used local and national dashboards to monitor performance, and they planned to embed the clinical searches used by CQC into the audit programme. • They demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. They were actively engaged in local networks and used these forums for learning and sharing good practice and innovations which could benefit the wider health economy. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were consistently high levels of constructive engagement with staff and patients, Rigorous and constructive challenge from patients, the public and stakeholders was welcomed and seen as a vital way of holding services to account. • As part of the CCG quality assurance visit in May 2022 it was noted that the practice ranked in the top third of practices based on the CCG PC Scorecard (Jan 2022). • Services were developed with the full participation of patients, staff and external partners as equal partners and there was a demonstrated commitment to acting on feedback. • Staff had a range of opportunities to share their views and engage in professional development. This included quarterly full practice meetings, covering a range of matters arising (clinical issues/pathways, staffing/recruitment, administrative changes) followed by protected time for learning and development. • The practice took a leadership role in its health system to identify and proactively address challenges and meet the needs of the patient population. This was reflected by the work done for the PCN and wider health and social care community. Partners, managers and some staff 	

attended a range of stakeholder meetings and met monthly as a PCN for whom one of the partners was the Clinical Director.

- The practice had an active Patient Participation Group with a core group of 12 members. The group met every three months. The group were involved in the practice decision to become a training practice and to introduce the new digital triage. They had also been involved in estate planning and some members had lobbied the Local Authority and ICB in support of the proposed renovations of the Greenfield site. The group were also consulted on how to approach the concerns the practice had, in being able to provide responsive care and treatment to those patients registered who were outside of the practice boundaries, with one of the members helping the practice to write a letter to those patients.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. There was a culture of improvement and it was seen as a positive way to deal with performance and for the organisation to learn and improve services for patients and staff. • The practice used a range of improvement methods across the organisation and staff were empowered to lead and deliver change. We were provided with a wide range of examples of quality improvement projects and audits which ensured care and treatment was being delivered in line with best practice, but also in response to patient feedback, for example improvement to the telephone system and the creation of an over 80s clinic to ensure those unable to utilise the digital triage system had easy access and continuity of care. • Safe innovation was celebrated, with staff and the patient participation group consulted on new innovations, including the introduction of the new digital triage system. • The practice made a strategic and clinical decision to become a training practice. In 2021 following two years of intensive work they were approved as a training practice by University of Manchester and NHS Health Education England (HEE). They now had 2 GP trainers and 3 registrars. • Staff were encouraged to develop professionally, and they were supporting for example health care assistants to undertake nurse associate training. • There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. They had submitted plans and were working with local commissioners to develop the Greenfield site, to enable them to provide more services at the branch site. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example

a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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