

# Care Quality Commission

## Inspection Evidence Table

### Didsbury Medical Centre (1-571125789)

Inspection date: **14 November 2022**

Date of data download: 01 November 2022

## Overall rating: Good

The practice was rated good overall because although there were gaps, the practice had achieved a high-level quality of service, safeguarded their patients and ensured that comprehensive governance arrangements were in place, allowing for a culture of innovation and high-quality care.

The overall rating for this practice is good. We inspected three key questions; safe, effective and well-led. Each of these key questions are rated good. 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: Good

The practice is rated good for providing safe services because they had comprehensive systems in place that were working effectively and as intended to safeguard patients and staff from abuse and harm. They demonstrated that prescribing was in line with targets in all areas.

### 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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
<p>Explanation of any answers and additional evidence:</p> <p>We found that the provider had systems and processes in place to keep patients safe from abuse; these included training of staff, a safeguarding lead and deputy lead, regular communications with other organisations and professionals and registers of safeguarded and looked after children that were maintained. We found that not all children on these lists had been linked with the adults in their households, but the practice remedied this immediately and updated their policy to reflect this change.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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
<p>Explanation of any answers and additional evidence:</p> <p>We looked at three recruitment records and found that all appropriate information had been obtained by the provider or assurances sought. For example, evidence of suitable conduct from a previous employer.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: July 2022 Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found all the actions from the fire risk assessment had been completed, although the practice acknowledged that they would document these more robustly going forward. Portable appliance testing and in-service inspection and testing of electrical equipment (IITEE, which includes the servicing of hardwired electrical equipment) were completed in February 2022, as was calibration checks on all equipment used by the practice. The practice also demonstrated that they had invited the local fire service to assess their readiness for fire emergencies, who recommended actions that were also completed. We found that fire drills occurred regularly, and fire alarms checks were conducted weekly.</p>	

## **Infection prevention and control**

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

	<b>Y/N/Partial</b>
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

The practice had acted on all recommendations in relation to the infection prevention and control audit including installing elbow operated taps and hand sanitizer pumps throughout the building, which they felt were necessary. We found that waste was managed well, and we saw that handwashing audits had been completed by the nursing staff. The practice building was visibly clean, cleaning schedules were available and there was appropriate oversight of these duties to ensure they were completed to a high standard.

## 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
Explanation of any answers and additional evidence:	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. <sup>1</sup>	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: We found that clinical records we reviewed were written clearly and were comprehensive. The practice utilised the Integrated Clinical Environment (ICE) to obtain clinical test results from secondary care for patients and downloaded those results into the clinical records on their computer system to ensure consistent oversight.	

## 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)	0.91	0.90	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)	9.9%	8.3%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.12	5.01	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	86.0‰	167.3‰	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)	0.82	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)	3.6‰	7.7‰	6.8‰	Tending towards variation (positive)

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 effective medicines reviews for patients on repeat medicines. <sup>1</sup>	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. <sup>2</sup>	Partial
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> <p>We asked the practice about their better than average prescribing of psychotropic medicines and how this had been achieved. They explained that they simply did not prescribe these medicines unless absolutely necessary and they did not have high demands for these from their patient population.</p> <p>The practice had a formal system of oversight for all staff, which they were able to demonstrate by showing us entries in the clinical records where discussions had taken place. They told us they would be consolidating this into a separate record to ensure efficient oversight.</p> <p>There was a system in place to monitor patients prescribed medicines that were higher risk which we found to be generally effective. However, monitoring for the patients who were prescribed direct oral anti-coagulants (DOACs) was not always taking place within the recommended time period. The practice acknowledged this as an oversight and addressed it immediately.</p> <p>The practice did not keep controlled drugs on the premises.</p>	

## 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:	21
Number of events that required action:	21
Explanation of any answers and additional evidence:  We found that the practice had a comprehensive system to capture significant events and learn from them. This information was categorised by the team it related to. For example, clinical or administration. This was also analysed annually to ensure that any trends were addressed.	

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

Event	Specific action taken
Complaints	The practice considered all complaints as significant events to bolster and aid learning for the whole practice team. These were discussed with individuals involved and then the learning disseminated through team meetings more generally.
Missed two week wait referral	In response to a missed two week wait referral, the practice reviewed its process and ensured a safety net system was in place and staff were aware of this.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We found that the practice had an appropriate system for identifying safety alerts and sharing this information within the practice. Also, there was evidence that action was taken routinely where appropriate, however, one exception was identified. We found 7 patients prescribed Mirabegron; the safety alert had recommended additional checks be carried out with these patients, but we found that one had had this completed, but the others had not been advised. The practice contacted these patients immediately and addressed the issue.	

## Effective

## Rating: Good

The practice was rated good for providing effective services because although there were some gaps, it provided high quality and effective care to patients and was generally aware of areas where it needed to improve and had taken steps to proactively address these areas. Those areas that were highlighted during the inspection prompted immediate action by the provider.

*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 were 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.	Partial
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 prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: The practice acknowledged the gaps identified in relation to monitoring of DOACs and the safety alert relating to mirabegron, they addressed these immediately and were confident that these were one off oversights. Records we reviewed supported this view as generally, patient records were complete and well written, and guidance was followed throughout the practice's areas of clinical responsibility.	

### Effective care for the practice population

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.



- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. The practice showed us that 51 reviews had been completed both this year and last year, which was all of the eligible learning-disabled patients.
- 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

- In our headline clinical searches, we found that of the patients with Hypothyroidism (an underactive thyroid gland), although they all had been monitored, 10 appeared to be overdue their monitoring. We looked at five records and found that four were indeed overdue from between 1 month and 2 years. The practice was not aware of this but addressed it immediately acknowledging the oversight.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met, with the exception of some hypothyroidism patients. 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 and had an effective system of oversight.
- 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,	117	127	92.1%	Met 90% minimum



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)				
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)	148	157	94.3%	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)	150	157	95.5%	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)	151	157	96.2%	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)	120	136	88.2%	Below 90% minimum

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

### Any additional evidence or comments

The practice was aware of their childhood immunisation uptake performance; higher than target uptake had been achieved by the practice for children aged 2 and this was due to a diligent, systematic and proactive approach by the practice. We were told that follow-ups were made if children failed to attend for their immunisations with the parents and also the Health Visitor if necessary. The practice felt that increases in the practice population, which had led to higher numbers of children aged 5 joining the practice from outside had led to their lower than target uptake data in this one area.

The practice demonstrated that it had run special themed clinics aimed at children in the practice with the waiting room filled with balloons to encourage children to fight disease like superheroes. They had aspirations to hold similar clinics in the future to continue to encourage the uptake of 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	70.2%	N/A	80% Target	Below 80% target

64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.1%	51.5%	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)	63.6%	54.8%	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)	75.0%	55.7%	55.4%	No statistical variation

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

#### Any additional evidence or comments

The practice was aware of their lower than target cervical screening uptake and explained that they were educating patients about the benefits of screening and allaying their fears about being screened in this way from a cultural standpoint. The practice had also established a project aimed at trans people to ensure appropriate cervical screening took place and was encouraged. They continued to offer screening opportunistically where possible and had recently increased the number of practice nurses in order to offer more opportunities for appointments. They also felt that an increasing population accounted for lower than target data.

They were confident that their control measures would increasingly address this as their population numbers stabilised.

The practice provided us with evidence of letters sent to various patients in different languages to encourage them to participate in screening and their own health. The practice was also involved in an additional screening project, to enable patients to more easily access the complex process of bowel screening. This project contributed to the higher than average screening uptake in bowel screening.

#### Monitoring care and treatment

**The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided but could not always provide full details.**

	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

#### Any additional evidence or comments

The practice had a programme of quality improvement activity in place including clinical audits and being involved in research. The clinical team worked additional hours, over and above their patient sessions, to involve their patients in up-to-date clinical research through established universities and organisation's projects. The aim of these projects was to involve patients in clinical studies, providing the best outcomes for them in a timely way and provide additional funding for the practice. We saw that these had delivered

positive outcomes for patients. The research projects which the practice was involved in included projects for cholesterol management.

Clinical audits that were presented to us included a gestational diabetes in pregnant women re-audit from August 2021, but the practice was unable to provide the original audit from 2019 when asked. This re-audit demonstrated actions that the practice felt they needed to take to improve outcomes for these patients and that discussions were ongoing around these. The second audit that was presented to us was also a re-audit from October 2022 concerning compliance with pregnancy prevention for women of childbearing age on Sodium Valproate. The practice was unable to provide the original audit when asked. The audit showed that four patients were in this category and were being monitored. The practice showed us that there were many other audits recorded on their clinical system but were unable to provide the details of a two-cycle audit that demonstrated positive outcomes for patients.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	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: The practice demonstrated that there was a system of oversight and supervision in place for staff in specialist roles. These supervisory interactions were documented on patient records which the practice showed us, but the practice leaders told us that they had decided to make this system more comprehensive and formally document it separately for their own records.	

## 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-centered care when they moved between services.	Y
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### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: The practice had access to social prescribers from the primary care network (PCN) and referred patients through this service as well as directly to mental health services locally.	

### Consent to care and treatment

#### The practice obtained consent to care and treatment in line with legislation and guidance, although records management would benefit from strengthening.

	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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence We found that the practice did not always have the DNACPR records on their clinical system pertaining to care home patients that had recently joined the practice in April 2022. We were told that these records had been viewed by clinical staff and we saw that on the practice spreadsheets, these records were highlighted as having been seen by the clinician responsible for the care home. The forms had not yet been scanned onto the records from the care home. Once the practice had identified this during our inspection, they committed to addressing it immediately. Those records that were on the clinical system from non-care home patients with DNACPRs were appropriate and contained all necessary information.	

## Responsive

**Rating: Good**

The above rating was awarded to the practice at the inspection undertaken 30 June 2016. However, as part of this inspection we looked at the systems in place to enable patients' timely access to care and treatment. This is a national initiative.

### 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	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
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
There were systems in place to monitor the quality of access and make improvements	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had 4 GP partners, 6 salaried GPs, 2 physician associates, 1 mental health worker, 2 pharmacists and 1 physiotherapist to provide as many appointments as possible for patients. The practice told us that clinicians had a fixed number of appointments which prevented them from working excessive hours.</p> <p>The practice offered same-day appointments as a standard and asked all patients to contact the practice on the day they wish their problem to be dealt with. Patients requested appointments on the practice website between 7-9am Monday to Friday and we were told that 99% of those requesting an appointment were triaged and then offered one on the same day. Where the practice were unable to offer an appointment on that same day, patients were signposted to NHS 111 or walk-in centres locally. After 9am patients with urgent health problems could still request a GP appointment if they were a child, over 65 years old, on an "at-risk" register, suffering from cancer, had severe symptoms or were having a mental health crisis. GP partners would further triage these requests and an appointment with the most appropriate clinician or service would then be arranged. Receptionists used flow-charts designed by one of the GP Partners to assist them to signpost patients to the most appropriate clinician. Records we saw confirmed this.</p>	

Patients could specify which clinician they would like to consult with to promote continuity of care, although this would be arranged where possible, patients might have to wait longer for an appointment.

Enhanced extended hours provided by the practice was staffed by a GP, nurses, HCAs and pharmacists to offer appointments to those unable to attend appointments during normal opening hours.

The practice provided video consultations for appropriate patients with an online service that was employed by them as well as telephone, face-to-face, online-messaging appointments.

From December 2022 the practice told us they would be increasing their capacity for respiratory illness appointments through collaboration with the Primary Care Network (PCN) and providing MARIS (Manchester Acute Respiratory Service) appointments in-practice.

The practice was fully aware of the barriers involved with using an online platform for requesting appointments, especially for those who are digitally excluded or those with additional communication needs. They accepted telephone requests for appointments during opening hours, but patients were encouraged to request appointments between 7-9am. The practice had established a Patient Services Team (PST), who completed appointment request forms (the same as those available online) with patients and this was then sent to GP partners for triage. Translation services were offered to patients where necessary via The Big Word for telephone appointments and interpreters for face to face appointments as well as for patients requiring British Sign language interpretation for face to face appointments.

The practice offered extended appointments for those with additional needs. For example, patients with learning disabilities and those with Dementia.

From the national GP patient survey, the practice achievement for questions relating to access was;

- The percentage of patients who find it easy to get through to this GP practice by phone was 63%, the local and national average was 53%.
- The percentage of patients who find the receptionists at this GP practice helpful was 88%, the local and national average was 82%.
- The percentage of patients who are satisfied with the general practice appointment times available was 66%, the local and national average was 55%.
- The percentage of patients who usually get to see or speak to their preferred GP when they would like to was 47%, the local and national average was 38%.
- The percentage of patients who were offered a choice of appointment when they last tried to make a general practice appointment was 52%, the local and national average was 59%.
- The percentage of patients who were satisfied with the type of appointment they were offered was 83%, the local average was 71% and the national average was 72%.
- The percentage of patients who took the appointment they were offered was 98%, the local and national average was 96%.
- The percentage of patients who describe their experience of making an appointment as good was 73%, the local average was 55% and the national average was 56%.
- The percentage of patients who were given enough time for their last general practice appointment was 92%, the local average was 88% and the national average was 90%.



## Well-led

**Rating: Good**

The practice was rated good for providing well-led services because they were able to demonstrate governance arrangements were in place and effective. Leaders were visible and were engaged, allowing the practice to adapt to challenges quickly and provide support for staff and high-quality delivery of services.

### 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: The practice provided us with a copy of their business plan and succession plan which detailed all the necessary actions and plans relating to the resilience of service delivery. The practice leaders formed a cohesive and well-functioning team that demonstrated leadership and modelled the work ethic they expected from staff.	

### 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: The practice mission statement included their values which included, respect, safety, quality, care and staff. “Didsbury medical centre will deliver a complete package of care to all our patients and support those who care for our patients. We will facilitate all aspects of care to include prevention, management and appropriate referral to other agencies, both health and others, for all our patients”.	

### Culture

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

	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <p>We found that the practice had appropriate governance arrangements in place, including policies and protocols, to allow staff the opportunity to raise concerns and drive improvement within the practice. Staff we spoke with remarked on the well-being they felt working in the practice and the practice had elected to provide up to a 5% pay rise for all staff (linked to their appraisal and performance) to help during the cost of living crisis.</p> <p>Staff were enthusiastic and motivated to provide the best possible service for patients and were able to articulate critical elements of the structure of the organisation and their role within it.</p>	

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

Source	Feedback
Staff conversations	Staff we spoke with told us that they enjoyed working at the practice and call it the Didsbury medical family; they felt supported and given opportunities to progress.

### 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us they had no backlogs left over from the pandemic period, but they had experienced a marked increase in demand, which they had adapted to, including increasing the number of staff. This was also to accommodate the continued increase in patient numbers. The provider was aware that a limit of patients was approaching, at which time they would re-evaluate their position and staff numbers to maintain a high-quality service.</p>	

### 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
<b>Any additional evidence</b>	
The practice had a comprehensive suite of risk assessments that they used to ensure they had an accurate and up to date picture of any risks, control measures were employed effectively, and actions were completed in a timely manner.	

## 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

## 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
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: The practice prepared and distributed a seasonal newsletter to all their patients detailing events, projects and any other news patients should be aware of.	

### Continuous improvement and innovation

**There were substantial evidence of systems and processes for learning, continuous improvement and innovation.**

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

### Examples of continuous learning and improvement

The practice showed us the results of a coding project they had set-up to ensure that all patients were coded correctly and therefore could be placed on the correct registers. This was important to ensure that these patients could be called in for reviews and appropriate assessments. The practice demonstrated that through this project, 97 new patients were added to the asthma register, 102 new patients were added to the depression register, 8 to the dementia register and 10 to the learning disability register. The practice was extensively involved in research conducted through various universities and organisations, where consenting patients were added to clinical trials in order to get the best outcomes for their patients a drive research outcome for all patients.

The practice was involved in 5 research projects:

- One to find out whether urine samples could offer an accurate alternative to traditional cervical smear tests.
- Clinical trials that involved diagnosis of non-alcoholic steatohepatitis (NASH – inflammation of the liver/fatty liver disease) and researching potential treatments aimed at reversing the condition.
- Assessing and contrasting the effectiveness of two treatments for the outpatient management of Asthma in children.
- Studying if using blood thinning medicines in patients under 75 with atrial fibrillation (AF – irregular heartbeat) reduced the risk of blood clots and dementia in later life.

- Contrasting two injectable cholesterol lowering treatments.
- A study to determine the efficacy, safety and tolerability of an oral medicine for a severe form of asthma.

These studies had not yet provided any data to support the outcomes for patients as these projects were still underway.

The practice was involved in a project to better enable them to detect cognitive impairment, and cardiovascular disease (CVD), employing technology, software and training to ensure additional safety netting for these patients and access to appropriate services in a timely manner. These had not yet produced effectiveness data.

#### 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 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.