Care Quality Commission

Inspection Evidence Table

Ashton Medical Group (1-547522539)

Inspection date: 13 August 2021

Date of data download: 21 July 2021

Overall rating: Good

The overall rating for this practice is Good.

At our previous inspection on 29 October 2019 the practice was rated requires improvement for providing effective and well-led services, and for care provided to population groups People with long-term conditions and People experiencing poor mental health. A requirement notice for breach of regulation 17 (good governance) was issued.

The practice is now rated as good as the provider has made improvements to the systems and processes to ensure good governance.

We inspected safe in line with our focused inspection methodology and have rated safe as good. The previous ratings of good for the key questions caring and responsive remain in place.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

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
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence: There were clear safeguarding policies and procedure in place for both children and adults, including domestic violence and Female genital mutilation policies and protocols were in place for patients who do not attend appointments.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Routine PAT testing was completed October 2019 and is carried out bi-annually. All medical equipment is tested annually and was completed May 2021.	Yes
There was a record of equipment calibration. Date of last calibration: May 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: October 2020	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: December 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes

Date of last assessment: December 2020	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

- The practice had clear protocols in place which were regularly updated, following the latest government advice in relation to Covid-19.
- There was evidence to show action had been taken following the last infection prevention and control (IPC) audit and regular hand hygiene audits were carried out.
- Risk assessments and audits had been carried out to ensure services such as flu vaccinations, which at the height of the Covid 19 pandemic were carried out in outdoor spaces, were safe and followed IPC good practice guidance.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Explanation of any answers and additional evidence:

- The practice has established a GP hub where they reviewed and actioned all test results. The hub was staffed by GPs daily between 8:00am and 6:30pm when GPs were available for staff to consult should they have any queries.
- One of the GP partners met with the administration team regularly to ensure they were appropriately processing and coding patient information into records and allocating to appropriate clinical staff where action was required.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.70	0.75	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	9.2%	8.5%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	3.46	4.16	5.37	Significant Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	193.0‰	193.6‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.02	0.83	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	9.9‰	8.6‰	6.7‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

- There were clear medicine management and prescribing policies and procedures in place including a home visit policy and a protocol for those patients prescribed lithium.

- As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches are visible to the practice. The records we examined provided evidence that most patients prescribed high risk medicines had been monitored appropriately. Where our searches identified gaps in monitoring, the practice immediately reviewed them and provided evidence that clinicians had risk assessed the continuation of medication without the need for blood tests as many of the patients had been identified as clinically vulnerable and shielding during the pandemic.

Medicines management	Y/N/Partial
During the pandemic the practice, in line with guidance, postponed routine medication reviews and phlebotomy unless considered necessary. The practice took a decision to protect high risk patients as the risk of COVID to these patients was greater than delaying recommended blood tests. • The practice had developed an action plan including an additional phlebotomist to catch up patients who have had monitoring and medication reviews delayed due to COVID and now restrictions have been lifted they have re-established routine monitoring as per the practice prescribing policy. • Non-medical prescribers were supported by GP partners and were able to access GPs for support and peer review. However, the process for formal supervision outside of appraisals to review prescribing practice and competencies was ad hoc.	

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	16
Number of events that required action:	12
Explanation of any answers and additional evidence: The practice used a red-amber-green rating system to assess, record and review actions of significant events and clearly documented the outcomes of investigations and shared learning. All the staff we spoke with were familiar with the system and staff were encouraged to report incidents. We saw they were discussed in practice meetings.	

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

Event	Specific action taken
GDPR breach where correspondence was sent to the wrong patient.	Breach reported to Information Commissioner's Office (ICO) in line with policy. Investigation completed and process revisited with all relevant staff to minimize risk of future errors.

	No further action taken by ICO, satisfied with the action taken by the practice
Blood taken from central line in error. A central line is a long, hollow tube inserted under the skin of the chest and into a vein close by. This line is then used to give treatment such as chemotherapy, blood transfusions or antibiotics.	The error was noted immediately and assessed for risk to the patient. The district nurses were contacted to check the central line and saw that no harm had been caused, however as a precaution the patient had to attend outpatients for a new line. A thorough investigation was carried out and all relevant clinical staff surveyed within the practice to ensure they understood bloods should not be taken via a central line unless specifically stated. Learning from the event was discussed during a clinical meeting and outcomes of the investigation was shared with the patient.

Safety alerts	**Y/N/Partial**
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

The practice has a central system to review and action safety alerts as appropriate and discussed during clinical meetings. From a sample of patients records we reviewed, we found action had been taken on the most recent alerts, however continued auditing of medicines previously subject to safety alerts needed to be incorporated into the on-going searches carried out by the practice to ensure prescribing continued to be in line with up to date guidance. Following the inspection, the practice provided evidence they had amended the monthly clinical record searches to include previous alerts to ensure actions taken are maintained.

Effective Rating: Good

The practice is rated as good for providing a effective service.

At the inspection on 29 October 2019 the practice was rated as requires improvement for providing effective services, as there was limited monitoring of the outcomes for patients with long term conditions or patients experiencing poor mental health.

This inspection identified several improvements in different aspects of this key question, including for people with long term conditions or those with poor mental health.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Explanation of any answers and additional evidence:

The practice had established a GP hub, providing a central point of contact for all staff for GP advice. GPs within the hub worked together in one space to manage all online consultation requests, urgent appointment and home visit requests and triage. The hub also managed and allocated for action all test results, managed prescription requests and followed up where required patients who had been discharged from hospital. The hub was on call and staffed daily between 8:00am and 6:30pm and offered staff the opportunity to get timely advice and support for patients with complex care needs and provided supervision for trainees and other clinical staff.

Older people Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice hosted regular multi-disciplinary meetings to ensure a coordinated approach across health and social care organization in meeting patients and their carers needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age, and for those patients who were assessed as frail an advanced care plan was developed and reviewed annually or sooner where required.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Following our last inspection, the practice had established a robust recall system which was monitored to ensure reviews were being carried out in a timely manner.
- During the pandemic the practice in line with guidance postponed routine face to face reviews unless it was considered necessary. Where possible they continued to offer some reviews by telephone or video. Now restrictions have been lifted the practice have a structured plan in place to reintroduce all annual reviews.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	73.6%	77.4%	76.6%	No statistical variation
PCA* rate (number of PCAs).	16.6% (210)	13.3%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	100.0%	88.5%	89.4%	Significant Variation (positive)
PCA rate (number of PCAs).	27.0% (159)	12.4%	12.7%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	89.8%	81.9%	82.0%	Tending towards variation (positive)
PCA* rate (number of PCAs).	15.5% (83)	4.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	100.0%	66.0%	66.9%	Significant Variation (positive)
PCA rate (number of PCAs).	45.5% (465)	13.6%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	81.7%	70.5%	72.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	20.0% (497)	6.0%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	91.0%	90.8%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.1% (14)	4.2%	4.9%	N/A

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	89.6%	76.0%	75.9%	Variation (positive)
PCA rate (number of PCAs).	30.4% (311)	9.0%	10.4%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

Data showed significant improvements in outcomes for people with long term conditions since our last inspection.

The practice introduced a number of new policies and procedures to improve the outcomes for patients with long term conditions since our last inspection including:

- Two senior partners were allocated the role of Long-term conditions leads.
- A new patient recall system, which allows the practice to send detailed invite letters to patients for long term condition reviews in their birth month.

Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% for four of five childhood immunisation uptake indicators and had a clear action plan in place to increase uptake for children aged 5 receiving immunisation for measles, mumps and rubella.
- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for five of five childhood immunisation uptake indicators, however they had a clear action plan in place to achieve the target.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	175	192	91.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	173	187	92.5%	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) (01/04/2019 to 31/03/2020) (NHS England)	172	187	92.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	173	187	92.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	161	188	85.6%	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
Data for childhood immunisations showed the practice had improved in all areas since our last inspection, and work continued in year to achieve the target set for children aged five years to receive two doses of MMR.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Patients were able to access the surgery seven days a week for non-urgent queries by using the online consultation system. Patients can access self-help information or submit a query for a doctor or the administration team, where they would receive a response or be contacted by the practice within two working days.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	64.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	70.3%	67.5%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.5%	61.0%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	92.9%	91.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	46.1%	45.8%	54.2%	No statistical variation

Any additional evidence or comments

The practice had a clear action plan in place to increase uptake of cervical screening, however this had to be put on hold, in line with guidance during the COVID pandemic. As restrictions have lifted the practice

have reinstated services and were actively contacting patients and encouraging patients to come forward for routine screening. Unverified data provided by the practice showed in August 2021, 75% of 50-64-year olds had been screened and 63% of 25-49-year olds and they were hoping to achieve the 80% target in year.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers. The practice had been awarded homeless friendly status.
- The practice utilised social prescribing and promoted the monthly walking group organised by the health champions. Volunteers helped to signpost patients who maybe socially isolated or benefit from support within the community.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	97.2%	88.7%	85.4%	No statistical variation
PCA* rate (number of PCAs).	16.5% (21)	11.5%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	75.0%	77.4%	81.4%	No statistical variation
PCA rate (number of PCAs).	6.3% (10)	6.7%	8.0%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments
• Data showed the practice had improved significantly for both mental health indicators since our last inspection. • To ensure improvements were maintained the practice has implemented a new robust recall system for annual reviews. In addition to this, the practice had increased the clinical team, including the appointment of additional advanced clinical practitioners and pharmacists, which had freed up GPs to have more daily appointments available within the GP hub to support patients experiencing poor mental health.

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.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	556.5	533.9
Overall QOF score (as a percentage of maximum)	99.6%	95.5%
Overall QOF PCA reporting (all domains)	11.4%	5.9%

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

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

- A programme of quality improvement had been established, and included a schedule of clinical and non-clinical audits.
- We noted learning shared from audits and quality improvement work was routinely discussed within clinical meetings.
- The practice engaged in local quality improvement initiatives and participated in local and national research programmes, for example, research linked to COVID treatment, diabetes care and asthma care.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

- Following our last inspection the practice had made improvements to the way in which it records and monitors the learning and development of staff. This included a revised training matrix, which the practice manager had oversight of and ensured, for example all staff had completed safeguarding training at the required level.
- There was a clear system in place for staff appraisals and a new process had been introduced which incorporated 360 feedback (a feedback tool in which employees receive confidential, anonymous feedback from the people who work around them). All staff had been scheduled for an up to date appraisal, with managers, patients' advisors and administrators having already taken place.
- Staff told us they were supported and encouraged to develop and were actively supported by the practice to gain additional skills and qualifications to enhance their roles.
- The installation of a new telephone system had enabled the practice to quality audit calls, allowing them to provide support and develop the skills and competencies of patient's advisors.
- The practice employed a number of staff in advanced clinical practice roles. Staff had access to GPs in the hub for support and guidance and participated in monthly clinical meetings. New staff or those undertaking additional training/qualifications had access to structured supervision and mentoring. However outside of the appraisal process, the supervision and monitoring of competencies was ad-hoc.

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

Helping patients to live healthier lives

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

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

Explanation of any answers and additional evidence:

- 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 support patients and their families at the end of life.
- The practice had launched a new website, which included a wealth of health information and advice alongside a new online consultation service where patients could contact a GP for non-urgent health advice.
- As part of renovation work within the practice dedicated space had been created for the patient champion volunteers. The volunteers will work alongside staff in the practice and the social prescriber based in the practice to signpost patients to local community support groups and active lifestyle initiatives taking place in the community.
- The patient champions also ran a monthly walking group for patients and they were in the process of creating a dementia garden at the side of the practice.
- During the height of the COVID pandemic the practice carried out welfare calls with those patients who were shielding and or vulnerable
- The practice had taken up the opportunity to have a social prescriber based in the practice four days a week and were piloting a project with a local Chaplin who will work from the practice once a week.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: • During the inspection we saw the practice had a clear protocol in place in relation to Do not attempt cardiopulmonary resuscitation (DNACPR) and we noted from a review of four records they were appropriate and completed in line with good practice.	

Well-led Rating: Good

At the inspection on 29 October 2019 the practice was rated as requires improvement for providing well-led services.

The practice is now rated as good for providing well-led services as the provider has made improvements and established effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

- Following our last inspection, the practice had developed and embedded a number of new systems which enables them to monitor quality and assess clinical and non-clinical risk, for example:
    - A structured recall system had been introduced to ensure patients with long term conditions attended annual reviews.
    - A new telephone system had been installed allowing the practice to monitor call volume and develop an improvement plan where required. As a result, the practice had reduced the average call wait time from approximately 7 to 10 minutes in 2019 to approximately 2 to 4 minutes in 2021.
    - The practice utilised a secure web-based platform to streamline management process such as human resources and training. We noted following our last inspection this new system enabled managers to have oversight of training, ensuring all staff are up to date and completed mandatory training relevant to their role.
    - The practice introduced a GP hub method of working, where GPs worked together in a central space, allowing them to share in real-time specialist knowledge, triage patients, respond to online consultation requests and pathology results, supervise trainees and support the clinical team with complex cases. Speaking with staff they all agreed that there was a positive impact for both patients and staff and were looking to develop the hub way of working further.

Vision and strategy

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

	Y/N/Partial

The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: • The practice had successfully merged three practices and developed a shared set of values. • The partners met on a monthly basis where they reviewed risk, discussed learning and improvements made as part of their quality improvement plan.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: • The practice continues to develop their strategy to be further engaged in the local community by working alongside the patient participation group, patient champions and local organisations. • Equality and diversity training was mandatory for all staff. • The policy and protocol for significant events and complaints highlighted the importance of a no blame culture and compliance with requirements of the duty of candour. We noted from the analysis of significant events and complaints shared with us, where appropriate the practice wrote to patients affected with an apology and shared the actions taken.	

- The practice regularly had team social events and had a social and charity secretary to coordinate events. While social gatherings were not possible during the COVID pandemic, they had virtual events and introduced 'Star of the month' to recognize individual achievements.
- The practice continued to host regular charity events, including a monthly non uniform day and Macmillan cake sales.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

- There was a clear management and leadership structure in place and leads in post for key areas, such as the appointment of a new nurse lead.

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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

- The practice had installed a secure web-based management tool which enabled them to maintain real-time oversight of risk, identify patterns and share learning from complaints and significant events for example.

- In 2019 the practice installed a new telephone system, which improved the way in which patients could access the surgery, but also provided them with real-time data on call handling performance, number of calls received and calls on hold. The practice had used the data to identify patterns and trends and make improvements to the system, for example they had successfully reduced the call wait times. The information was also used to audit patient advisor's interaction with patients, and this was shared with individuals to identify good practice and agree development plans where required.
- There was a system in place to monitor prescribing, respond to MHRA and safety alerts. Results and learning from audits were shared during clinical meetings and published within the team intranet, with staff encouraged to comment and discuss outcomes. Where we noted discrepancies from the clinical searches we carried out as part of the inspection, for example, prescribing of high risk medicines, the GPs were able to provide details of the protocols followed to reach clinical decisions and the risk assessments undertaken to manage risk for those patients who were clinically vulnerable during the pandemic.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Explanation of any answers and additional evidence:

- There were clear risk assessments, policies and procedures in place to enable the practice to deliver services and keep staff and patients safe. To ensure staff were kept up to date there was a dedicated space on the practice intranet for COVID related updates, policies and procedures.
- Throughout the COVID pandemic the practice was proactive in sharing accurate health information via text messaging, social media channels and website. One of the GP partners created information videos and ran live chat sessions on social media.
- During the pandemic the practice launched an online consultation service, where patients could request non urgent advice from a GP, and they would receive a response within two working days. Data provided by the practice showed on average in July 2021 they received 352 requests for online consultations a week.

- The practice operated a triage system for appointments, and where required patients would be offered face to face appointments or home visits.
- The practice had a clear COVID recovery plan in place, which included additional pharmacists and phlebotomists hours to catch up on those patients who required medication or long term conditions reviews which had been postponed were it was safe to do so and in line with guidance.
- The practice was aware that not all patients would be able to make use of the new digital services offered, and the patient advisors would support patients over the telephone where appropriate. They were aware further improvements were needed to ensure patients were not excluded going forward and they were working with staff, the patient participation group and patient champions to address this.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

- Since our last inspection the practice had introduced a system to ensure it had continued oversight of performance relating to the screening and immunisation targets or achievements in line with Quality Outcomes Framework indicators (QoF). We noted from data a significant improvement in performance in QoF indicators, in particular for people with long term conditions and people experiencing poor mental health. We also noted improvements in the uptake of childhood immunisations and an action plan was in place to increase the uptake of cervical screening.
- The practice had acted to address performance in response to patient feedback and the results of the national GP survey, and in-house surveys.

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes

Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Explanation of any answers and additional evidence:

- There was an active patient participation group, who had continued to hold virtual meetings with the practice throughout the pandemic and are hoping to start meeting again in person. The chair met regularly with the practice manager.
- The practice had a group of volunteer patients champions who, after recent renovations now have a dedicated space in the waiting area and hope to shortly have volunteers in the practice to signpost patients to local community organisations alongside supporting patients to sign up for the new digital services the practice offer such as online consultations. The practice supported the volunteers to create a dementia garden at the side of the practice.
- The practice used social medical channels to engage patients and ran Facebook live question and answer sessions relating to the COVID vaccine with 73 people joining the event.
- During July and August 2020, the practice ran an in-house patient satisfaction survey, asking patients to rate and comment on the new telephone system. They sent a text message to 2000 patients and received 403 responses and 382 people rated the system, of which 62% rated the system as excellent and 20% rated it good.
- The practice also acted on comments and concerns which came via NHS choices, Healthwatch or directly from patients.
- The practice worked closely with the primary care network, the Clinical Commissioning Group and Greater Manchester Health and Social Care Partnership to meet the needs of the local population.

Feedback from Patient Participation Group.

Feedback
We spoke with the chair of the patient participation group and the chair of the patient champions. Both felt they had a positive relationship with the practice and were able to raise issues and concerns and felt their ideas were listened to.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

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

Explanation of any answers and additional evidence:

- The practice explored opportunities to be involved in clinical research and in the past 18 months they have been involved in over 10 studies, including, COVID Treatment and developing a text message-based system to help people with type 2 diabetes to manage their condition. There were plans in place to participate in two new studies, relating to asthma and cholesterol treatments.
- The practice had a proactive group of volunteer patient champions. As part of recent renovation, a patient hub had been created in the waiting area which will be staffed by the volunteers who will help patients sign up and use the new online services and signpost patients to community events/groups. They were also developing a dementia garden in the grounds of the practice.
- The practice embraced new technology to improve in house clinical and non-clinical management systems and communication with patients, for example, the use of Facebook live events, promoting the online consultation service and expanding the use of text messaging services.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.