

# Care Quality Commission

## Inspection Evidence Table

### Manor View Practice (1-540128150)

Inspection date: 21 January 2020

Date of data download: 07 January 2020

## Overall rating: Good

During this inspection we inspected the following key questions: Safe, Effective and Well-Led.

- We rated the provider as good for providing safe effective and well led services.

We rated the population group families, children and young people in the effective domain as requires improvement because:

- Uptake for childhood immunisations were lower than expected compared to the World Health Organisation (WHO) standard of 95% of children to receive recommended vaccinations.

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

# Safe

Rating: Good

## Safety systems and processes

The practice had 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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	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
Staff who acted as chaperones were trained for their role.	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

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

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 6 January 2020	Y
There was a record of equipment calibration. Date of last calibration: 6 January 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: Weekly every Thursday	Y
There was a log of fire drills. Date of last drill: 17 November 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly every Thursday	Y
There was a record of fire training for staff. Date of last training: Various	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 25 October 2018	Y
Actions from fire risk assessment were identified and completed. (no actions identified)	N/A

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: October 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 November 2019	Y

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: September 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice maintained a summary of the infection control risk assessments. The latest update made on 4 January 2020 showed that issues identified for improvements had been rectified.	

## Risks to patients

### There were 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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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 was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

## Appropriate and safe use of medicines

### The practice had systems for the 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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.72	0.84	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	11.7%	9.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	6.51	5.87	5.60	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.70	1.60	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y

Medicines management	Y/N/Partial
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	N/A
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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The prescription of controlled drugs was managed through a practice protocol.</li> <li>• The practice was supported by four clinical pharmacists (three employed by the practice and one accessed through the primary care network (PCN) who undertook a variety medicines related activities. These included insulin initiation for new diabetic, working with a local care home to ensure safe and appropriate prescribing of medicines, medicine reviews including for patients with long terms conditions and undertaking medicine related audits to ensure prescribing was in line with best practice guidance.</li> <li>• The defibrillator was shared with an adjoining practice.</li> <li>• The practice was aware of the higher than expected comparisons with CCG and England data for the prescribing of medicines for urinary tract infection. The practice had audited prescribing patterns in December 2019 and had identified areas for improvements. Following the audit all prescribers were reminded of the criteria for prescribing these medicines. A re audit was planned for March 2020 check the efficacy of improvements made.</li> </ul>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	23
Number of events that required action:	0

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

Event	Specific action taken
Patient test results review	Mix up at reception over an urgent review appointment directly booked with the patient by their GP. As reception was unaware the patient was turned away and asked to attend a previously pre-booked routine review appointment. Since this incident the practice had introduced clearer communication lines with GPs when urgent direct appointments were arranged.
Administration of non-age appropriate flu vaccine	Flu vaccine administered was not age appropriate. Following a review, the practice had strengthened procedures, so flu vaccine was administered in an age appropriate manner.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: A GP Lead assisted by a pharmacist managed safety alerts. The practice maintained an electronic record which recorded the status of each alert including actions taken. We reviewed an alert related to a potential syringe failure (to treat an anaphylactic shock due to blockage of the needle). We found the practice had acted in line with the guidance.	



## Effective

## Rating: Good

### 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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	0.53	0.58	0.74	No statistical variation

## Older people

## Population group rating: Good

### Findings

- Older people were offered a priority telephone line to improve access to appointments.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital including those discharged to care homes. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- 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 including through home visits for house bound patients.

## 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. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- There were specific clinical leads for managing long term conditions and staff who were responsible for reviews of patients had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions including access to the community heart failure nurse and respiratory clinic where relevant.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.0%	79.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	12.2% (136)	13.0%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.2%	75.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	10.2% (114)	10.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.7%	81.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	14.0% (156)	11.8%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.8%	75.9%	75.9%	No statistical variation
Exception rate (number of exceptions).	4.5% (59)	5.9%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.7%	91.3%	89.6%	No statistical variation
Exception rate (number of exceptions).	5.7% (21)	10.1%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	82.3%	82.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (107)	3.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	86.7%	91.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.3% (17)	4.9%	5.9%	N/A

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- 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. The practice jointly with the community midwife provided them with advice and post-natal support in accordance with best practice guidance.
- The practice offered on the day appointments and duty doctor call backs for advice if needed.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	131	191	68.6%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	148	186	79.6%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	148	186	79.6%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	148	186	79.6%	Below 80% uptake

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 the lower than expected uptake for childhood immunisations when compared with the CCG and England averages. To encourage uptake the practice had developed a childhood immunisations uptake strategy. Elements of the strategy included:

- A named clinical lead supported an administrator to oversee the strategy
- Monthly clinical meeting to review uptake and develop further plans to engage parents
- Working jointly with the PPG to provide information and education events on childhood immunisations
- Providing flexible access to immunisations including during weekends
- Further engaging with the PCN to develop further strategies for engagement.

The lead GP told us that the practice was monitoring the efficacy of the measures implemented to make sure it resulted in improved uptake in line with WHO targets.

## Working age people (including those recently retired and students)

Population group rating: **Good**

### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication using the electronic prescription service (EPS) without the need to attend the surgery.

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). (31/03/2019 to 30/06/2019) (Public Health England)	72.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	74.9%	69.3%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	56.4%	55.8%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	66.7%	73.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	52.2%	51.4%	53.8%	No statistical variation

### Any additional evidence or comments

The practice was aware of the lower than expected uptake rate for cervical cancer screening. The practice had reinforced their recall and reminder systems as well as opportunistically reminding patients during their attendance at the practice for other health matters. Unverified current data seen during the inspection appeared to suggest that the practice was just below the 80 % target.

## People whose circumstances make them vulnerable

Population group rating: **Good**

### Findings

- Patients with a learning disability and their carers were offered a priority telephone line to improve access to appointments.
- Same day appointments and longer appointments were offered when required.
- Patients with a learning disability were offered an annual health check. The practice was a recent recipient of The Purple Star award which recognised the delivery of high quality reasonably adjusted services to adults with learning disabilities across Hertfordshire, in line with the requirements of the Equality Act 2010.
- Vulnerable patients were proactively encouraged to arrange health checks.
- 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 supported patients at a local home for people with a learning disability.

## People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

### Findings

- A named mental health GP oversaw health care for this population group.
- 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 medication.
- 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.
- 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 (01/04/2018 to 31/03/2019) (QOF)	92.0%	93.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	4.7% (8)	7.5%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12	93.3%	92.3%	90.2%	No statistical variation



months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	3.5% (6)	6.6%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	84.9%	88.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	5.3% (10)	5.2%	6.7%	N/A

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.0	543.4	539.2
Overall QOF score (as a percentage of maximum)	98.8%	97.3%	96.7%
Overall QOF exception reporting (all domains)	4.9%	5.2%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- In October 2019 the practice audited the monitoring of patients that received a medicine primarily used to treat depressive illness or depression or treat major depressive disorder that did not improve following the use of antidepressants. The initial findings showed there was scope for improvements in the monitoring of these patients. Following implementation of the good practice guidance, a re - audit in January 2020 had shown that monitoring had improved to 94%.
- Between September 2019 and January 2020, the practice audited the prescribing of a medicine primarily used to treat partial seizures in adults and children. Good practice guidance recommended the maximum quantity prescribed should not exceed 30 days' supply to prevent addiction and misuse. Initial findings had suggested scope for improvement and the practice had refreshed all prescribers with the guidance. A re - audit was planned in six months' time to check improvements made.

## Any additional evidence or comments

- There were regular clinical meetings where specific clinical issues were discussed and implemented. Agenda items included significant events, clinical updates, policy updates, clinical



audits and other studies of clinical significance to improve clinical practice and patient outcomes.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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
<p>Explanation of any answers and additional evidence:</p> <p>On the day of our inspection, the practice could not provide evidence of training updates for a practice nurse that undertook cervical cancer screening and immunisations. The practice after our inspection sent us records which confirmed the practice nurse had received the relevant training updates.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other 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, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice hosted regular lifestyle events aimed at specific patient population. Recent events had covered:</p> <ul style="list-style-type: none"> <li>• Live longer by living healthier, which discussed lifestyle changes that could influence healthy living including tips on how to involve and use locally available support services.</li> <li>• Diabetes and fasting during Ramadan, which discussed how a diabetic patient could safely manage their diabetes whilst fasting.</li> </ul> <p>Where appropriate the practice involved external specialist speakers during these events.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94.0%	94.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (24)	0.8%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

## Well-led

**Rating: Good**

### Leadership capacity and capability

**There was compassionate and inclusive leadership at all levels to deliver sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>To aid and facilitate the merger process the practice had undertaken a review of senior management to ensure strong leadership at all levels. The management structure included a managing partner, a finance manager, an operations manager and HR and operations assistant. There was succession planning in place with the practice planning to recruit additional staff which included a community matron.</li></ul> The practice had identified key challenges to maintaining quality and sustainability and noted key areas for improvements that included: <ul style="list-style-type: none"><li>Diversifying the clinical team to include advanced nurse practitioners and non-medical prescribers, clinical pharmacists and a paramedic.</li><li>Encouraging collaborative working across both sites for example the on-call duty doctor on both sites worked on the same system to ensure uniformity.</li><li>Improving quality, including through audits, clinical meetings and clinically led care.</li><li>Introduced EZ DOC a system to manage GP letters.</li><li>Improving access to services by installing modern telephony and integration of telephone lines across both sites and considering the implementation of 'Doctor Link' (a digital tool that provided a clinically approved digital triage and advice tool). The practice was aiming for 30% reduction in telephone queries once implemented.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:
<ul style="list-style-type: none"> <li>The practice aimed to provide healthcare of a high quality, that encouraged continuous improvements in the health status of the practice population overall.</li> <li>Through a welcoming, family friendly, caring, innovative and responsive service that reflected the latest advances in primary health care.</li> </ul>

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff feedback	Staff we spoke with told us that leaders operated an open-door policy and were all approachable. There was a communal area for staff where they could all meet informally. Continuous learning was encouraged, and the practice had facilitated team building peer support through various centrally organised events.

## Governance arrangements

### There were established 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff accessed practice specific policies and procedures on the practice intranet system.</li> </ul>	

- There were designated leads for specific governance areas. For example, a GP assisted by a practice nurse led on infection control and a GP led on safeguarding.
- There were quality improvement activities to improve outcomes for patients.
- There were regular meetings which facilitated effective communication and patient care. This included partners and manager meetings, staff meetings, clinical meetings, nurses' meetings and multidisciplinary team meetings.
- There was a process to review and act on significant events, and complaints.

## Managing risks, issues and performance

**There were processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	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
Explanation of any answers and additional evidence: Staff had received an annual appraisal of their work, which included a discussion about their training needs. The practice had a variety of risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control, fire safety and legionella.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Improvements were evident through quality improvement activities including through clinical audits.</li><li>Leaders proactively engaged in seeking positive health outcomes for their patient populations through regular monitoring of clinical performance data including the QOF.</li></ul>	

If the practice offered online services:

	Y/N/Partial
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
Any unusual access was identified and followed up.	Y

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>During our inspection we spoke with six patients. All were complementary of the services provided. They all said that GPs, other clinical and reception staff had been very helpful and considerate when providing care.</li> <li>During our inspection we received 22 comment cards. Patient's comments were positive about the care provided. We saw comments that staff and GPs had been accommodating of their care needs, including by giving them an appointment with a GP at very short notice. Patients noted that they were listened to during consultations and staff had provided excellent health care.</li> <li>Patients had rated the practice positively overall in the 2019 GP patient survey in relation to caring and responsive questions. However, the practice was planning further improvements through digital enhancements including to their telephone system as well as by considering implementing 'Doctor Link' (a digital tool that provided a clinically approved digital triage and advice tool).</li> <li>Further service improvements were planned through the participation in the recently constituted PCN.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
We spoke with the chair of the patient participation group (PPG). They told us that the PPG usually met four times a year. Currently there were eight members though not all attended PPG meetings. The PPG enjoyed a good working relationship with the practice management and had helped with local patient satisfaction surveys and suggesting improvements as a result. The results of the PPG survey of September 2019 was due for discussion at the next PPG meeting. At present the PPG was engaging the practice with a view to improving car parking as patients had found difficulty in finding a parking space.

## 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.	Y
Learning was shared effectively and used to make improvements.	Y

### Examples of continuous learning and improvement

- The practice provided training to qualified doctors to become GPs. At the time of our inspection there was one in training.
- The practice supported continuous learning and career progression. At the time of our inspection the practice was supporting a health care assistant to obtain the required competencies to undertake extended roles. Staff were also encouraged learning that enhanced their competencies thereby benefiting patient care.
- The practice provided learning opportunities for staff through teaching by specialist consultants.
- The practice worked proactively with other agencies to achieve better health outcomes for patients. For example, with Age UK to improve care for the housebound patient.
- In recognition of the diverse practice population, the practice had planned educational diabetic evenings in English and Urdu.
- The practice engaged with one other practice in the Manor View Pathfinder Primary Care Network (PCN) to collaboratively provide needs-based care for the population.

## 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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **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.