

Care Quality Commission

Inspection Evidence Table

Park View Medical Centre (1-566796375)

Inspection date: 25 February 2020

Date of data download: 10 February 2020

Overall rating: Good

At our last comprehensive inspection in July 2019, we rated the practice as inadequate overall as we identified concerns relating to governance systems and processes that impacted on all patient population groups. For example, in relation to the management of high-risk medicines. At this inspection we found that areas of concern had been addressed and governance processes had significantly improved.

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

Safe

Rating: Good

At our last comprehensive inspection in July 2019, we rated the practice as inadequate for providing safe services. At this inspection we found that action had been taken to improve the management of high-risk medicines, address outstanding medication reviews and respond to all drug safety alerts.

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.	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

Safeguarding	Y/N/Partial
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
<p>At our inspection in July 2019, we identified gaps in safeguarding and chaperone training for some staff. Furthermore, we noted that two patients did not have alerts on records to identify them as vulnerable or subject to a safeguarding concern.</p> <p>At this inspection we noted that clinical and non-clinical staff had completed safeguarding training to the appropriate levels for their role. Safeguarding registers had been reviewed and updated where necessary and a 'vulnerable patients' policy had also been developed which clarified the arrangements for recording and coding patients at risk. All non-clinical staff had also completed chaperone training.</p>	

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
<p>At our inspection in July 2019, we noted there was no health assessment or medical declaration on three recruitment files viewed. There was also no proof of identity on one recruitment file for a GP. Furthermore, the DBS on file for the GP pre-dated the start date of their employment by over 12 months. A risk assessment had not been completed to document the rationale for not undertaking an updated check.</p> <p>At this inspection we looked at three personnel files which included the file for the GP which was missing key information at our July 2019 inspection. Files viewed were found to contain the information required under Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>	

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: 03/04/2019	Y
There was a record of equipment calibration. Date of last calibration: 03/04/2019	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.	Y

Date of last check: March 2019	
There was a log of fire drills. Date of last drill: 4/07/2019	Y
There was a record of fire alarm checks. Date of last check: 20/02/2020	Y
There was a record of fire training for staff. Date of last training: 09 May 2019 to 24/10/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 05/02/2019	Y
Actions from fire risk assessment were identified and completed.	N/A
<p>There were no actions identified in the fire risk assessment.</p> <p>At our inspection in July 2019, the provider did not have an up-to-date electrical wiring certificate for the premises. The provider sent us a copy of a scheduled 5-year fixed wiring electrical installation condition report for the premises dated 19 October 2019, prior to us undertaking a focused inspection in November 2019 to follow up actions taken by the practice in response to a warning notice. This confirmed that that overall assessment of the electrical installation was satisfactory.</p> <p>The last fire certificate evidencing fire safety equipment had been serviced was dated 9/01/2020.</p> <p>The last annual gas safety inspection certificate was dated 27/03/2019.</p> <p>The last water hygiene / legionella inspection was dated 24/07/2019. The two requirements issued in the report had been actioned.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2020	Y
<p>A new premises risk assessment had been undertaken for the practice during January 2020. The purpose of the risk assessment was to highlight and address any risks associated with health and safety, premises and security, information governance, fire safety, infection control and general maintenance. The assessment included key findings, action required, location, person responsible for actioning a response and date completed.</p>	

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: 09/07/2019	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
The infection prevention and control (IPC) audit / checklist did not include an action plan. Any significant information was recorded within a comments box. Records indicated that advice had been given or action taken where necessary to maintain IPC standards. The nurse manager showed us evidence of a new audit tool that was in the process of being completed to ensure continuous improvement.	
The provider had a cleaning contract in place with an external contractor who produced regular audits. The last audit was dated 31/01/2020 and indicated that a compliance score of 97.94% had been achieved.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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
At our inspection in July 2019, we found gaps in the monitoring of patients prescribed high risk medicines. We also identified that staff working in the practice had not completed sepsis awareness training.	

During this inspection we noted that action had been taken to improve the monitoring of high-risk medicines and relevant health checks for these patients had been completed as required. Searches had been routinely undertaken and patients had been invited to attend appointments with clinicians for reviews. Additionally, we saw evidence that confirmed all staff had been supported to complete sepsis awareness training between 16 September 2019 and 31/10/2019. Staff had also completed basic life support training between 2 October and 4 November 2019.

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
At this inspection we saw that the practice leadership team had developed a document management policy dated September 2019. Quality control audits had also been undertaken between 7 August 2019 and 18 February 2020 by a GP to ensure GPs had sight of the correspondence they needed to and that none had been missed. These audits were due to continue to ensure ongoing monitoring and accountability.	
Clinicians continued to retain individual responsibility for clinical oversight of test results.	

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.97	1.00	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)	7.1%	8.7%	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)	5.17	5.39	5.60	No statistical variation
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)	1.91	2.24	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.	N/A
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>At our inspection in July 2019, we identified issues in relation to the safe management of high-risk medicines requiring monitoring and review including the management of patients on repeat prescriptions. Furthermore, a log of prescriptions was not maintained to provide an audit trail of their location and prescription stationery was not stored securely. There was also no risk assessment in place to determine the range of emergency medicines held by the practice and a log of vaccine stock was not maintained.</p> <p>We undertook a focused inspection in November 2019 to follow up actions taken by the practice in response to a warning notice. Prior to the inspection the registered manager sent us a copy of an updated prescription security policy dated September 2019. We also received a Therapeutic and Drug Monitoring Policy dated October 2019 together with summary information on high risk drug monitoring audits that had been undertaken. Additionally, we were sent a Medication Review Policy dated October 2019 together with an action plan to address historical medication reviews. This indicated that the practice had completed searches to review the numbers of patients where coding needed to be addressed and that they were aiming to complete the final stage of their plan by 31/12/2019.</p> <p>During the November 2019 inspection we noted that action had been taken to improve the monitoring of high-risk medicines. All patient records we reviewed prescribed methotrexate, lithium and azathioprine indicated relevant monitoring and health checks were now completed as required. However, we noted that two patients identified at the last inspection remained in need of medication reviews or intervention for different reasons. We noted that appropriate systems had been established to record incoming and outgoing prescription numbers and to ensure the safe storage of prescription stationery stock.</p>	

Medicines management	Y/N/Partial
<p>At this inspection we noted that clinicians and the pharmacist working at the practice had continued to run searches and embed systems and processes to ensure effective monitoring and coding of patients prescribed high risk medicines. The practice had also employed an additional pharmacist to undertake specific pharmacy project work for the practice for a fixed period. Risk assessments had been completed where necessary for patients who were reluctant to engage with clinicians.</p> <p>Systems to ensure the safe storage of prescription stationery remained effective and a log of prescriptions had continued to be maintained to ensure a clear audit trail.</p> <p>A risk assessment to determine the range of medicines held by the practice had been developed. This provided information on the range of medicines held by the practice, factors determining whether to hold specific medicines and whether they were held in the surgery or a GP's bag. The proximity of the practice to the local accident and emergency department had been used as mitigation for not holding some medicines and the policy had been updated to consider the time an ambulance would take to arrive and transport a patient to hospital.</p> <p>A log of immunisation and vaccines had been established to ensure a record of stock and batch numbers was maintained.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	18
Number of events that required action:	16
Practice leaders had established systems to identify, record and disseminate information and learning pertaining to significant events.	

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

Event	Specific action taken
Sudden illness of a senior management team leader.	A succession plan was formalised and action was taken to ensure that all tasks, systems and / or roles had more than one member of staff who was able to access or complete the task. Additional training was offered to relevant staff.
A fridge temperature cold chain issue was identified.	The cold chain policy was updated to reflect how staff should reset the fridge temperatures.

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
<p>At our inspection in July 2019, we were informed that the practice did not have a written policy or procedure for the management of safety alerts. Clinicians spoken with were not aware of some recent medicines safety alerts that had been issued by the Medicines and Healthcare Products Regulatory Agency (MHRA). For example, in relation to medicines used to treat thyroid problems, blood pressure and diabetes. We reviewed patients prescribed these medicines and found not all had received appropriate advice in line with these alerts.</p> <p>We undertook a focused inspection in November 2019 to follow up actions taken by the practice in response to a warning notice. Prior to the inspection the registered manager sent us a copy of a new Policy for Dealing with Medical Alerts and Formulary Guidance dated October 2019. During the inspection we found that some actions had been taken in response to issues identified at the last inspection. However, we found that not all safety alerts had been received, logged and/or actioned by the practice. For example, in relation to prescribing medicines for patients with renal impairment, diabetes and asthma. Practice staff told us that they had experienced difficulties as alerts were sent to the practice via a generic mailbox and sometimes via the practice manager. We saw evidence that the project lead pharmacist, practice manager and practice pharmacist had attempted to contact MHRA prior to and following this inspection in an attempt to rectify the matter. However there remained a risk to patient safety as key personnel had not received important alerts including the above examples or logged or acted upon the alerts.</p> <p>At this inspection we noted that practice leaders had established robust systems to ensure all safety alerts were received, logged, disseminated and acted upon correctly. Action had also been taken in response to outstanding safety alerts identified at our last inspection.</p> <p>Staff spoken with were clear about their roles and responsibilities in dealing with safety alerts and the project lead pharmacist and practice pharmacist continued to undertake ongoing searches to identify and safeguard patients prescribed specific medicines.</p>	

Effective

Rating: Good

At our last inspection in July 2019, we rated the practice as requires improvement for providing effective services. At this inspection we found that action had been taken to strengthen quality improvement activity and to ensure patients prescribed high risk medicines received regular reviews.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
<p>At our inspection in July 2019, we were not assured that clinicians were up-to-date with evidence-based practice as we identified issues in relation to the safe management of high-risk medicines requiring monitoring and review. We also noted that processes around exception reporting were not working effectively.</p> <p>At this inspection we found that action had been taken to review systems and processes regarding the management of high-risk medicines requiring monitoring and review. We found that clinicians, the project lead pharmacist and practice pharmacist continued to undertake regular searches to monitor patients prescribed high risk medicines, review coding and ensure that action had been taken to address historical medication reviews.</p>	

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) <small>(NHSBSA)</small>	1.11	1.10	0.74	No statistical variation

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 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 medication 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.
- 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. 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 or were being mentored and in the process of undertaking relevant 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.

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) (QOF)	85.1%	77.3%	79.3%	No statistical variation
Exception rate (number of exceptions).	21.5% (99)	13.5%	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) (QOF)	75.3%	75.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	13.2% (61)	11.2%	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>	83.5%	80.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	14.8% (68)	11.6%	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>	72.6%	74.7%	75.9%	No statistical variation
Exception rate (number of exceptions).	3.3% (16)	7.9%	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>	84.0%	87.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	11.4% (20)	11.1%	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)	79.7%	80.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.5% (51)	5.5%	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)	98.6%	91.2%	91.1%	Variation (positive)
Exception rate (number of exceptions).	11.0% (9)	6.8%	5.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had not met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for any of the four childhood immunisation uptake indicators.
- 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) (01/04/2018 to 31/03/2019) (NHS England)	72	79	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) (01/04/2018 to 31/03/2019) (NHS England)	77	86	89.5%	Below 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) (01/04/2018 to 31/03/2019) (NHS England)	77	86	89.5%	Below 90% minimum
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)	77	86	89.5%	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

We were informed that the lower levels of child immunization rates were attributable to population factors and advised that some sections of the community elected not to have their children vaccinated due to cultural reasons. The practice met with the health visitors and shared information on any children that did not attend appointments. Patients who did not attend appointments were also sent a WHO information leaflet from the practice to raise awareness of the risks. Additionally, a link to the Oxford Vaccine Group website was shared with patients via text to promote further knowledge and understanding or the benefits of the childhood vaccination programme.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to opportunistically 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 medication 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). (01/07/2019 to 30/09/2019) (Public Health England)	60.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	61.7%	58.3%	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)	51.5%	46.1%	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)	56.7%	69.5%	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)	48.0%	53.3%	53.8%	No statistical variation

Any additional evidence or comments

The practice continued to struggle to increase cervical smear uptake due to multifactorial reasons. For example, a lack of patient awareness that was often due to lack of education, poor literacy, language difference as well as cultural factors. Many of these factors were prevalent amongst a large group of the practice population. Jo's Trust, a charity to support and increase cervical smear uptake undertook work during 2019 in the local area at the behest of the neighbourhood community development coordinator. The practice reported that the whole area of Cheetham Hill and Crumpsall struggled with this work so outreach was done on a locality basis.

We saw evidence that practice leaders continued to work with Jo's Trust and other local partners to try to increase cervical cancer screening among the black, Asian and minority ethnic communities. We noted there were plans for the practice to engage in a local project with other GP practices in the area to explore the barriers to screening and how best to engage in these communities based on the findings of local research. Additionally, a number of road shows were planned during 2020 across Manchester to improve health in Black and Minority Ethnic (BME) communities and raise awareness on a number of topics such as breast cancer, cervical cancer, ovarian cancer, depression and healthy eating. This will involve further work with the local mosque and presentations in Urdu, Punjabi and English.

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 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 medication.
- 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.
- 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 (01/04/2018 to 31/03/2019) (QOF)	88.9%	84.7%	89.4%	No statistical variation
Exception rate (number of exceptions).	3.1% (4)	11.0%	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 months (01/04/2018 to 31/03/2019) (QOF)	90.5%	88.7%	90.2%	No statistical variation
Exception rate (number of exceptions).	3.1% (4)	9.0%	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)	78.7%	85.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.2% (4)	4.9%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.0	532.7	539.2
Overall QOF score (as a percentage of maximum)	98.7%	95.3%	96.7%
Overall QOF exception reporting (all domains)	8.6%	7.4%	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

Any additional evidence or comments

At our previous inspection in July 2019, we were not given an audit programme by the provider. There was limited evidence of quality improvement and clinical audit activity.

Prior to this inspection, we were provided with a detailed log and schedule of quality improvement and clinical audits that had taken place in 2019 and 2020. This detailed the audits, re-audits and reviews that had been undertaken and the scheduled date for the next review or re-audit. We were also provided with examples of a two-cycle audit for valproate prescribing in women of child bearing age and use of effective contraception and for the use of antidepressants and antipsychotics in patients with learning disabilities.

The practice quality improvement programme was based on key quality improvement work such as regular reviews of a new document management process, specific pharmacy project management work and monitoring and analysis of the Manchester Standards (a set of objectives for the practice to achieve to deliver safe and effective services). The practice reviewed this performance data to benchmark themselves, monitor achievement and identify areas for improvement.

Clinical audit activity had also focused on a range of important areas. For example, areas of long-term condition management, high risk medication reviews, minor surgery, end of life care and cervical smear non-responders etc. There were also non-clinical audits such as audits of patient urgent referrals, children not brought to appointments and infection prevention and control (cleaning).

The practice had developed a comprehensive service level agreement for the pharmacy project lead and practice pharmacist to action. Medicines audits and searches were also routinely undertaken to ensure appropriate prescribing and patient safety.

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.	N/A
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>At our last inspection in July 2019, two experienced members of the nursing team were absent from work. A new junior practice nurse had recently commenced in post and was being supported to develop the necessary skills for their role.</p> <p>Electronic training records viewed indicated gaps in training modules for administration staff. For example, in relation to areas such as basic life support, equality and diversity and fire safety. Electronic training records for the new practice nurse were also incomplete and several training courses completed had not transferred across to the practice's electronic training records.</p> <p>At this inspection we found that the practice nurse manager and another experienced nurse had returned to work. We saw evidence that the practice nurse manager continued to mentor the two practice nurses to ensure they received the necessary support, supervision, training and guidance for their roles and responsibilities. For example, in relation to undertaking health reviews for patients with long term conditions. Training records confirmed that specific training on immunisation and cervical cancer screening had been completed however one nurse was awaiting her competency to be assessed.</p> <p>Discussion with staff and examination of training records confirmed they had completed a range of training including basic life support, safeguarding, equality and diversity and fire safety.</p>	

Coordinating care and treatment

Staff worked 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) (QOF)	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.	N/A

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>At our last inspection in July 2019, we noted that reviews of some patients with long term conditions were not consistently undertaken or overdue monitoring. Some patients had received medication reviews although there was evidence to demonstrate in some patient records that a medication review code had been added without any evidence of a review being done.</p> <p>We spoke with the nurse manager during the inspection who provided evidence that health reviews were on target for patients with long term conditions. Systems had also been established to ensure all patients on repeat medicines received a medication review.</p> <p>Information to promote cancer screening and other public health information was displayed in the waiting area and on the practice website. Clinicians also used health information templates and shared information to patients via a text messaging service.</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) <small>(QOF)</small>	95.7%	94.2%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.0% (14)	1.2%	0.8%	N/A

Consent to care and treatment

The practice 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
Clinicians spoken with were aware of the consent process and demonstrated knowledge and understanding of consent issues. There was a practice policy for documenting consent for specific interventions.	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
We observed staff greeting patients in the reception area in a friendly, polite and professional manner. All staff had trained in equality and diversity and demonstrated knowledge and understanding of the patient demographic. The practice had also been awarded a gold certificate pride in practice award. This is a quality assurance support service that recognises, strengthens and develops relationships with lesbian, gay, bisexual and trans (LGBT) patients within the local community.	

CQC comments cards	
Total comments cards received.	95
Number of CQC comments received which were positive about the service.	72
Number of comments cards received which were mixed about the service.	20
Number of CQC comments received which were negative about the service.	3

Source	Feedback
NHS Choices	We saw one patient comment on NHS Choices in the last 12 months. This feedback raised concern regarding a 25-minute waiting time delay and the response by a clinician. The comment was responded to in a timely way by the practice manager.
Patient comment cards	Patient feedback received via patient comments cards was generally positive about the standard of care and treatment received. Staff were described as wonderful, respectful and caring. The mixed feedback also contained feedback and highlighted different concerns such as appointment availability, waiting times, use of locum GPs and not always managing to get an appointment with a preferred GP.
Friends and Family	We looked at the results for the practice's friends and family test for the period 26/02/2019 to 25/02/2020. This showed that out of 953 responses, 91% of patients would be highly likely or likely to recommend the practice.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	86.9%	88.6%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	90.3%	86.6%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	94.3%	95.3%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	90.2%	82.2%	82.9%	No statistical variation

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

Any additional evidence
The practice had commissioned an independent organisation to undertake a patient experience survey during September 2019. 154 patients responded to the survey. The results were used by the practice to benchmark their performance in relation to other practices who had carried out the survey. 86% of all patient ratings about the practice were good, very good or excellent. The results were analysed by practice leaders and a summary of the key findings and action points had been summarised in a "you said, we did" document. This enabled patients to view the action that the practice was taking to continuously improve the quality of service provided or to clarify any misunderstanding. For example, some patients suggested that the practice should extend its opening hours for people who work. The practice already provided late and evening appointments so as part of the feedback patients were reminded of the extended hours appointments and how to book.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Patient comment cards	Many patient comments cards mentioned specifically they had been listened to and information had been given to help them understand their care and treatment. They said they felt care had been given according to their own individual needs.
Interviews with patients	We spoke with one patient who was also a representative of the practice's patient participation group (PPG). The patient was complimentary of the standard of care they had received and reported that clinicians and staff were professional, attentive, friendly and responsive. The patient also told us that practice leaders were open and honest, committed to empowering the PPG to function as an autonomous group and were always supportive to members.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	94.1%	93.2%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Easy read and pictorial materials were available. The practice had access to sign language support and a telephone and face-to-face translation service for those patients for whom English was not their first	

language. Information was also accessible in different languages upon request or subject to individual needs.

The practice was equipped with information leaflets and a telephone that enabled patients to have free access to the Citizens Advice Bureau. The practice team also advertised health promotion initiatives via their digital information display screen and referred patients to other social prescribing schemes and services. For example, BUZZ (the Manchester Health and Wellbeing Service) and The High Impact Primary Care (HIPC) Team (a service that provides care and support to people with complex health and care needs). The practice website also provided information to patients about the range of services available and leaflets and posters were displayed in the practice waiting area for patients to view.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 173 patients as carers (3% of the practice patient list).
How the practice supported carers (including young carers).	All carers on the practice register had alerts added to their electronic health record so flexible appointments could be offered if needed. All carers were offered an NHS health check and annual flu vaccinations. Carers were also signposted to the Manchester Carer's Network for additional help and support as necessary.
How the practice supported recently bereaved patients.	There was no formal policy. However, practice leaders told us they would contact patients who were bereaved by telephone, arrange a visit if it was appropriate and/or refer to bereavement support services.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:30am to 6:00pm
Tuesday	08:30am to 6:00pm
Wednesday	08:30am to 6:00pm
Thursday	08:30am to 6:00pm
Friday	08:30am to 6:00pm
	08:30am to 6:00pm
Appointments available:	
Monday	08:40am to 12:00 mid-day and 2pm to 6 pm
Tuesday	08:40am to 12:00 mid-day and 2pm to 6 pm
Wednesday	08:40am to 12:00 mid-day and 2pm to 6 pm
Thursday	08:40am to 12:00 mid-day and 2pm to 6 pm
Friday	08:40am to 12:00 mid-day and 2pm to 6 pm

Out of hours arrangements:

Registered patients can access extended hours appointments via the Manchester Extended Access Service (MEAS). The extended access service is delivered from a number of 'hubs' across Manchester. A number of appointments are bookable via the practice and the operating times of the service vary between each location. Appointments are available at all sites between 18:00 and 20:00 on weekdays and on Saturday and Sunday mornings.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	96.5%	93.8%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Good

Findings

- The practice offered patients with multiple conditions a 30-minute appointment so their needs could be reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice coordinated monthly multi disciplinary team (MDT) meetings and liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Nurse appointments were available at the practice until 6pm on a Monday and Tuesday so school age children did not need to miss school. Appointments were also available via the extended access service.
- There were systems to identify and follow up children who were deemed at risk.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- A baby clinic was available on a Thursday from 9:30 am to 11:30 am.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6pm Monday to Friday. Pre-bookable appointments were also available to patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available between 18:00 and 20:00 on weekdays and on Saturday and Sunday mornings.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
The practice aimed to see all patients requiring emergency treatment on the same day. Home visit requests were logged on to the practice's electronic system (EMIS) for clinicians to review and act upon.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	78.8%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	79.8%	65.9%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	71.5%	66.0%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	79.6%	70.4%	73.6%	No statistical variation

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>The practice recorded and responded to all complaints, both written and verbal.</p> <p>The practice had developed a complaints procedure and an information leaflet on how to raise a complaint was available for patients to reference. This included the contact details of the Parliamentary and Health Service Ombudsman. Systems had also been established to enable practice leaders to maintain an overview of complaints and to analyse key information regarding the type of complaint, specific details and the outcome of any investigation.</p> <p>We looked at two examples of complaints and noted that in both cases correspondence sent to complainants did not include the contact details of the Parliamentary and Health Service Ombudsman.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A concern was raised regarding the attitude of a member of the practice team.	The complaint was investigated by the practice manager and found to be unsubstantiated. A detailed response letter was sent to the complainant in a timely manner to provide an explanation of the investigation and outcome.
A patient raised concern regarding some correspondence that had not been sent to another agency.	The complaint was investigated by the practice manager. The patient was informed that it was not the responsibility of the practice to return the correspondence in this case and an apology was given for any misunderstanding. Additional support was also offered in the matter from a GP.

Well-led

Rating: Good

At our last inspection in July 2019, we rated the practice as inadequate for being well led. At this inspection we found that governance systems and processes had been reviewed and improved to safeguard patient safety and ensure effective care and treatment.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>At our inspection in July 2019, we found that practice leaders had not effectively assessed and addressed gaps in the service. We identified issues in relation to governance and the safe care and treatment of patients during our inspection. For example, in relation to the effective management of patient's medicines, prescription stationery and electrical safety.</p> <p>We undertook a focused inspection in November 2019 to follow up actions taken by the practice in response to a warning notice. At the focused inspection we found that the provider had developed a range of policies, procedures and / or protocols in relation to the management of medicines, patient safety alerts, exception reporting and prescription security to provide guidance to clinicians and staff. Furthermore, a range of audits had been undertaken for patients prescribed high risk drugs and an action plan produced to address outstanding medication reviews. We could see that progress had been made to improve performance however some areas were not fully embedded or required further action. For example, in relation to the effective management of some safety alerts and the management of some patients in need of medication reviews.</p> <p>At this inspection we noted that practice leaders had continued to embed their action plan to ensure the effective management of patient's medication and the facilitation of medication reviews and risk assessments. Furthermore, systems had been established to ensure all safety alerts were received, logged, disseminated and acted upon.</p> <p>A leadership and succession plan had also been developed that had been incorporated into a business plan for 2019-2024. This highlighted that as of 1st April 2020, the practice was aiming to be completely governed by Northern Health GPPO (an alliance of local practices in North Manchester).</p>	

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.	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
<p>Since our inspection in July 2019, practice leaders had developed a business plan. The document included information on the practice's vision and ethos and outlined a mission statement. Staff spoken with demonstrated a sound understanding of the vision and ethos of the practice and their role in delivering the objectives.</p> <p>The business plan included key information such as the history of the practice, services provided, aims and objectives, practice demographics, organisation chart, staffing, succession planning, practice predictive growth, recruitment, retention and training and audit processes.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice'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
<p>At our inspection in July 2019, we noted that the practice did not have a duty of candour policy for staff to reference. However, systems were in place to ensure compliance with the requirements of the duty of candour and we saw examples of how practice leaders were open and transparent and offered apologies when necessary. For example, in relation to the management of complaints. Electronic training records also indicated that only one out of 10 administration staff and one out of three nurses had completed equality and diversity training.</p> <p>At this inspection, we received a new duty of candour policy and an updated training matrix with the provider information return. Discussion with staff and examination of training records during this inspection confirmed all staff had completed equality and diversity training. Staff we spoke with also told us that there was an open and transparent culture within the practice and that any concerns could be raised with practice leaders.</p>	

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

Source	Feedback
Staff interviews	Staff told us that there was a good team ethic at the practice and that they were keen to provide the highest levels of service to patients.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>At our inspection in July 2019, we found that the practice lacked internal comprehensive systems and processes to ensure effective governance structures were established. Where systems were in place, they had not been reviewed to ensure they were operating appropriately. For example, in relation to the management of MHRA alerts, medicines requiring regular monitoring not being implemented in practice, wrong number of repeat prescriptions being authorised, health checks, exception reporting, the management of blank prescription stationery, the absence of a minor surgery audit and the absence of an electrical wiring certificate for the premises. The practice did not have a documented policy around monitoring high risk medicines and there was a lack of overview of staff training and recruitment files.</p> <p>At this inspection we found that action had been taken to establish, implement and sustain improvements regarding the above concerns. A wide range of policies, procedures and protocols had been developed that were accessible to staff. Staff were clear regarding their roles and responsibilities and who to contact should they need to raise an issue or receive help and support. Designated leads had been appointed for key areas such as safeguarding, health and safety, data protection, patient liaison, medical alerts, infection control, medicines management and long-term conditions. Communication was effective and facilitated via a range of structured minuted meetings on a weekly, monthly, bi quarterly and quarterly basis. For example, in relation to safeguarding, multi-disciplinary team, clinical, practice staff and patient participation. Minutes of meetings were available for reference.</p> <p>Practice leaders maintained oversight of key areas such as significant events, complaints, safety alerts, clinical cases and policies and procedures. Key information was also discussed and shared via relevant meetings.</p>	

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a 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
At our inspection in July 2019, there was not effective oversight by practice leaders with regards to potential risks and the mitigation of risks. We did not see evidence of a structured approach to audit or to issues noted during the inspection. For example, the effective management of patient's medicines, prescription stationery and electrical safety. Additionally, staff training and development records were not up-to-date for some staff.	
At this inspection we were assured that systems and processes had been established to ensure the identification, management and mitigation of any risks identified at our inspection in July 2019. A detailed log and schedule of quality improvement and clinical audits that had taken place in 2019 and 2020 had also been produced. This detailed the audits, re-audits and reviews that had been undertaken and the scheduled date for the next review or re-audit.	
A staff performance review policy was in place to provide practice leaders and staff with information on performance management processes. A business continuity plan was also available which offered guidance for staff on the action to take in the event of an emergency.	

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 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
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
At our inspection in July 2019, we found areas of concern in relation to the safe care and treatment of patients. For example, in relation to systems to ensure that timely health checks of patients receiving medicines requiring regular monitoring and review.	
At this inspection we were assured that action had been taken to ensure patients in need of health checks due to receiving medicines requiring regular monitoring had been reviewed and that systems were in place to ensure ongoing monitoring.	
The practice continued to proactively monitor its performance against local quality measures such as the Manchester Standards.	

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
Representatives from the practice continued to attend a variety of internal and external meetings to engage with other clinicians and providers and ensure the provision of coordinated and integrated pathways of care. Examples of external meetings attended by the practice included Clinical Commissioning Group and Federation meetings, neighbourhood meetings with the local primary care network, practice manager and practice nurse forums and multi-disciplinary meetings.	

Feedback from Patient Participation Group.

Feedback

We spoke with one patient who was a representative of the practice's PPG. The patient reported that clinicians and staff were professional, attentive, friendly and responsive. They told us that practice leaders coordinated and attended regular meetings to engage with the PPG, were open and honest, committed to empowering the PPG to function as an autonomous group and were always supportive to members.

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
At our inspection in July 2019, we identified gaps in training for some staff.	
At this inspection we found that practice leaders had supported staff to complete identified gaps in training. Systems were also in place to support staff to develop their knowledge, skills and understanding. For example, the practice was supporting two practice nurses to develop competencies across a range of topic areas	
Discussion with staff and examination of records and minutes of various meetings within the practice provided assurance that information pertaining to operational and clinical matters were routinely discussed with clinicians and practice staff.	

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)	≤ -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.