Care Quality Commission

Inspection Evidence Table

Park View Medical Centre (1-566796375)

Inspection date: 15 July 2019

Date of data download: 05 July 2019

Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Inadequate

The practice is rated as inadequate for providing safe services as the systems for the safe management of medicine were inadequate. We identified concerns in relation to healthcare monitoring for those prescribed high-risk medicines, medication reviews and responding to drug safety alerts.

Safety systems and processes

The practice did not have clear systems 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.	P
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	P
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.	P
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
We were informed that the majority of staff completed training via an on-line training resource. We asked to view evidence of training completed by staff and were provided with electronic training records. The	

Safeguarding	Y/N/Partial
electronic training records indicated that two out of three practice nurses had not completed training in safeguarding for either children or adults. We were informed that the necessary training had been completed by one nurse and that the information had not been transferred to the training record. The other nurse was absent from work at the time of our inspection. Nine out of 10 of the reception staff had completed level 1 children and level 1 adults safeguarding training. Training records showed that eight out of 10 reception staff had completed chaperone training. Staff were not expected to act as chaperones until training was completed The practice did not have a Duty of Candour Policy at the time of our inspection however staff spoken with demonstrated that they understood and acted upon this duty. We noted that two patients did not have alerts on records to identify the patient as vulnerable or subject to a safeguarding concern.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
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
There was no health assessment or medical declaration on the three recruitment files viewed. There was 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.	

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: 3/04/2019	Y
There was a record of equipment calibration. Date of last calibration: 3/04/2019	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: March 2019	Y
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: 1/07/2019	Y
There was a record of fire training for staff. Date of last training: 22/11/2017	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 5/02/2019	Y
Actions from fire risk assessment were identified and completed.	N/A
There were no actions identified in the fire risk assessment. The electrical wiring inspection certificate could not be located for the premises during the inspection. Following our inspection, the provider contacted us on 1/08/2019 to advise the practice was awaiting an electrician to provide an up-to-date certificate. On 5/08/2019, the provider sent us an electrical wiring certificate dated 4/08/2019 for the new sockets and lights fitted in the extension. This did not provide evidence that the electrical safety of the original building had been periodically inspected and checked. The last fire service certificate was dated 3/01/2019. The last annual gas safety inspection certificate was dated 27/03/2019. The last water hygiene / legionella inspection was dated 10/05/2017. Five remedial actions had been identified. Three were recorded as areas requiring immediate action and two were recommended actions. The action plan had not been updated to confirm that actions had been acted upon.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 1/04/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1/04/2019	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: 9/07/2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
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 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 provider had a cleaning contract in place with an external contractor who produced regular audits. The last audit was dated 8/07/2019 and indicated that a compliance score of 97.7% had been achieved.

Risks to patients

There were gaps in 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.	N
Risk management plans for patients were developed in line with national guidance.	N
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	P
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.	P
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

Explanation of any answers and additional evidence:

Gaps in the monitoring of patients prescribed high risk medicines potentially put their health and wellbeing at risk. For example, we identified a patient prescribed high risk medication who was overdue the required blood monitoring tests and had been continually prescribed the high-risk medication despite having not had a blood test at the required frequency.

Staff working in the practice had not completed sepsis awareness training. However, staff were aware of the need to seek advice from a clinician if a patient was unwell.

We identified that MHRA alerts were not always being actioned appropriately. The monitoring of high-risk medicines were not up to date and there was no proactive system to address medication review codes being added when patients were overdue for monitoring or not attending for reviews. Exception reporting was not always appropriate and a risk assessment for emergency medicines had not been undertaken.

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
The practice had very recently developed a new practice correspondence management – process map, to provide guidance to staff on how to manage workflow processes within the practice. Plans were in place to commence auditing processes with immediate effect. Clinicians retained individual responsibility for clinical oversight of test results.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	1.01	1.00	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	6.7%	8.7%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	5.28	5.45	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.21	2.24	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N
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.	N
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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of	Y

Medicines management	Y/N/Partial
unusual prescribing, quantities, dose, formulations and strength).	
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.	P
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.	P

A log of prescriptions was not maintained to provide an audit trail of their location. Prescription stationery was not stored securely.

There was no risk assessment in place to determine the range of medicines held by the practice. We also found a box of out-of-date medicines in the oxygen bag. Following our inspection, the provider sent us a copy of an emergency drugs policy dated July 2019. This provided information on the range of emergency 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. We noted that the proximity of the practice to the local accident and emergency department had been used as mitigation for not holding some medicines. However, the policy did not take into account the time an ambulance would take to arrive and transport a patient to hospital.

A log of vaccine stock was not maintained.

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. For example, we noted that a patient prescribed a high-risk medicine was overdue the required blood monitoring tests. The patient had continued to be prescribed the medicine despite no blood tests being done and the prescriptions on the system had been authorised for six months of issues. We also viewed four patient records where medication reviews had been coded as being completed, but there was no evidence in the patient's record to confirm such a review had been undertaken.

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make 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:	11
Number of events that required action:	8
Systems were in place 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
A patient did not attend (DNA) a two week wait referral. A letter was sent to the practice about the DNA which was filed before being sent to a clinician.	Staff reminded to ensure all DNA letters are sent to the GP via workflow processes.
Incorrect medical records were sent to HM Tribunals and Courts	Staff reminded to ensure that letters requesting medical information are checked thoroughly.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	N
The practice manager reported that the practice did not have a written policy or procedure for the management of safety alerts and that they were responsible for the distribution of alerts to clinicians. Clinicians spoken with were not aware of some recent drug safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA). For example, in relation to medicines to treat thyroid problems, blood pressure and diabetes. Clinicians spoken with also described different approaches to the distribution and management of safety alerts. We reviewed patients prescribed these medicines and found not all had received appropriate advice in line with these alerts	

Effective Rating: Requires Improvement

The practice is rated as requires improvement for providing effective services as quality improvement activity was limited and action to ensure patients prescribed high-risk medicines received regular reviews was not undertaken consistently.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always 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.	N
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
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.	N
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

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. Exception reporting is when patients are removed from the list of healthcare checks. For example, one patient record indicated that a patient had not been seen by a clinician since 2016, although they had continued to be prescribed numerous medicines for diabetes, respiratory diseases and mental health problems. A medication review code had been added to the patient's computer record in April 2019 despite the patient not having been seen or monitored for several years.

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) (01/04/2018 to 31/03/2019) (NHSBSA)	1.18	1.13	0.77	No statistical variation

Older people

Population group rating: Requires Improvement

Findings
The concerns identified around the provision of effective care impacted on all patients, including this population group. • The practice did not routinely actively search out and review older patients who were living with moderate or severe frailty. • 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. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings
The concerns identified around the provision of effective care impacted on all patients, including this population group. • The practice had not undertaken long-term condition reviews for some patients due to the absence of two experienced practice nurses. • 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. • Exception reporting was not being added appropriately in some instances.

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 (01/04/2017 to 31/03/2018) (QOF)	84.8%	78.3%	78.8%	No statistical variation

Exception rate (number of exceptions).	21.9% (96)	13.4%	13.2%	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 (01/04/2017 to 31/03/2018) (QOF)	81.9%	76.6%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.6% (42)	11.0%	9.8%	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 (01/04/2017 to 31/03/2018) (QOF)	79.2%	81.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.9% (83)	12.7%	13.5%	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 (01/04/2017 to 31/03/2018) (QOF)	70.8%	75.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.4% (17)	7.9%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	89.3%	87.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	22.5% (38)	11.9%	11.5%	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 (01/04/2017 to 31/03/2018) (QOF)	83.4%	81.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.8% (36)	5.3%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	95.2%	89.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (9)	6.1%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

The concerns identified around the provision of effective care impacted on all patients, including this population group.

- Childhood immunisation uptake rates were not in line with the World Health Organisation (WHO) targets. We were informed that the lower levels of child immunisation rates were attributable to population factors. We were told that some sections of the community elected not to have their children vaccinated. The practice met with the health visitors and shared information on any children that did not attend appointments. We were not informed of any outreach or in practice education to raise awareness amongst patients.
- 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.
- 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)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	79	86	91.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	72	84	85.7%	Below 90% minimum (variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	70	84	83.3%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	72	84	85.7%	Below 90% minimum (variation negative)

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

The concerns identified around the provision of effective care impacted on all patients, including this population group.

- The practice had systems to opportunistically inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- There was appropriate and timely follow-up on the outcome of health checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat prescriptions 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) (01/04/2017 to 31/03/2018) (Public Health England)	59.5%	65.3%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	63.0%	59.0%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) **(PHE)**	49.4%	45.1%	54.4%	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. (01/04/2017 to 31/03/2018) **(PHE)**	87.5%	72.4%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	30.4%	48.5%	51.9%	No statistical variation

Any additional evidence or comments

We were informed that the practice struggled 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 differences 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 earlier in 2019 in the local area at the behest of the neighbourhood community development co-ordinator. The practice reported that the whole area of Cheetham Hill and Crumpsall struggled with this work so outreach work was done on a locality basis. This included work with the local mosque.

We noted that the female GPs had undertaken more smear tests as two of the experienced nurses were absent from work and one had not completed the necessary training.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

The concerns identified around the provision of effective care impacted on all patients, including this population group.

- Same day appointments and longer appointments were offered when required.
- 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: Requires Improvement

Findings

The concerns identified around the provision of effective care impacted on all patients, including 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. Although patients who were inappropriately exception reported above had mental health problems and not been monitored or reviewed, just codes added.
- Same day and longer appointments were offered when required.
- 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.
- 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 (01/04/2017 to 31/03/2018) (QOF)	91.2%	87.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	4.6% (6)	12.3%	12.7%	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 (01/04/2017 to 31/03/2018) (QOF)	91.9%	88.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.3% (7)	9.6%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	88.5%	83.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.5% (3)	6.7%	6.6%	N/A

Monitoring care and treatment

There was limited internal monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	553.0	535.1	537.5
Overall QOF score (as a percentage of maximum)	98.9%	95.7%	96.2%
Overall QOF exception reporting (all domains)	7.4%	7.3%	5.8%

	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.	P
Quality improvement activity was targeted at the areas where there were concerns.	N

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

We were not given an audit programme by the provider. There was limited evidence of clinical audit although the first cycle audit for anti-depressant and antipsychotic usage in patients with a learning disability was available. This showed that in January 2019 only 35% of learning disability patients had had a learning disability review since 1/04/2018. This was a single cycle audit so any improvements implemented by the practice had not been reviewed at the time of our inspection.

We were also provided with the latest re-audit for women taking Valporate dated May 2018. Actions were taken in regard to the health and wellbeing of five patients to ensure safe care and treatment.

The last available minor surgery audit was from 2014/15. The practice provided this after the inspection visit.

Any additional evidence or comments

The practice had also signed up to 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.

Effective staffing

The practice was unable to demonstrate that some 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.	P
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
At the time of our inspection, two experienced members of the nursing team were absent from work. A new junior practice nurse had commenced in post in April 2019 who was being supported to develop the necessary skills for their role. The practice had hired a locum nurse to provide additional support to the practice clinical team in the interim. Electronic training records indicated gaps in training modules for administration staff. For example, in areas such as basic life support, equality and diversity and fire safety. Electronic training records for the new junior practice nurse were also incomplete. The junior practice nurse told us that she had completed a number of training courses including safeguarding level 1 and 2 however the data had not transferred across to the practice's electronic training records.	

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 (01/04/2017 to 31/03/2018) (QOF)	Yes
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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
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.	N
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
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. We noted that reviews of some patients with long term conditions were not consistently undertaken. 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. Some patients had not always been seen and were overdue monitoring.	

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 (01/04/2017 to 31/03/2018) (QOF)	96.5%	94.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (8)	0.9%	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 we spoke with were aware of the consent process and demonstrated a good knowledge of consent issues. There was a practice policy for documenting consent for specific interventions.	

Well-led Rating: Inadequate

The practice is rated as inadequate for being well led. Governance systems and processes to ensure patient safety and the effectiveness of the care and treatment were not effectively established or implemented**.**

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality 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.	P
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	P
Since the last inspection, the provider had extended the building to provide more capacity. Staff were able to articulate their plans for staff development however a documented development programme and succession plan had not been established at the time of our inspection. 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.	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
The provider was able to articulate their vison and plans for developing the practice in the future in order to respond to the growing patient list size, the changing needs of the local practice population and to address GP partner recruitment difficulties. However, we were not shown any documented business or strategic plan to support this vision or for staff to reference. Some staff spoken with were not aware of the stated vision or ethos of the practice.	

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.	P
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.	P
The practice did not have a duty of candour policy for staff to reference. Following our inspection, the provider wrote to us to confirm that that a policy would be developed and to offer assurance and examples of how the practice was open and transparent. We saw examples of how the practice manager had responded and, when appropriate, given an apology to patients who had left comments on their experience of using the practice via the NHS Choices website. We also saw an example of a significant event following which the provider met with a patient and their relative to share information in relation to a specific incident. Electronic training records indicated that only one out of 10 administration staff and one out of three nurses had completed equality and diversity training.	

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

Source	Feedback
Staff interviews	Staff spoken with reported that leaders were approachable and that they felt part of a team that worked well together and was generally well-supported.

Governance arrangements

The overall governance arrangements were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y

There were appropriate governance arrangements with third parties.	Y

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.

We noted that a meeting structure had been established within the practice which included management, clinical practice, staff and the patient participation group. A list of areas of responsibility had also been produced for staff employed in the practice that outlined individual roles, the responsible person and who they were accountable to. This included areas such as Medicines & Healthcare products Regulatory Agency alerts (MHRA) alerts, medicines management and clinical and public health domains.

Despite the above governance structures and systems being in place, we identified a number of concerns during our inspection. 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.

At our request, the provider wrote to us following our inspection to provide assurance that they undertook monitoring of the care provided to their patients prescribed high risk medicines.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	P
There were effective arrangements for identifying, managing and mitigating risks.	N
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
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 formal or structured approach to audit or to identify 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. We were shown only a single cycle audit of anti-depressant and antipsychotic usage in patients with a learning disability undertaken in January 2019. We were also provided with re-audit for women taking Valporate dated May 2018. Following our inspection, the provider sent us a copy of a minor surgery audit for the period 1/04/2014 to 31/03/2015.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	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.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
On the day of our inspection 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. Systems for identifying such risks were not effective.	

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

The practice manager told us that representatives from the practice attended a variety of internal and external meetings to engage with other clinicians and providers to 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 a representative of the Patient Participation Group (PPG) who had been a member for approximately three years. The representative told us that the PPG was promoted and supported by the practice team to be autonomous and to represent the diverse needs of the local patient population. We noted that meetings were coordinated on a quarterly basis which were attended by the provider and other members of the PPG.

Any additional evidence
We spoke with one patient at the time of our inspection and they provided positive feedback about the service they received. They told us they could get appointments when needed and that the service received was caring and responsive to their needs. We also received 57 comment cards from patients. 48 of the comment cards provided positive feedback, eight offered mixed views and one was negative. We also saw evidence that the practice had commissioned an independent organisation to undertake a patient survey during May 2018. 117 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. Overall, the results were positive.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	P
Learning was shared effectively and used to make improvements.	Y
We saw records and minutes of various meetings within the practice which highlighted that clinical and operational matters including significant events were routinely discussed. We identified gaps in training for some 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.

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

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.