Care Quality Commission

Inspection Evidence Table

Meir Park Surgery (1-540617623)

Inspection date: 16 September 2019

Date of data download: **03 September 2019**

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

At our previous inspection in March 2019, we rated safe as inadequate and issued a warning notice in relation to safe care and treatment. This was because:

- Not all the suggested emergency medicines were available at the branch practice. A risk assessment to mitigate potential risks to patients had not been completed.
- The process for monitoring patients prescribed high risk medicines was not always effective.
- Medicines and Healthcare products Regulatory Agency (MHRA) alerts were not always acted upon.
- The provider could not demonstrate that staff had completed training required for their role. In particular, safeguarding children and vulnerable adults, infection prevention and control, sepsis, chaperoning and fire marshal.
- Regular children's safeguarding meetings with other agencies had not been held. A system of reconciling children at risk of harm, as identified by the practice, with health visitors and school nurses was not in place.
- The practice did not have arrangements for following up failed attendance of children's appointments following an appointment in secondary care or children who were frequent A&E attenders.
- Recruitment checks had not always been carried out in accordance with regulations.

At the warning notice follow up inspection on 30 April 2019 we found there had been improvement in the issues identified in the warning notice. However, despite progress being made, the practice had not completed risk assessments for staff without a health assessment or implemented systems to promote patient compliance with required blood test monitoring. In addition, the practice had not established safeguarding meetings with other agencies or reconciled the practice's list of children at risk of harm with appropriate agencies.

Although it was noted that improvements have been made, the practice was rated as Requires Improvement in providing a safe service because:

- The practice did not have a system in place to ensure the safeguarding register of patients identified as at risk was current and up to date.
- Staff training on how to identify deteriorating or acutely unwell patients had not been embedded.
- The use of prescription stationery was not always monitored.

- Medicine review dates were amended prior to annual blood tests being completed.
- The security of the medicine cupboard keys was inadequate although this was addressed at the time of the inspection. The records for the Controlled Drugs (CDs) did not meet the requirements of the CD register.
- There was no documentary evidence of staff shared learning following significant events.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

During this inspection we found that:

- Staff confirmed that they had attended safeguarding training and were able to locate the policies. The contact details for the local safeguarding teams were also on display around both practice sites.
- The practice was aware of the need for all clinicians, including nursing staff, to complete level 3 safeguarding training for adults.
- The practice had been unable to arrange children's safeguarding meetings with other agencies. Discussion took place around safeguarding being added as a standing agenda item at clinical and practice meeting, so the care and needs of these patients was discussed internally.
- The practice maintained a safeguarding register of patients identified as at risk. However, this was not completely up to date as not all alerts had been placed on the electronic records, particularly for patients newly registered at the practice. This was addressed by the GP safeguarding lead during the inspection.

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

Explanation of any answers and additional evidence:

At our previous inspection in March 2019 we found not all required recruitment checks had been completed. During our follow up inspection in April 2019 we found that improvements had been made but health assessments were not always completed.

During this inspection (September 2019), the practice manager told us that all staff complete an occupational health assessment form.

At this inspection we reviewed four staff files. The files were well organised, and most of the recruitment checks were in place. However, we found that not all information which had been checked, for example professional registration and performers list, had been recorded in the staff file.

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: Main Practice: 21/02/2019 Branch Practice: 25/01/2019	Yes
There was a record of equipment calibration. Date of last calibration at main and branch practice: 21/02/2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 14 August 2019	Yes
There was a log of fire drills. Date of last drill: Main Practice: 20 February 2019 Branch Practice: November 2018	Yes
There was a record of fire alarm checks. Date of last check: Main Practice: stated checked weekly but no records maintained Branch site: records not seen during this inspection	No
There was a record of fire training for staff. Date of last training: February 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: Main Practice: May 2019 Branch Practice: records not seen during this inspection	Yes
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

The practice did not have a maintenance contract in place for the fire alarm system, although this was in place for the emergency lighting. The practice told us they intend to extend the current contract to cover the fire alarm.

The fire alarm and the smoke detectors were tested but the practice did not record this. The practice devised a log for recording this information during our inspection, which will be used moving forward.

The practice had not completed all the actions as outlined in the fire risk assessment, for example, fitting fire door seals.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Main Practice: May 2019 Branch Practice: records not seen during this inspection	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2019 Branch Practice: records not seen during this inspection	Yes
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Main Practice: 25 June 2019 Branch Practice: September 2018	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: At our previous inspection in March 2019 we found that not all staff had completed infection control training. We found at this inspection all staff had completed this training. The legionella risk assessment for the main practice, dated May 2019, identified a high level of risk. The practice told us to mitigate this risk, a new hot water heating system was being installed on 21 September 2019 and a further risk assessment would be carried out on completion of the work. The practice told us that they ran the water off at each outlet every day to reduce the risk. Records for the branch practice were not seen during this inspection.	

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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Explanation of any answers and additional evidence:

At our previous inspection in March 2019 we found that not all non-clinical staff had been trained to identify deteriorating or acutely unwell patients suffering from potential illnesses such as sepsis. During our follow up inspection in April 2019 we found that staff had been trained.

During this inspection we found that although non-clinical staff had received training, the knowledge had not been fully embedded and not all staff were able to describe what symptoms to be aware of. Staff did not have a check list to refer to on reception to assist them with identifying deteriorating or acutely unwell patients.

Non-clinical staff told us that although staffing levels were generally sufficient, it could be difficult to cover holidays and sickness. They felt they would benefit from an additional member of staff. Staff also told us that there had been a reduction in nursing hours, due to staff leaving and short-term sickness, and this had impacted on the availability of appointments. The practice told us they were trying to recruit additional practice nurses but had been unsuccessful so far.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
Explanation of any answers and additional evidence: The practice was not fully up to date with adding all relevant information to the electronic record for patients newly registered at the practice.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, but these were not always effective.

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.79	0.97	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). (01/07/2018 to 30/06/2019) (NHSBSA)	7.8%	7.0%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	5.99	5.28	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.41	2.09	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.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	No
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	NA
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

At the time of our previous inspection in March 2019 we found that not all the suggested emergency medicines were available at the branch practice. A risk assessment to mitigate potential risks to patients had not been completed. We also found that the process for monitoring patients prescribed high risk medicines was not always effective. During our follow up inspection in April 2019 we saw that all the suggested emergency medicines were in place at the branch practice. We also found that processes had been implemented for monitoring patients prescribed high risk medicines, although the practice needed to consider alternative ways to promote compliance with blood test monitoring.

At the time of this inspection we found that the suggested emergency medicines were in place at both the main and branch practice.

We saw that the use of prescriptions was not always monitored, particularly prescription pads.

The Advanced Nurse Practitioner told us that oversight of their consultations was provided by one of the GP Partners, although they did not know if any information was recorded. We were unable to verify this with the GP as they were away from the practice at the time of the inspection.

We saw that the security of the medicine cupboard keys (including the Controlled Drug (CD) cupboard) was inadequate. The practice addressed this at the time of the inspection. The records for the CDs did not meet the requirements of the CD register. Following the inspection, the practice advised us that they had decided to no longer stock CDs and had contacted the medicines management team for advice on safe disposal.

Medicines management	Y/N/Partial
We checked the Patient Group Directions (PGDs) at the branch practice, which were all in date and signed. The practice nurse told us the PGDS were checked monthly to ensure they remained in date. We discussed implementing a system to easily identify the expiry dates of PGDs. Patients on high risk medicines continued to be monitored at the practice or by secondary care. It was not clear if a system to promote patient compliance with required blood test monitoring had been implemented. Discussion took place regarding downloading blood results requested by secondary care into patient notes so there was a record available for clinicians to see. In addition, we saw that some medicine review dates had been moved forward before patients had attended for annual blood tests for lower risk medicines.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	7
Number of events that required action:	7

Explanation of any answers and additional evidence:

At our previous inspection in March 2019 we found that a system for sharing learning from significant events was not in place. During this inspection we found that discussion and learning from significant events was discussed at the monthly staff meetings. However, it was not clear whether significant events were discussed and learnt from within the clinical staff team.

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

Event	Specific action taken
A patient handed in an ice-cream container filled with used sharps.	This is contradictory to the process in place. Staff were reminded that they should only accept proper sharps bins, which have been sealed, signed and dated by the patient.
Staff had not checked the contents of a package being transferred between sites.	Staff had transferred a package between sites, without first thoroughly checking the contents. The package contained items that needed to be refrigerated. As a consequence, of not checking the contents, the items had to be discarded due to incorrect storage. Staff were reminded to thoroughly check all deliveries on receipt.

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

Explanation of any answers and additional evidence:

At our previous inspection in March 2019 we found that not all Medicines and Healthcare products Regulatory Agency (MHRA) alerts had been acted upon. We reviewed two recent alerts during this inspection. We found that patient searches had been completed and alerts put on the electronic records. One patient had been given an appointment but had not attended. The practice had taken follow up action to ensure the information was shared with the patient.

Effective Rating: Requires Improvement

At our previous inspection in March 2019, we rated effective as requires improvement because:

- There were multiple gaps in staff training in relation to equality and diversity, basic life support, fire safety, mental capacity act, health and safety and safeguarding vulnerable adults and children.
- 248 patients potentially in the pre-diabetic stage had not been coded appropriately within the practice's computer system or received appropriate life style advise.

At the warning notice follow up inspection on 30 April 2019 we found there had been improvements and the practice had been actively recalling and coding patients in the potentially pre-diabetic phase and offering life-style advice.

The practice was rated as requires improvement in providing an effective service because:

- Staff were up to date with their required training.
- Pre-diabetic patients records had electronic read codes applied and patients had been provided with lifestyle advice in those records sampled.
- There was a lack of evidence of a timely action plan following an audit where there were identified areas for improvement to mitigate patient risk.
- The uptake of cervical screening was below the national target.

As the issues identified have an impact on every population group, we have rated them all as requires improvement.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant	Yes

digital and information security standards.	

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) (01/07/2018 to 30/06/2019) (NHSBSA)	1.27	0.82	0.75	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

- The practice used a clinical tool to identify older patients aged 85 year and over who were living with moderate or severe frailty. These patients were offered an assessment with the practice nurse, which included health checks, a medication review and assessment of the person's care 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.
- 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

- 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.
- They practice's performance on quality indicators for long term conditions was in line with the local and national averages.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The specialist diabetic nurse supported the practice through a weekly diabetic clinic.
- 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 identified as potentially in the pre-diabetic phase had been recalled and coded and offered life style advice.

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)	81.2%	74.7%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.3% (64)	9.6%	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)	77.1%	75.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.8% (35)	7.5%	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)	85.0%	80.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.0% (67)	11.9%	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)	77.5%	77.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.9% (17)	5.2%	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)	92.9%	88.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	10.8% (17)	9.8%	11.5%	N/A

Indicator	Practice	CCG	England	England

		average	average	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)	81.6%	81.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.3% (46)	3.2%	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)	92.7%	91.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.1% (11)	5.1%	6.7%	N/A

Any additional evidence or comments
QOF data for 2017/18 showed that the exception rate for some patients with diabetes was above the local and national averages. We reviewed this at our previous inspection in March 2019 and saw that they had all been appropriately excepted.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were above the 90% minimum target (93.3% to 94.2%) but were slightly below the World Health Organisation (WHO) targets of 95%.
- The practice held weekly immunisation clinics and had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with the practice's safeguarding lead as required.
- Pregnant women were offered flu vaccinations and whooping cough vaccination at 16 to 32 weeks gestation.
- Midwife led clinics were held twice weekly at the practice.
- Young people could access services for sexual health and contraception.

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)	65	69	94.2%	Met 90% minimum
The percentage of children aged 2 who	70	75	93.3%	Met 90% minimum

have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)				
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)	70	75	93.3%	Met 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)	70	75	93.3%	Met 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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat 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) (01/04/2017 to 31/03/2018) (Public Health England)	70.1%	N/A	N/A	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	71.4%	71.4%	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)	55.3%	53.2%	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	62.1%	71.7%	70.2%	N/A

diagnosis. (01/04/2017 to 31/03/2018) (PHE)				
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)	43.3%	60.0%	51.9%	No statistical variation

Any additional evidence or comments

The practice's cervical screening rate of 70.1% was below the national target of 80%. Staff told us they had system in place to recall patients who failed to attend their screening. They also told us they remind patients opportunistically when they attend the practice, and we saw evidence of this in the records. The practice manager also planned to organise an awareness event around cervical screening.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- 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 held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice shared an example where they had supported a patient who was not accessing appropriate services due to their circumstances. The patient was offered joint home visits with the GP and practice nurse.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

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.
- Patients presenting with insomnia, anxiety or depression were not fully assessed to identify their risk of suicide or self-harm.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.8%	84.9%	89.5%	No statistical variation
Exception rate (number of exceptions).	17.9% (7)	9.1%	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)	97.1%	89.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.3% (4)	7.9%	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)	72.0%	79.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	16.7% (5)	6.9%	6.6%	N/A

Any additional evidence or comments
QOF data for 2017/18 showed that the exception rates for patients experiencing poor mental health was above the local and national averages. There were reviewed during the inspection in March 2019 and it was found that they had all been appropriately excepted.

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)	554.1	535.8	537.5
Overall QOF score (as a percentage of maximum)	99.1%	95.8%	96.2%
Overall QOF exception reporting (all domains)	6.0%	5.6%	5.8%

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

appropriate action.	

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

The practice had audited five patient records who had been identified as having made attempts to commit suicide. The audit looked at how appropriate the clinical care provided by the practice team had been, the reasons for not providing intervention and/or the learning from the review of the notes, and action required by the practice team. The audit noted that the patients had been seen by the practice prior to their attempted suicides and concluded that their deliberate self-harm risks had not been properly addressed. In additional the practice did not have a self-harm protocol or system to follow up patients with mental health issues. A second cycle had not been completed, so it was not clear if action had been taken following this audit.

Any additional evidence or comments
The practice completed audits requested by the local clinical commissioning group. We did not see evidence of quality improvement work initiated by the practice.

Effective staffing

The practice was able/ unable 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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: During our inspection in March 2019 we found there were gaps in staff training. At this inspection we found that staff had completed training as required by the practice. The practice maintained a training	

matrix to identify when training required updating. The practice was not able to evidence how they had assured the competence of staff employed in advanced clinical practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 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 organisations were involved.	Yes
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.	NA

Helping patients to live healthier lives

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

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

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)	96.8%	95.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (8)	0.6%	0.8%	N/A

Consent to care and treatment

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

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

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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	14
Number of CQC comments received which were positive about the service.	14
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	Fourteen comment cards were completed by patients. Patients said they felt the practice offered a good service and that staff were professional and kind.
NHS Choices	No new comments have been left on the NHS website since our previous comprehensive inspection in March 2019.
Interviews with patients	We spoke with one patient during the inspection. They told us they were very happy with the service provided.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6525	274	102	37.2%	1.56%

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)	78.4%	88.3%	88.9%	Tending towards variation (negative)
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)	80.2%	87.1%	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)	93.5%	95.5%	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)	72.0%	83.4%	82.9%	No statistical variation

Any additional evidence or comments
At this inspection we saw that data from the national GP patient survey demonstrated that patient satisfaction with how they were treated had improved. At our previous inspection in March 2019, data showed that 56% of respondents responded positively to the overall experience of their GP practice. At this inspection we saw that patient satisfaction had increased to 72%. However, practice results for the indicators reminded lower than the local and national averages.

Question	Y/N

The practice carries out its own patient survey/patient feedback exercises.	Yes

Any additional evidence
We spoke with a member of the patient participation group (PPG). They told us the group had developed a satisfaction survey which was due to be implemented soon. Members of the PPG would be actively involved in implementing the survey across both sites. Patients had access to the Friends and Family Test comment cards to provide feedback, and the practice had also provided a suggestion box.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

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)	91.1%	93.0%	93.4%	No statistical variation

Any additional evidence or comments
At this inspection we saw that data from the national GP patient survey demonstrated that patient satisfaction with their involvement in their treatment had improved. At our previous inspection in March 2019, data showed that 88% of respondents responded that they were involved as much as they wanted to be in decisions about their care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: Staff at both sites told us they could access language line to support patients who did not have English as their first language.	

Carers	Narrative
Percentage and number of carers identified.	The practice population was approximately 6,794. The practice had 124 identified carers. This represented 1.8% of the practice population.
How the practice supported carers (including young carers).	The practice maintained a carers register, and carers were entitled to a flu vaccination, which was given if requested. Information about support organisations was available in the waiting room.
How the practice supported recently bereaved patients.	The practice contacted bereaved patients by telephone.

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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Partial
Explanation of any answers and additional evidence: There was a lack of privacy at the main site, at the reception desk and in the waiting area. Calls to the practice were answered on the reception desk and conversations could be overheard in the waiting area. Staff had access to a private room if patients wished to discuss sensitive issues. There was no signage at the main site asking patients to stand back from the desk to respect the privacy of the person speaking with reception staff.	

Responsive Rating: Requires Improvement

At our previous inspection in March 2019, we rated responsive as requires improvement because:

- Patient satisfaction with access to appointments was significantly below the national average.
- A system was not in place to follow up children and young people with a high number of accident and emergency attendances or children who failed to attend hospital appointments.
- There was no system in place to share learning from complaints with staff across both sites.

The practice was rated as requires improvement in providing a responsive service because:

- Although action had been taken to improve patient satisfaction with access to appointments, it remained below the national average.

We have rated all the population groups requires improvement for providing responsive services because poor access to appointments affected all the populations groups.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	**Time**
Opening times: **Meir Park Surgery**	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 1pm
Friday	8.30am to 6.30pm
Appointments available:	
Monday	9.30am to 12.30pm and 3pm to 5.30pm
Tuesday	9am to 12pm and 2pm to 3pm
Wednesday	9am to 12pm and 5pm to 6pm
Thursday	10.30am to 1pm
Friday	9am to 1pm and 4pm to 5pm

Opening times: **Meir Park Care Centre**	
Monday	8.30am to 6pm
Tuesday	8.30am to 6pm
Wednesday	8.30am to 6pm
Thursday	8.30am to 1pm
Friday	8.30am to 6pm
Appointments available:	
Monday	9.45am to 11.15pm and 3.30pm to 5pm
Tuesday	9am to 12pm and 2pm to 5pm
Wednesday	9.30am to 11am and 4pm to 5.30pm
Thursday	9.30am to 11.30am
Friday	9am to 10am and 2pm to 4pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6525	274	102	37.2%	1.56%

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)	92.5%	95.1%	94.5%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

- All patients aged 85 years and over had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice nurse provided a home assessment service and health checks for elderly, housebound and vulnerable patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice 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.
- The practice provided in house spirometry. (Spirometry is a test used to help diagnose and monitor certain lung conditions).

Families, children and young people

Population group rating: Requires Improvement

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice has also introduced a system to follow up children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments and telephone consultations outside of school and college hours were available for children so that they did not need to miss school.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

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
- Patients had access to telephone consultations, on line services and access to the extended hours hub for evening and weekend appointments.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, carers, housebound and those nearly the end of their life.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- 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: Requires Improvement

Findings

- Priority and longer 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.
- Staff had completed dementia training.

Timely access to the service

People were access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

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)	51.1%	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)	54.0%	68.7%	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)	46.4%	66.8%	64.7%	Tending towards variation (negative)
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)	74.5%	76.2%	73.6%	No statistical variation

Any additional evidence or comments
There had been improvements in patient satisfaction in relation to access to the practice and appointments. The practice had acted to improve telephone access and the number, type and location of appointments available for patients. The practice had yet to carry out an internal patient satisfaction survey although this was planned for the near future. The recent changes needed to become embedded to further promote patient satisfaction. At our previous inspection in March 2019, data from the national GP patient survey showed that 39% of respondents found their experience of making an appointment as good; 35% responded positively to how easy it was to get through on the phone, and 59% were satisfied with the type of appointment they were offered. At this inspection we found that patient satisfaction relating to getting through the practice and making an appointment had improved, although the results remained lower that the

national average. Patient satisfaction with the type of appointments they were offered was in line with the national average.

An increase in patient satisfaction with appointment times was also noted which had increased from 34% in 2018 to 46.4% in 2019, although satisfaction rates continue to be lower than the local and national averages.

At our previous inspection we found that the two sites were working independently of each other and patients contacted the practice they were originally registered with. The practice had introduced a new telephone system with one telephone number for both sites. Incoming calls were answered at both sites and patients offered the next available appointment at either site, unless they requested to see a specific GP.

The practice had also reviewed their appointment system and now offered 50% pre-bookable and 50% on the day appointments for GPs. There had also been an increase in capacity following the employment of an additional locum GP. We saw that patients still queued at the main site to get an appointment on that day. We observed staff offering alternatives when appointments weren't available, such as making an appointment with the extended hours service later that day.

Source	Feedback
NHS Website	No new comments have been left on the NHS website since our previous comprehensive inspection in March 2019.

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.	5
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Explanation of any answers and additional evidence:

At our previous inspection we found that a system was not in place to share the learning from complaints with staff throughout the practice. During this inspection we saw that complaints were discussed at the practice meeting, attended by the reception / administrative team and nursing team. There was no evidence to support that discussions amongst the GPs took place.

We were told that verbal complaints were dealt with as they arose. The practice was advised to keep a record of verbal complaints and actions taken to resolve, so these could be reviewed for any trends.

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaints regarding access	The practice had had purchased a new telephone system, with one telephone number for both sites. Incoming calls were answered at both sites, and patients informed of their place in the queue.
Patient complained about the side effects of a medicine.	The patient was provided with a written rationale as to why the medicine had been prescribed. The patient had a further discussion with a GP, who reassured them that the correct clinical pathway was being followed.

Well-led Rating: Requires Improvement

At our previous inspection in March 2019, we rated well-led as inadequate and issued a requirement notice in relation to good governance. This was because:

- Action plans to address the challenges faced by the practice were not in place. This included succession planning and delivery of the service in relation to very low patient satisfaction with access to appointments.
- Staff were not aware of the practice's vision.
- There were very low levels of staff satisfaction and high levels of stress across both practices. Staff did not feel that their views were listened to or valued.
- Staff were confused regarding where they would locate the most up to date policies.
- An overarching system to monitor staff compliance with essential training was not in place.
- A system of sharing learning from significant events and complaints with staff was not in place.
- Five of the eight recommendations we made at our previous inspection had not been fully implemented

Although it was noted that improvements have been made, the practice was rated as Requires Improvement in providing a well-led service because:

- There remained inconsistencies in ways of working across the two sites, for example, use of the electronic records system
- Staff knowledge and understanding of the mission statement and core values was not yet fully embedded.
- The systems in place for identifying, managing and mitigating risks needed to be strengthened and become embedded.

Leadership capacity and capability

The GPs worked in parallel to each other for their patients. However there was little evidence to demonstrate a joint leadership approach.

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

Explanation of any answers and additional evidence:

During our previous inspection in March 2019 action plans to address the challenges faced by the practice were not in place. This included succession planning.

During this inspection we saw that a three-year business development plan had been put in place. The purpose of the business plan was two-fold; setting out clear objectives and to understand the changes that were important to introduce. The plan also referred succession planning and the practice was

looking to recruit an additional partner.

Staff spoken with told us they valued the monthly practice meetings for reception/administration and nursing staff. They told us the meetings gave them the opportunity to discuss any issues and raise any concerns with business manager and practice manager. They felt that their views were being listened to and taken forward where possible.

It was less clear whether the GP team were working well together as staff reported that the partners tended to review their own previous patients' correspondence rather than it being shared across the GP team. However, one GP was responsible for reviewing all results received by the practice. There was little evidence of minuted meetings between the partners and locum, which included shared learning and development.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care, although this was not fully embedded.

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

Explanation of any answers and additional evidence:

The mission statement was set out in the business development plan, as were the core values. Staff were aware there was a mission statement but their knowledge and understanding of this was not yet fully embedded.

Progress against delivery of the strategy was built in to the business development plan, which had only recently been implemented.

Culture

The practice had a culture which was beginning to support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

We found from speaking with staff that staff morale had improved since our previous inspection. They told us they felt the two sites were beginning to work together better and they valued the monthly team meetings. They told us the meetings gave them the opportunity to discuss any issues and raise any concerns with business manager and practice manager. They felt that their views were being listened to and taken forward where possible. Staff described suggestions that they had for improving the ways of working with the practices.

Governance arrangements

Staff had clear roles and responsibilities, however, systems to support good governance and management were not always in place.

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

Explanation of any answers and additional evidence:

During our previous inspection in March 2019 we found that the practice did not have an overarching system to monitor staff compliance with essential training. During this inspection, we saw that a system had been put in place and staff were up to date with training.

We found that not all clinicians were using the electronic records system to its full potential, thereby reducing the ability to audit actions that had been taken. Staff told us that not all of the GPs used the electronic task system and messages were passed between reception staff at both sites, for tasks to be passed on to the GP for action. In addition, one of the GPs preferred to review information in paper

form and provide instructions for staff, rather than reviewing electronically and sending a task to staff.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance, although these needed strengthening and embedding.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

Although there were systems in place for identifying, managing and mitigating risks, these needed to be strengthened and become embedded. For example:

- The practice was not fully up to date with adding all relevant information to the electronic record for patients newly registered at the practice.
- The practice had not completed all the actions as outlined in the fire risk assessment.
- Although training on identifying deteriorating or acutely unwell patients had been provided, the knowledge had not been fully embedded and not all staff were able to describe what symptoms to be aware of.
- The use of prescriptions was not always monitored, particularly prescription pads.
- The practice was not able to evidence how they had assured the competence of staff employed in advanced clinical practice.
- The practice had not embedded a system to ensure that patients on high risk medicines remained up to date with their blood monitoring.
- There was limited evidence to support the practice completed their own audits, as those seen had been requested by the local clinical commissioning group.

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.	Yes

Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: Although there were systems in place for identifying, managing and mitigating risks, these needed to be strengthened and become embedded.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice had begun to involve and engage the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: Since our previous inspection in March 2019, the practice had engaged on a monthly basis with the NHS England GP Support Team and Clinical Commissioning Group for support with the development of the practice. The business manager and practice manager engaged with the GP support team on a weekly basis. The practice had acted on patient feedback regarding telephone access and appointments. Consequently, a new telephone system had been installed, with one telephone number for both sites, access to appointments at both sites, and introducing a 50/50 split for pre-bookable and on the day appointments.	

Feedback from Patient Participation Group.

Feedback
We spoke with the chairperson of the Patient Participation Group. They told us they met with the practice manager on a quarterly basis. The PPG managed these meeting and organised the agenda. The PPG had developed a patient satisfaction survey, which they planned to implement in the near future. They told us they had plans to produce a newsletter three times a year. The PPG recognised the challenges of bringing the two PPG groups together, and unfortunately representatives from the original group at Weston Coyney Medical Practice had not attended the last meeting. The representative told us that the recent changes to the telephone system and access to appointments at both sites had bought about improvements for patients.

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.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	

We found that discussion and learning from significant events and complaints was discussed at the monthly staff meetings attended by nursing and reception / administration staff. However, it was not clear whether significant events and complaints were discussed and learnt from within the clinical staff team.

Although the practice participated in quality improvement work, this tended to be led by the clinical commission group.

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.