

Flixton Road Medical Centre

Inspection report

132 Flixton Road
Urmston
Manchester
Lancashire
M41 5BG

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires improvement 
Are services safe?	Requires improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Requires improvement 

Overall summary

This practice is rated as Requires improvement overall. (Previous rating January 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

The population groups in effective were rated good overall.

The population groups in the responsive domain were all rated good.

We carried out an announced comprehensive inspection at Flixton Road Medical Centre on 22 October 2018 as part of our inspection programme

At this inspection we found:

- There were systems in place to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. However, we saw examples where care and treatment had not been delivered according to evidence-based guidelines.
- Systems to manage read coding, prescribing, medical alerts and care planning required improvement in order to ensure consistency and safety.
- The systems to manage medicines safely were not consistently applied.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

- Patients found the appointment system easy to use and reported that they could access care when they needed it.
- The governance structure did not encourage whole team working. Clinical discussions regularly took place but were not attended by nurses. However, communication about changes or news at the practice was disseminated weekly to reception and nursing staff by newsletter.
- There was a focus on continuous learning and improvement at all levels of the organisation and the practice supported trainee GPs.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Improve meeting minutes to ensure that consistent information is channelled from one meeting to another.
- Improve whole-team working.
- Improve identification of carers
- Improve risk management overall

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

Older people	Good 
People with long-term conditions	Good 
Families, children and young people	Good 
Working age people (including those recently retired and students)	Good 
People whose circumstances may make them vulnerable	Good 
People experiencing poor mental health (including people with dementia)	Good 

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser.

Background to Flixton Road Medical Centre

Flixton Road Medical Centre is situated in a two-story converted house and the practice formed in 2012 when two single handed GPs merged. The practice provides General Medical Services commissioned by Trafford Clinical Commissioning Group (CCG) to 5321 patients.

Regulated activities of Diagnostic and Screening Procedures, Family Planning, Maternity and Midwifery Services, Surgical Procedures and Treatment of Disease, Disorder or Injury are delivered from 132 Flixton Road, Urmston, Manchester.

The practice is situated in an area at number eight on the scale of deprivation (where the worst is one and the best is 10) and the population is mainly white British. People living in the least deprived areas tend to live longer than those in the most deprived areas.

The practice website can be found at

There are two male GP partners and two female trainee GPs. There are two practice nurses and a reception/administration team supported by a Practice Manager.

The practice is open Monday to Friday 8am until 6.30pm. On weekend mornings the building is used by Trafford Primary Health to offer Trafford patients an appointment with a Trafford Nurse or GP. In addition, when the practice is closed, patients are directed to the out of hours service provided by Mastercall.

Appointments are available at various times during the day and can be booked in person, by telephone or on line.

Are services safe?

We rated the practice as Requires Improvement for providing safe services.

The practice was rated as requires improvement for providing safe services because :

- Clinicians did not consistently act on safety alerts
- Clinicians did not consistently act according to clinical guidelines
- Clinical coding required improvement
- Medicines management was not failsafe
- Patients did not consistently receive copies of their care plans
- There was no protocol for the management of high risk medicines

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- We saw that monitoring occurred within the practice.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis and had alerted patients to the dangers by way of literature in the waiting room.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- The system for sharing information with staff, patients and other agencies to enable them to deliver safe care and treatment was not failsafe. Administrative staff, nurses and GPs worked mostly in silo.
- Care plans were only completed for patients who were high risk and they were not offered a printed copy of their care plan.
- There was no formal sharing of information between GPs and nursing staff. Nurses did not attend formal clinical meetings.
- The information needed to deliver safe care and treatment was not always effective. Clinical coding required improvement.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The systems for appropriate and safe handling of medicines required improvement.

- There was no formal review of antibiotic prescribing to support good antimicrobial stewardship in line with local and national guidance. Guidance was not always followed in the prescribing of antibiotics.
- We saw an example where the practice knew action was required following advice from the medicines management team, but action had not been taken.

Are services safe?

- The management of controlled drugs was driven by medicines management and no internal monitoring was done by the practice. The practice was unaware of higher than average prescribing of hypnotic medicines (medicines prescribed to sedate or calm).
- There was no formal process to disseminate, log and review whether appropriate action was taken when medical alerts were received.
- There was no protocol or policy in place for the management of high risk medicines. The practice said they review this and put a policy in place.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to most safety issues with the exception of medicines management.
- The practice monitored and reviewed safety using information from a range of sources with the exception of medicines management.

- There was no risk assessment of emergency medicines.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Significant incidents were well recorded and reviewed regularly and there was evidence to support this.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice specifically around incidents and complaints.
- The practice acted on and learned from external safety events with the exception of medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice as Good for providing effective services overall and across all the population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice but these were not implemented consistently. We saw that clinicians assessed needs and delivered care and treatment mostly in line with current legislation, standards and guidance.

Assessments were supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were assessed including their clinical needs and their mental and physical wellbeing using a Trafford-wide template.
- Care planning was limited to patients with complex care needs. Patients with long term conditions such as asthma and chronic obstructive pulmonary disorder (COPD) did not routinely receive copies of their care plans.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- All referrals to other services were monitored by the reception team with dual processes to ensure that no referrals were missed. We reviewed the log that had been introduced following participation within Productive General Practice and saw a good system in place.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs.
- The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care and treatment 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.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, COPD, atrial fibrillation and hypertension. However, exception rates for COPD and asthma were higher than the local and national average. Patients can be exception reported from individual indicators if they do not attend appointments or if they decline treatment or investigations. We discussed this during the inspection and found that insufficient clinical coding and/or inconsistent protocols could be a contributor.
- Despite the higher than average exception rates for COPD the practice's performance on quality indicators for long term conditions was in line with, or higher than, local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were higher than the target percentage of 90%. Nursing staff were pro-active in recalling parents of children who had missed immunisation appointments at the practice.
- The practice had arrangements for following up attendance of children's appointments following a failed appointment in secondary care.
- The medical team was aware of "milk ladder" and treatment options so that babies with cow milk protein problems could be managed where possible within the practice. (The milk ladder is a specific tool used when there is possible or probable milk allergy).

Are services effective?

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

- 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 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. However, we noted that preferred place of death was not something that was discussed or recorded.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Clinical staff knew the patients well and reception staff knew how to escalate any concerns about vulnerable patients.

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

- 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. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- There were clinical coding issues on patients with depression that needed to be rectified.

- The practice offered annual health checks to patients with a learning disability.
- The practice's performance on quality indicators for mental health (including people with dementia) was in line with, or higher than the CCG and national average as were the exception rates.

Monitoring care and treatment

The practice was involved in quality improvement and carried out clinical audit. Where appropriate, clinicians took part in local and national improvement initiatives.

- We saw many examples where the practice reviewed the effectiveness and appropriateness of care provided and made improvements.
- The practice engaged in the Productive General Practice programme and reviewed areas such as the Choose and Book referral process, room layout and stock maintenance and patients who attended more than necessary for appointments.
- The practice submitted a number of audits that had been undertaken with improvements identified. However, there was no clinical audit plan.

Effective staffing

All staff had, or were provided, with knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. Reviews were mostly nurse led with the input of GPs when required.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff if their performance was poor or variable.

Are services effective?

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment, although some improvements were necessary.

- 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 where necessary.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents.
- They shared information and liaised with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. However, there was a lack of evidence in care planning for patients who were not in the severe or complex category and patients with long term conditions such as asthma or diabetes were not routinely given a copy of their care plan.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. However, end of life discussions did not include preferred place of death.

Helping patients to live healthier lives

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

- 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and offered patient education evenings.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were above local and national averages for questions relating to kindness, respect and compassion.
- The staff at the practice were proud to report three generations of patients continuing to be cared for by these GPs.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice had identified carers through questioning and provided links to carers associations and support within the community. However, currently only 33 patients were identified as carers which was less than 1% of the patient population. Many who were asked did not respond as seeing themselves as a carer.
- The practice's GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided care coordination via Trafford Care Co-Ordination services for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP and GPs supported patients in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice dependent on the reason.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. We saw alerts on patient records that highlighted any risks.
- All parents or guardians calling with concerns about a child under the age of 16 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care
- The practice did not partake in the extended hours' initiative. Early morning and late evening appointments were available two days a week at the practice as part of the hub.
- Appointments were available at four hubs across the neighbourhood on Saturday and Sunday mornings where patients could see a GP or a nurse.
- Phlebotomy services were available at all the hubs.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances such as homeless people, travellers and/or those with a learning disability.
- Patients with a learning disability were invited in annually for a review and home visits were undertaken to suit the need of the patients.
- People in vulnerable circumstances were easily able to register with the practice.
- Interpreters were available for patients whose first language was not English. One of the GPs was trained in using sign language.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice liaised with social services, community matrons, community mental health teams and district nurses and a dementia service in the local area to co-ordinate patient care.

Are services responsive to people's needs?

- The practice communicated with two specific charities in the area supporting younger patients with depression and anxiety.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practice's GP patient survey results were above local and national averages for all questions relating to access to care and treatment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice complaint leaflet referred patients to the Ombudsman if they were not happy with the response from the practice but the Care Quality Commission was not cited as an option of contact.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as Requires Improvement for providing a well-led service.

The practice was rated as requires improvement for providing a well-led service because processes in place did not ensure safety overall. Governance arrangements did not encourage whole team working and GPs and nurses worked in silo. Policies and procedures needed review to ensure they were being implemented and all practice staff were working in a consistent manner.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the wider challenges within the community and were addressing them. However they had not identified high exception reporting and high hypnotic prescribing within the practice.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the current needs of patients.

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams although discussions were mostly informal and teams continued to work mostly in silo.

Governance arrangements

The responsibilities, roles and systems of accountability were in place to support good governance and management. However, not all systems in place were completely effective.

- Structures, processes and systems to support good governance and management were clearly set out and understood. Some systems and ways of working needed to be reviewed to ensure they remained effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety but some of these required review.

Managing risks, issues and performance

The processes for managing risks, issues and performance were not always effective.

Are services well-led?

- The processes to identify, understand, monitor and address current and future risks including risks to patient safety required review to ensure they remained effective.
- The practice had processes to manage current and future performance. Practice leaders were aware of incidents, and complaints but there was no effective review of medical alerts to ensure they were being managed appropriately.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. However, information was not always acted on in a timely way.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

Appropriate and accurate information was available to staff at the practice.

- Quality and sustainability were discussed in clinical meetings but only between the GPs. Whole staff meetings were held quarterly but did not follow a standard agenda and did not always discuss significant incidents.
- Clinical meetings were mostly informal and not attended by practice nurses. There was a lack of evidence that all necessary information was disseminated as standard, for example in relation to safety alerts.
- The practice used information technology systems to monitor and improve the quality of care. However, some identified weaknesses, such as responses to safety alerts, had not been addressed.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- The practice submitted data or notifications to external organisations as required.

- There were clear arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The service was transparent, collaborative and open with stakeholders about performance.
- There was a patient participation group. However, the number of members was not representative of the whole population and the practice was aware of the need to change this.
- Patient education evenings were offered.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Medical students and GP trainees were mentored at the practice.
- The practice nurses were training and mentoring a new nurse who was new to general practice.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints to learn and make improvements to the services offered.
- Staff said there was protected time for learning.

Please refer to the evidence tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of diseases	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: There was a lack of evidence that safe monitoring and action was occurring in the management of medicines. There was a lack of evidence that care planning was taking place for patients who were not in the severe or complex category. Patients with long term conditions such as asthma or diabetes were not routinely given a copy of their care plan. The processes around communication and dissemination of patient safety alerts were not failsafe. Clinical coding required improvement There was no arrangement to monitor exception reporting. There was no protocol or policy in place for the management of high risk medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: Insufficient clinical coding and inconsistent protocols had a negative effect on patient records and ultimately their long term care. Teams worked in silo and information was not

This section is primarily information for the provider

Requirement notices

consistently disseminated. Staff meetings did not follow structured agendas to ensure a consistent flow of information. There was no formal process to monitor and take action on patient safety alerts. There was no plan of future clinical audit. The patient participation group was not reflective of the patient population. The processes to identify, understand, monitor and address current and future risks including risks to patient safety required review to ensure they remained effective.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
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