

Peel Hall Medical Practice

Quality Report

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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 service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Requires improvement 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Peel Hall Medical Practice on 21 July 2015. The overall rating for the practice was requires improvement with the key questions of safe and well-led rated as requires improvement. The full comprehensive report on the July 2015 inspection can be found on our website at <http://www.cqc.org.uk/location/1-526710208>.

This inspection was an announced comprehensive inspection carried out on 14 August 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 21 July 2015. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

- At our inspection in July 2015, we found that systems for recording significant events were lacking. At this

inspection, we saw that a comprehensive incident reporting form had been introduced and a system for sharing and reviewing events was in place although this system was not always followed or sufficiently documented.

- The practice had systems to reduce risks to patient safety. The system for securely storing and monitoring loose prescriptions in the practice had been improved since our last inspection and a new cleaning record for clinical equipment was in place. At our inspection in July 2015, we found that the system for managing patient safety alerts was insufficient; however, at this inspection we found that this had improved.
- The practice was able to demonstrate safe staff recruitment although there was a lack of some suitable checks for a recent locum GP working in the practice.
- The practice was clean and tidy and an infection prevention and control (IPC) audit had been carried out. However, the practice lacked some policies and procedures for infection prevention and control and there was no record of IPC training for some staff.

Summary of findings

- The practice had copies of risk assessments for the premises and all building safety checks were in place although there was evidence of insufficient risk assessment for staff working. Recruitment processes and procedures did not allow for non-clinical staff to be risk-assessed for the role and there was no confidential health questionnaire issued to staff on recruitment.
- The practice had adequate arrangements to respond to emergencies and major incidents although there had been no review of those emergency medicines held by the practice. The practice business continuity plan was not complete.
- At our previous inspection, we found that staff had not been trained to the appropriate level for safeguarding children and vulnerable adults. At this inspection, we saw evidence that clinical staff had trained to the appropriate safeguarding level although records of non-clinical staff training were sometimes lacking. We found that all staff we spoke to had a good knowledge of their responsibilities regarding safeguarding. Meetings with other health professionals for safeguarding discussions were often informal and not minuted.
- Staff were aware of current evidence based guidance. Clinical staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment although records of non-clinical staff training were incomplete. There was no management overview of staff training.
- The practice had introduced a programme of staff appraisal since our inspection in July 2015 and all staff had received an appraisal; however, records of discussion at nurse appraisals were lacking and lacked a personal development plan to guide future training.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. We saw that the system for documenting patient complaints had improved since our last inspection.
- Patients we spoke with told us they liked the practice morning walk-in surgeries with GPs. They understood

that this meant that they did not always see the same GP and that they needed to wait sometimes. Patients could also book appointments with a named GP up to two weeks in advance.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management. There were policies and procedures in place to govern activity although these were insufficient for some areas of practice service delivery and some needed review. Not all staff we spoke to were able to access the policies when asked.
- There was no overarching governance framework to support the delivery of the strategy and good quality care. Quality improvement was not embedded in the practice; there was no set agenda of quality improvement items for staff meetings.
- The practice encouraged feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The area where the provider must make improvement is:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the practice should make improvements are:

- Review the practice process for identifying significant events and follow the significant event procedure to review actions taken as a result of events.
- Consider what medicines are held by the practice for use in medical emergencies.
- Improve the clinical staff appraisal process to document discussion at appraisal and produce staff development plans.
- Improve the overview of training, particularly to demonstrate all staff have undertaken safeguarding training and training relevant to their role.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

At our previous inspection, we found that the practice required improvement for providing safe services. At this inspection, we saw that many improvements had been made in the areas of safeguarding training, the significant event reporting process, the management of patient safety alerts, blank prescription security and equipment cleaning schedules.

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an improved system for reporting and recording significant events although this system was not always followed. We saw evidence that indicated that the practice did not always take the opportunity to record incidents using the significant event recording system. When things went wrong, patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Patient safety alerts were well-managed and blank prescriptions held securely. Meeting minutes did not always record discussion of patient safety alerts but we saw evidence of actions taken.
- Staff demonstrated that they understood their responsibilities and all clinical staff had received training on safeguarding children and vulnerable adults relevant to their role. All staff interviewed demonstrated a good understanding of safeguarding.
- The practice was clean and tidy and an annual infection prevention and control (IPC) audit was carried out, although the practice IPC policies and audit tool were incomplete.
- Practice recruitment procedures were safe although there was evidence that the procedure had not been followed in the recruitment of a locum GP.
- The practice had copies of risk assessments for the premises and all building safety checks were in place.
- The practice had adequate arrangements to respond to emergencies and major incidents although there had been no review of those emergency medicines held by the practice.

Good



Summary of findings

Are services effective?

At our last inspection in July 2015, we indicated that some improvements were needed in staff training for the areas of patient consent to treatment and understanding the Mental Capacity Act, also for the selection of audit activity and staff appraisal. We saw at this inspection that improvements had been made.

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment although records of non-clinical staff training were incomplete and lacked management overview.
- There was evidence of appraisals and personal development plans for staff. Clinical staff had received a development review as part of their revalidation although details of discussion and forward development plans were lacking.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved and there were regular, minuted meetings to discuss these patients.

Good



Are services caring?

At our previous inspection in July 2015 we rated the practice as good for providing caring services and this was unchanged at this inspection.

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care provided by the GPs although lower than others for aspects related to consultations with nurses.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. One patient told us that the practice had "saved her life".
- Information for patients about the services available was accessible. The practice made efforts to provide information in other languages where possible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Summary of findings

Are services responsive to people's needs?

The practice was rated as good at our last inspection although we identified that some improvement was needed in the documentation of patient complaints. We saw that this had improved at this inspection.

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. They had appointed a practice nurse to work with vulnerable patients to provide a service in their own homes.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said that they liked the practice walk-in surgeries so that they could see a GP on the same day. They understood that this meant that they did not always see the same GP and that they needed to wait sometimes. However, some working patients found it difficult to attend. Patients could also book appointments with a named GP up to two weeks in advance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples we reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice was rated as requires improvement at our last inspection in July 2015. We identified concerns related to the governance and leadership of the practice. Whilst we recognised at this inspection that there had been improvements in some areas, we saw that governance systems at the practice were still lacking.

The practice is rated as requires improvement for being well-led.

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients and staff told us that they strived to fulfil this. However, there was a lack of a documented business development plan.
- There was a leadership structure and staff felt supported by management. GPs had leads in specific areas of patient care however, clinical leadership of infection prevention and control was not in place. The practice had policies and procedures to

Requires improvement



Summary of findings

govern activity although there was a lack of policies and procedures for some areas of practice service delivery and some policies needed review. Not all staff we spoke to were able to access the policies when we asked them to.

- The practice held regular governance meetings although these meetings did not always include all staff and meeting minutes were not comprehensive. There was insufficient detail recorded to evidence discussion and share learning.
- There was no overarching governance framework to support the delivery of the strategy and good quality care. Quality improvement was not embedded in the practice; there was no agreed audit programme or set agenda of quality improvement items for staff meetings.
- Staff had received inductions although there was no mandatory training specified and there was no management overview of staff training or established training programme. Annual performance reviews had been carried out however, clinical reviews lacked details of discussions and there was no action plan for future personal development.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not comprehensive. Non-clinical staff had not generally been risk assessed for carrying out the roles for which they were employed and no member of staff had been issued with a confidential health questionnaire on recruitment to ensure that their health needs were met.
- The provider was aware of the requirements of the duty of candour. In the examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents although there was insufficient evidence to show that information was always shared appropriately with staff. We saw evidence of action taken as a result of patient safety alerts.
- The practice encouraged feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement although this was not always well managed. Clinical staff confirmed that their training was a priority and said it was built into rotas; however, there was no management oversight of this. We saw that clinical staff update training to maintain their professional competencies was all up to date.

Summary of findings

- GPs who were skilled in specialist areas used their expertise to offer additional services to patients. The principal GP was trained in the management of diabetic patients and offered a specialist service for patients at the practice.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Older people with long-term conditions who could not come to the practice were reviewed in their own homes.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. The practice shared patient care plans with the out of hours service and the ambulance service.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. Isolated or lonely people were referred to a volunteer community care service for support and friendship.
- The Citizen's Advice Bureau had a telephone in a dedicated area of the practice that gave direct access to this service for patients.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The principal GP was specialised in the care of diabetic patients and offered an extended care service for diabetic patients including initiating insulin. Nurses had also trained in order to support these patients.

Summary of findings

- One of the practice nurses had a particular interest in the management of patients with respiratory disease. She had introduced a monthly meeting for patients with lung conditions and their families to provide patients with support and further information on these conditions.
- Performance for diabetes related indicators was comparable to the local and national averages. For example, blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 78% of patients had well controlled blood sugar levels, the same as the CCG and national averages. Also, the percentage of patients with blood pressure readings within recommended levels (150/90 mmHG or less) was 90% the same as the CCG average and comparable to the national average of 88%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. Staff worked proactively with these patients to prevent unplanned hospital admissions.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found 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.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. All children needing a GP appointment were seen on the same day.

Good



Summary of findings

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice's uptake for the cervical screening programme was 73%, which was lower than the local average of 79% and the national average of 81%. The practice had systems in place to continue to encourage patients to attend for this screening.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours on a Thursday evening.
- The practice worked with other local surgeries to provide further evening surgeries until 8pm on weekdays and on Saturday mornings.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice sent text message reminders of appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- One of the practice nurses worked in the community with vulnerable patients to ensure that their health needs were met and to proactively manage their care and treatment.
- 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 offered longer appointments for patients with a learning disability and for those with complex needs. They had a policy to telephone patients to remind them of appointments where it was appropriate.

Good



Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients. A support worker from the young drug users support group visited the practice to care for young patients experiencing drug misuse and a member of the community team responsible for caring for patients who had experienced domestic violence visited the practice regularly.
- Some staff had trained in accessible information standards to develop an understanding of ways to ensure that disabled patients received information in formats that they could understand, and received appropriate support to help them to communicate.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- Patients at risk of dementia were identified and offered an assessment. A total of 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the local and national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. All these patients were invited to the practice for an annual health review.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 92% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the local average of 86% and national average of 89%.

Good



Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

What people who use the practice say

The national GP patient survey results were published on 7 July 2017. The results showed the practice was performing in line with local and national averages for some areas of the survey but lower than average for others. A total of 382 survey forms were distributed and 87 were returned (23%). This represented 1% of the practice's patient list.

- 76% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 84% and the national average of 85%.
- 53% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 52% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 77%.

This survey was carried out before the practice introduced daily walk-in clinics for patients in order to try to address patient difficulties in booking appointments with GPs.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards, six of which were positive about the standard of care received. One card referenced difficulties with getting an appointment but others praised the new walk-in clinics and said that they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They said that they were always “well looked after” by everyone at the practice and that the service was “wonderful”.

We spoke with eight patients during the inspection. All eight patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One patient told us that the practice had “saved her life”.

Areas for improvement

Action the service **MUST** take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service **SHOULD** take to improve

- Review the practice process for identifying significant events and follow the significant event procedure to review actions taken as a result of events.

- Consider what medicines are held by the practice for use in medical emergencies.
- Improve the clinical staff appraisal process to document discussion at appraisal and produce staff development plans.
- Improve the overview of training, particularly to demonstrate all staff have undertaken safeguarding training and training relevant to their role.

Peel Hall Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and two additional CQC inspectors.

Background to Peel Hall Medical Practice

Peel Hall Medical Practice is situated at Forum Health, Simonsway, Wythenshaw, M22 5RX. It is housed in a purpose-built health and community services building and has occupied these premises since 2006. All patient treatment rooms are situated on the ground floor of the surgery and access to the first floor is by way of a lift or stairs.

The practice is situated in the centre of Wythenshaw and has limited patient parking. Close public pay-and-display parking is available and there is easy access to public transport.

The practice is part of the NHS Manchester Clinical Commissioning Group (CCG) and services are provided under a general medical service (GMS) contract with NHS England.

Services at the practice are provided by the principal male GP assisted by two male and five female salaried GPs. There is a clinical pharmacist, two practice nurses and an assistant practitioner working at the surgery and a practice manager, an assistant practice manager and eight members of reception and administration staff.

The surgery is open to patients between 8am and 6.30pm on weekdays with extended hours appointments offered

on Thursday evenings until 7.30pm. The practice is closed for two hours on a Wednesday between 1pm and 3pm. The practice offers a walk-in surgery every day from 8.30am to 10am where patients can attend without an appointment. Further bookable appointments are from 2pm to 5pm every afternoon. The practice is also part of a local federation of practices that served about 45,000 patients. Through this arrangement, patients can also access appointments at one of three different locations, including Peel Hall, from 6pm until 8pm on weekdays and from 8.30am to 12 noon on Saturday. In addition to pre-bookable appointments that can be booked up to two weeks in advance, urgent appointments are also available for patients that need them. Telephone appointments and home visits are also available as well as online booking.

When the practice is closed, patients are able to access out of hours services offered locally by telephoning NHS 111.

The practice provides services to 9053 registered patients. There are lower numbers of patients aged over 65 years of age (12%) than the national average (17%) and higher numbers of patients aged under 18 years of age (25%) than the national average (21%). There are more patients aged between 25 and 39 years of age than the national average; 26% compared to 21%.

Information published by Public Health England, rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Life expectancy is lower for males as the national figure; 74 compared to 77 years of age, and also lower for females; 78 compared to 83 years of age. There are 61% of patients with a long-standing health condition compared to the national average of 53%. A total of 9% of patients are unemployed compared to the national average of 4%.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Peel Hall Medical Practice on 21 July 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement and requirement notices were issued in relation to safe care and treatment, good governance and safeguarding service users from abuse. The full comprehensive report following the inspection in July 2015 can be found on our website at <http://www.cqc.org.uk/location/1-526710208>

We undertook a follow up comprehensive inspection of Peel Hall Medical Practice on 14 August 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 August 2017. During our visit we:

- Spoke with a range of staff including the principal GP, one salaried GP, the practice nurses, the clinical pharmacist, the practice manager, the assistant practice manager and an additional member of the practice administration team.
- Spoke with eight patients who used the service one of whom was a member of the practice patient participation group (PPG).

- Observed how staff interacted with patients in the waiting area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

At our previous inspection on 21 July 2015, we rated the practice as requires improvement for providing safe services. We found that records of significant events were lacking and that the management of patient safety alerts and medicines in the practice was not sufficient. The practice business plan was lacking some detail and records of staff immunisation status were incomplete. There were no records kept for the cleaning of clinical equipment and staff were not trained to the appropriate level for safeguarding vulnerable patients.

At this inspection, we found that improvements had been made in these areas.

Safe track record and learning

There was an improved system for reporting and recording significant events although we saw evidence that this system was not always followed or sufficiently documented.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system which supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a verbal or written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where we were told significant events were discussed. However, where incidents were recorded as being discussed, they were not able to be identified from meeting minutes. Records of significant events were stored on the practice shared drive although some staff we spoke to were unable to show us these. Although dates were set for review of any actions taken as a result of significant events, there were no records of these reviews being carried out. We saw

evidence of two significant events shared and discussed at a meeting with other local practices that had not been documented as significant events within the practice.

- There was evidence that patient safety alerts were well-managed and we were told that these were also discussed at clinical staff meetings. However, minutes of these meetings lacked details of discussion to evidence and share learning.
- We saw evidence that action was taken to improve safety in the practice. For example, following a patient safety alert, the practice had reviewed all pregnant women taking a certain medicine to assess the risks of this. Dates for further review had also been planned. The practice had also improved the management of patients referred urgently to the hospital under the two-week-wait rule following a significant event in the practice.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The principal GP was the practice lead for safeguarding. We were told that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. We noted that there were no formal safeguarding meetings to review children who were on the safeguarding register; however, health visitors were situated in the same building and the practice told us that ad hoc communication with them was good.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding although there was no documented evidence that four non-clinical staff had received training on safeguarding children and vulnerable adults. GPs were trained to child protection or child safeguarding level three and nurses to level two. The local clinical commissioning group (CCG) link nurse attended a meeting with clinical staff at the practice twice a year to provide updates to policy and procedure and clinical staff training.
- Notices in the waiting room and in clinical rooms advised patients that chaperones were available if

Are services safe?

required. The practice used clinical staff to act as chaperones who 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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice infection prevention and control (IPC) policy gave the practice manager as the IPC lead and one of the nurses as the clinical lead. However, both nurses told us that the principal GP was the IPC clinical lead. The practice manager had conducted an IPC audit and we saw that identified actions had been addressed or were scheduled for future action. There was an IPC protocol in place; however, there was no evidence that all staff had received training or annual updates in IPC. Records of training indicated that only one non-clinical, one clinical and one GP staff member had trained since October 2015. Staff we spoke to had trained in IPC and demonstrated a good knowledge of the subject.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice clinical pharmacist carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. The other practice nurse had recently completed training for this

and expected to be able to prescribe for patients in the near future. Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. At the time of our inspection, we saw that the PGD for administering Hepatitis A was out of date. The practice supplied us with a signed copy of an updated PGD following our visit. The assistant practitioner had trained to administer vaccines and medicines, and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed four personnel files, including one for a locum GP. We found that there was no evidence of satisfactory conduct in previous employments in the form of references in one of the clinical staff files and for the locum GP. The practice told us that the staff member had previously been employed by the practice before leaving for a period of three to four years. There was evidence that some appropriate recruitment checks had been undertaken prior to employment. For example, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS for clinical staff. However, the only documents in the file for the locum GP was proof of professional registration, proof of current medical indemnity and a CV. There was no proof of identity in the files and there was no DBS check or risk assessment done for the non-clinical staff member. The practice had guidelines in place for the recruitment and selection of staff which indicated that these pre-employment checks should be carried out.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of

Are services safe?

substances hazardous to health and infection control and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. Staff were multi-skilled and the rota allowed for them to experience different roles on a rolling programme.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency and panic buttons in all of the treatment rooms and reception.

- All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had not risk-assessed the medicines that it held for use in emergencies or reviewed why certain medicines were not stocked.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit was available and an accident book was situated in a secure area of the community services reception in the building.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. We saw that the plan needed updating including the flowchart for cascading information to staff and emergency contact numbers for staff and clinical suppliers.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in July 2015, we rated the practice as good for providing effective services. The practice is still rated as good for providing effective services.

We saw that although the appraisal system for non-clinical staff had improved, there were continued improvements to be made, and although staff training had been addressed, no documented overview of training was in place.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015/16 were 95.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 94.2% and national average of 95.3%.

Exception reporting for 2015/16 was 12.2% which was the same as the local CCG level and higher than the national average of 9.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was comparable to the local and national averages. For

example, blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 78% of patients had well controlled blood sugar levels, the same as the CCG and national averages. Also, the percentage of patients with blood pressure readings within recommended levels (150/90 mmHG or less) was 90% the same as the CCG average and comparable to the national average of 88%.

- Performance for mental health related indicators was generally higher than or comparable with the local and national averages. For example, 92% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the CCG average of 86% and national average of 89%. Also, 83% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the CCG average of 81% and national average of 84%. The practice had not exception reported any patients for this indicator.

There was evidence of quality improvement including clinical audit although a rolling programme of regular clinical audit and re-audit was not established and topics for audit were selected on an ad hoc basis:

- There had been three clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included improvements made to the process of monitoring patients who were taking blood-thinning medicines to ensure that they were safely and effectively managed.
- The practice, together with the local federation of practices, employed a clinical pharmacist. This clinician reviewed prescribing for practice patients; specifically patient repeat prescribing, patients on certain identified medicines and practice prescribing systems. She liaised with community pharmacists and, as a result of changes made to repeat medicines ordering processes, helped to achieve considerable savings in the practice's prescribing spend. She also reviewed changes to medicines made for patients recently discharged from hospital and liaised with doctors, patients, hospital and community pharmacists as necessary to ensure that they were correctly prescribed.
- The practice GPs met informally daily after the morning surgeries to discuss patients and to review referrals

Are services effective?

(for example, treatment is effective)

made by GPs in training and locum GPs. They told us that peer review was an important part of their practice to ensure that learning was shared and standards maintained.

Information about patients' outcomes was used to make improvements such as better diagnosis and treatment of patient urinary tract infections.

Effective staffing

- The practice had an induction programme for all newly appointed staff. New staff were supplied with a handbook that contained some work-related policies and a log-on for practice online training. However, there was no mandatory list of training to be completed within a set timeframe and the staff induction checklist used by the practice was not comprehensive. The practice purchased an online training system in 2015. This training covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We saw evidence that one new staff member had completed this training within three months of starting at the practice
- The practice could demonstrate how they ensured role-specific training and updating for relevant clinical staff. For example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at practice meetings.
- The practice told us that the learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. We saw that staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. Non-clinical staff had a performance development review every year. At the time of inspection, these reviews were approximately three months overdue because of staff sickness. The practice told us that they would address this as soon as possible although they said that the "open door" nature of the practice ensured

that staff could access the practice management team at any time. The practice nurses had both been revalidated in 2017. The principal GP had reviewed their performance in order to complete the necessary assurances needed for revalidation. The practice told us that this constituted their appraisal, however, there was no record of the discussions and no training or action plan developed from these meetings for future needs.

- In-house training for basic life support was provided for all staff which they had attended. We also saw that clinical staff had undertaken training on the Mental Capacity Act and consent since our last inspection.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We saw that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs although meeting minutes sometimes lacked detail to sufficiently identify the patients discussed.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Meeting minutes for these patients were comprehensive. They shared information for these patients with the out of hours service and the ambulance service.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, drug and alcohol cessation and patients experiencing memory loss.
- The practice provided advice, support and treatment to patients who wanted to stop smoking.
- A service for young patients who were drug users visited the practice to see patients when needed.

The practice's uptake for the cervical screening programme was 73%, which was lower than the CCG average of 79%

and the national average of 81%. The practice told us that they took every opportunity to encourage patients to attend for this screening. There was a policy to offer written reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer by displaying leaflets in the practice waiting areas.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to one year olds and five year olds were above the 90% expected standard at 92% for both. However, uptake rates for two year olds only achieved 87%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, NHS health checks for patients aged 40–74 and health checks for patients aged over 70 years of age. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

At our previous inspection in July 2015, we rated the practice as good for providing caring services. The practice is still rated good for providing caring services.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

Of the seven patient Care Quality Commission comment cards we received, six were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They said that they were always "well looked after" by everyone at the practice and that the service was "wonderful". One card commented only that it was impossible to get an appointment.

We spoke with eight patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. One patient told us that the practice had "saved her life".

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs. For example:

- 92% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG and the national average of 86%.

- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national average of 95%
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and the national average of 86%.

Results for consultations with nurses were lower than local and national averages. For example:

- 85% of patients said the nurse was good at listening to them compared with the CCG and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and the national average of 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 74% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were higher than local and national averages when they related to consultations with GPs and lower when related to those with nurses. For example:

Are services caring?

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and the national average of 82%.
- 85% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG and the national average of 90%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice documented that they had reviewed the results of the survey published in July 2016 and had discussed them with the patient participation group (PPG). They said that they had focused on areas of the survey where the results were poorest in relation to the appointment and the telephone systems and had celebrated where they were doing well.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We spoke to a patient who confirmed that this had worked well when it was needed. The practice website had a translation service available.
- At the time of inspection, the practice was in the process of arranging for new patient information to be translated into Polish.
- The Choose and Book service was used with patients when appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. Practice clinical staff were able to refer to a volunteer community care service for isolated or lonely people. This enabled people to access a programme of different group activities and support services. The practice also participated in a pilot project with the Citizens' Advice Bureau (CAB). They had a telephone in a dedicated area of the practice that gave direct access to this service. Patients could discuss social care needs and make further appointments with the CAB or other identified social care services. Staff at the practice directed patients to this service when it was indicated. The CAB gave the practice feedback on the use of the service every month.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 99 patients as carers (1.1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, their usual GP contacted them if they felt it to be appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in July 2015, we rated the practice as good for providing responsive services. The practice is still rated good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Thursday evening until 7.30pm for working patients who could not attend during normal opening hours. The practice acted as a hub for the local federation of practices serving approximately 45,000 patients. Members of the practice administration staff worked to provide a service that offered appointments every weekday evening from 6pm to 8pm to these patients. The practice GPs worked with the other local GPs to provide surgeries. Appointments were also offered through this arrangement on Saturday mornings from 8.30am to 12 noon. The practice premises was used as the hub for these federated appointments once every three weeks.
- There were longer appointments available for patients with a learning disability and for those with complex needs or needing translation services.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. One of the practice nurses had previously worked as a community, district nurse. She spent four of her eight working sessions at the practice visiting and caring for housebound and vulnerable patients. She also contacted vulnerable patients recently discharged from hospital and arranged to visit where necessary. She told us that her work was responsible for a reduction in unplanned hospital admissions for vulnerable patients.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and told us that they would also telephone patients to remind them where they felt it was appropriate.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available. The practice was situated in purpose-built premises with automatic doors and a lift to aid access to the upper floors.
- Some staff had trained in accessible information standards to develop an understanding of ways to ensure that disabled patients received information in formats that they could understand, and received appropriate support to help them to communicate.
- A child vaccination and immunisation clinic was held at the practice weekly to run consecutively with the health visitor child health clinic.
- The principal GP was trained in the management of diabetic patients and offered a specialist service for patients at the practice. Nurses were trained in the initiation of insulin and supported patients newly diagnosed with diabetes.
- One of the practice nurses had a particular interest in the management of patients with respiratory disease. She had introduced a local initiative for patients with lung conditions and their families, backed by the British Lung Foundation; a meeting at the practice once a month to provide patients with support and further information on these conditions.
- A member of the community team responsible for caring for patients who had experienced domestic violence visited the practice regularly to see these patients.
- A support worker from the young drug users support group visited the practice to care for young patients experiencing drug misuse.
- There were other health services in the building including a community dental practice, a service for patients with heart failure, a family planning service for people aged under 25 years of age, a treatment room service, a phlebotomy service (for taking patient blood), a speech and language service and a podiatry service for diabetic patients.
- The building was a local forum for several different organisations including a leisure centre, a café, a library, an employment meeting point and a theatre.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday and closed for two hours on a Wednesday between 1pm and 3pm. The practice offered a walk-in surgery every day from 8.30am to 10am where patients could attend without an appointment. Further bookable appointments were from 2pm to 5pm every afternoon. Extended hours appointments were offered by the practice until 7.30pm on Thursday evening. The practice was also part of a local federation of practices that served about 45,000 patients. Through this arrangement, patients could also access appointments at one of three different locations, including Peel Hall, from 6pm until 8pm on weekdays and from 8.30am to 12 noon on Saturday. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for patients that needed them. Telephone appointments were also available as well as online booking.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was notably lower than local and national averages.

- 63% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average and the national average of 76%.
- 23% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 71%.
- 63% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 81% and the national average of 84%.
- 64% of patients said their last appointment was convenient compared with the CCG average of 76% and the national average of 81%.
- 53% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 31% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

These results were from the most recent GP patient survey that was conducted between January and March 2017. The practice had considered the results from the previous

patient survey published in July 2016 which were very similar and had reviewed ways to address them. They told us that attempts to address problems with the telephone system in the building had been unsuccessful. In order to improve patient access and because the telephone system could not be improved, they had introduced open access surgeries every weekday from 8.30am to 10am in April 2017. Patients told us on the day of the inspection that they liked these new surgeries even though they sometimes had to wait a considerable amount of time to see a GP. We saw patient comments on our comment cards that said the same. However, one working patient told us that they found it difficult to attend these open surgeries during working hours because of the long wait.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Staff recorded patient requests for home visits and passed them to the GPs. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice. Complaints were documented appropriately.
- We saw that information was available to help patients understand the complaints system although this information was held in the reception office. There was a box on the reception counter for patient complaints and suggestions and the practice told us that they would put some information next to this box for easier patient access.

We looked at three complaints received in the last 12 months and found they had been dealt with in a timely way and with openness and honesty. Lessons were learnt from individual concerns and complaints and also from analysis

Are services responsive to people's needs? (for example, to feedback?)

of trends, and action was taken as a result to improve the quality of care. For example, following a patient complaint,

the practice ensured that all patients whose requests for repeat medications were rejected by a GP were given a reason for this and invited into surgery to see a clinician if appropriate.

Are services well-led?

Requires improvement 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our inspection in July 2015, we rated the practice as requires improvement for providing well-led services. We identified concerns related to the lack of governance systems to implement and embed quality improvement and to share information with all staff. We noted a lack of training for staff and GPs and there was no patient participation group (PPG). At this inspection, we saw that although some improvements had been made, governance systems still required improvement.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement and staff knew and understood the values. This statement was: “To work in partnership with patients by listening and responding to needs whilst promoting health and wellbeing. We will do this utilising the skills and expertise of our team, providing a quality patient experience that is timely and appropriate”.
- The practice was working with the local federation of practices and the wider clinical commissioning group (CCG) to plan and develop future services but did not have a documented succession plan or business development plan for the practice.

Governance arrangements

The practice did not have an overarching governance framework to support the delivery of the strategy and good quality care.

- Staff had allocated leads for different clinical and administrative key areas of practice, although staff were not always aware of their own roles and responsibilities. One of the practice nurses was documented as the clinical lead for infection prevention and control (IPC) but was unaware of this, and both nurses told us that the clinical lead was the principal GP. The practice manager was the other IPC lead who carried out the IPC audit, although there had been no training to enable this role to be carried out effectively and IPC policies and audit were insufficient.
- Practice specific policies were implemented and were stored on the practice shared drive. However, on the day of inspection some staff we spoke to were unable to

access these. We saw that some policies were not dated and some policies that we would expect to see were not in place. This included an information governance policy. Following our inspection, we were sent an information governance policy. This document was an overarching policy that made reference to other policies and procedures that the practice did not yet have in place. The practice told us that policies and procedures were updated and reviewed regularly.

- A comprehensive understanding of the performance of the practice was not sufficiently maintained. Clinical staff practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. We saw that significant events were sometimes discussed at clinical staff meetings although there was a lack of detail recorded to identify the events. There was no evidence of discussion for some significant events. Non-clinical staff meetings were also held every three months. We saw no documentation of discussion of significant events at these meetings. All meeting minutes failed to show that quality improvement items such as audit activity, patient safety alerts or patient complaints were regularly discussed at these meetings to evidence and share learning. Although meeting minutes and significant events were stored on the practice shared drive, some staff were unable to show us these when we asked.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements. We saw that the clinical pharmacist was carrying out medicines audits and that GPs were doing clinical audits, however, there was no management overview of or planning for audit activity.
- Online training had been organised and enabled for all staff, however, there was no oversight of this training and staff were not managed to ensure that annual mandatory training was undertaken. There was no programme or oversight of mandatory training for new staff.
- Appraisal had been introduced for clinical staff although there was no documentation of discussion during appraisal or recording of future development plans.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not comprehensive. The practice had not carried out risk assessments for staff working, except for one pregnant staff member. One of the practice nurses

Are services well-led?

Requires improvement 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

worked in the community for a large part of her role with the practice. Following our inspection, the practice sent us a policy for staff working on their own although there was no associated risk assessment. Non-clinical staff had not been checked with the Disclosure and Barring Service (DBS). (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). The practice was not using a confidential health questionnaire for staff to identify any potential risks associated with the role.

Leadership and culture

GPs told us they prioritised safe, high quality and compassionate care. Staff told us the GPs were approachable and always took the time to listen to all members of staff. The principal GP encouraged an open working environment and put time aside to meet with other GPs for informal discussion and peer review.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The principal GP encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment the practice gave affected people reasonable support, truthful information and a verbal and/or written apology.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and other members of the primary care health team to monitor vulnerable patients, although minutes lacked sufficient detail to identify the patients discussed. GPs, where required, contacted health visitors to monitor vulnerable families and safeguarding concerns although there were no formal meetings to review patients routinely.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at any time and felt confident and supported in doing so. Team social events were encouraged and supported by management.
- Staff said they felt respected, valued and supported, particularly by the GPs in the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG had formed since our last inspection and met regularly. They were consulted on changes to the practice and submitted proposals for improvements to the practice management team. For example, they had suggested that the practice make improvements to access to appointments. This supported the practice review of the GP patient survey results and the introduction of the daily walk-in surgery.
- the NHS Friends and Family test, complaints and compliments received.
- staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was participating in the pilot of the direct telephone link to the Citizens' Advice Bureau and also a new patient frailty assessment service.

The practice had a commitment to continue to improve their prescribing practice with the help of the clinical pharmacist and they had already achieved a considerable saving on prescribing due to work with local community pharmacies.

The practice told us that they planned to continue to work closely with the CCG, supporting their plans for developments for health improvements across Manchester.

Are services well-led?

Requires improvement 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The practice was a training practice for GPs in training and planned to extend this service.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The practice must comply with Regulation 17(1).</p> <p>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.</p> <p>How the regulation was not being met:</p> <p>The registered person had systems or processes in place that operated 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:</p> <ul style="list-style-type: none">• Practice governance meetings did not always include all staff and meeting minutes were insufficient to evidence discussion and share learning.• Quality improvement was not embedded in the practice; there was no agreed audit programme or set agenda of quality improvement items for staff meetings. <p>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.</p> <ul style="list-style-type: none">• Practice infection prevention and control was not comprehensively managed.• There was a lack of risk assessment for staff working.• There was no effective overview of staff training or identification of mandatory training.• Practice policies and procedures were insufficient and were not available to all staff.

Requirement notices

The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person had maintained securely such records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity or activities. In particular:

- The practice did not always carry out safe processes and procedures in the recruitment of staff.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.