Northcote House Surgery

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Northcote House Surgery on 20 April 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, actions identified to address concerns with infection control practice had not been taken.
- Significant events were not adequately managed or recorded.
- Patients were positive about their interactions with most staff and said they were treated with compassion and dignity by those staff members.
- The practice's branch location in Fenstanton had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear leadership structure, but insufficient leadership capacity and limited formal governance arrangements.
- The provider was aware of and complied with the requirements of the Duty of Candour.

The area where the provider must make an improvement is:

- Ensure appropriate security systems are in place so that only authorised practice staff can access the dispensary.
- A risk analysis must be carried out on the safe transport and storage of medicines to the branch surgery at Fenstanton.
- Ensure all emergency prescriptions issued are signed by a GP before being issued to a patient.
- Ensure that staff caring for patients have undergone a Disclosure and Barring Service check (DBS).
- Ensure all staff training deemed mandatory by the practice is up to date, including training for safeguarding.

Summary of findings

- Ensure all policies, procedures and guidance are up to date so that staff are able to operate in accordance with up to date procedures.
- The provider must have an adequate infection control system in place to ensure that patients and staff are adequately protected.
- The practice must comply with relevant Patient Safety Alerts issued from the Medicines and Healthcare products Agency (MHRA) and through the Central Alerting System (CAS).

The areas where the provider should make improvements are:

- Improve confidentiality at the front desk and in the hallway at the St Ives location as well as for phone calls.
- Ensure thermometers used to record refrigerator and room temperatures where medicines are stored are validated before use to ensure their accuracy. In addition, the automated external defibrillator must be checked and serviced at regular intervals and at least annually.
- Ensure actions from the legionella assessment are undertaken.
- Ensure effective control of substances hazardous to health is in place.
- Ensure blank prescription forms are kept securely at all times.
- Significant events, complaints, (medicines) audit results and the associated learning should be shared across practice staff teams to ensure that lessons are embedded and to prevent reoccurrence of errors.
- Ensure staff receive timely appraisals and support.
- Ensure chaperone training is available for all staff undertaking such duties.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made so a rating of inadequate remains for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

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?

Inadequate

The practice is rated as inadequate for providing safe services.

- The system in place for reporting and recording significant events was not robust and did not provide assurances that the practice was able to investigate, review, share and learn from incidents.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again. However, learning was not always shared within the practice.
- The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. The safeguarding policy was not up to date and there were gaps in safeguarding training for various members of staff other than GPs.
- Infection control management processes were not robust and there was no clear leadership on these.
- Risks to patients had been assessed and partially managed but improvement was needed in addressing further findings as well as outcomes from the legionella assessment. There was no evidence that control of substances hazardous to health (COSHH) was in place.
- Recruitment checks including checks with the Disclosure and Barring Service were not consistently undertaken. We saw evidence that one clinical member of staff had not undergone a DBS check.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were overall below local and national averages in 2014/15 but this had significantly improved in 2015/16, but this data was not yet verified at the time of inspecting or reporting.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice undertook clinical audits that demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment but were not supported enough when needing to undertake mandatory training.
- Not all staff had received up to date appraisals. We noted appraisals were due for five members of staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in January 2016 showed patients rated the practice higher than others for several aspects of care.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The front desk did not provide sufficient confidentiality with limited queuing space and the adjacent waiting room being within earshot; phone calls were being answered at the front desk and could be overheard.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was not shared with staff and other stakeholders.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

Summary of findings

- The practice had a vision to deliver high quality care and promote good outcomes for patients and staff were clear about their responsibilities in relation to this but there was no business plan incorporating a clear vision and strategy.
- There were structures and procedures in place but these were not robust enough to ensure the practice had an effective governance framework to support the delivery of the strategy and good quality care.
- There was a clear leadership structure but not all staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but these were three years old and had not been reviewed since.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data from 2014/15 showed that outcomes for patients for some conditions commonly found in older people, including osteoporosis: secondary prevention of fragility fractures, were below local and national averages. We saw data that was not yet publicly available or validated which indicated that this had improved for 2015/16.

People with long term conditions

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Nursing staff had lead roles in chronic disease management, and patients at risk of hospital admission were identified as a priority.
- The practice participated in the Quality and Outcomes Framework (QOF - is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2014/2015 performance for asthma related indicators was higher compared to the CCG and national average. With the practice achieving 100%, this was 2.4% above the CCG average and 2.6% above the national average.
- Performance for diabetes related indicators was lower compared to the CCG and national average. With the practice achieving 87.6%, this was 1.9% below the CCG average and 1.6% below the national average.

Summary of findings

- Performance for heart failure related indicators was higher compared to the CCG and national average. With the practice achieving 100%, this was 4.2% above the CCG average and 2.1% above the national average.
- Longer appointments and home visits were available when needed.
- 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

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Immunisation rates were relatively high for all standard childhood immunisations.
- Some patients told us that children and young people were not always treated in an age-appropriate way but we did not observe this during the inspection.
- The practice's uptake for the cervical screening programme was 80.0%, which was in line with the national average.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as health promotion and screening that reflects the needs for this age group.
- The practice offered early morning nurse appointments on Tuesday and Thursday morning between 7am and 8am. The practice had also provided several Saturday morning sessions with both GP and nurse appointments over the previous year but this was not a regular occurence.

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice held a register of patients living in vulnerable circumstances, including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice kept a register of patients that were carers.
- GPs carried out home visits for patients with palliative care needs.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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. .
- The practice carried out annual health checks for people with a learning disability and 15 out of 17 of these patients had received a review since April 2015.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as requires improvement in the effective domain and inadequate in the domains of safe and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- 94.1% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan, which was 7.1% above the CCG average and 5.8% above the national average. The exception reporting for this indicator was 10.5%, which was below the CCG average and national average.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they might have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. The practice had 18 registered patients with dementia of which 17 had received an annual review since April 2015.
- 19 of 25 patients with mental health needs had a care review recorded since April 2015.

Summary of findings

What people who use the service say

The National GP Patient Survey results were published in January 2016. The results showed the practice was performing above or line with local and national averages. 252 survey forms were distributed and 110 were returned. This was a 44% response rate.

- 96% found it easy to get through to this surgery by phone compared to the local average of 75% and national average of 73%.
- 84% were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 87% and national average of 85%.
- 87% described the overall experience of their GP surgery as good compared to the local average of 86% and national average of 85%.
- 73% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to the local average of 80% and a national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection; we collected 14 completed cards. Nine of the comment cards we received contained positive and complimentary patient views about the service, one card contained negative comments regarding care and referrals received, two cards contained comments that a high staff turnover was evident but were positive about the care received, one card contained negative comments on a GP coming across as uncaring and positive comments on another GP coming across very good and one card contained comments that service was not bad but it was difficult to see a GP of choice.

We spoke with five patients who provided varying responses in being able to get an appointment with one stating it could be difficult and three stating it was easy. They told us they felt the practice offered a good service and that staff were polite, helpful, caring and treated them with dignity and respect but one patient commented that the lead GP sometimes came across rude.

Areas for improvement

Action the service MUST take to improve

- Ensure appropriate security systems are in place so that only authorised practice staff can access the dispensary.
- A risk analysis must be carried out on the safe transport and storage of medicines to the branch surgery at Fenstanton.
- Ensure all emergency prescriptions issued are signed by a GP before being issued to a patient.
- Ensure that staff caring for patients have undergone a Disclosure and Barring Service check (DBS).
- Ensure all staff training deemed mandatory by the practice is up to date, including training for safeguarding.
- Ensure all policies, procedures and guidance are up to date so that staff are able to operate in accordance with up to date procedures.
- The provider must have an adequate infection control system in place to ensure that patients and staff are adequately protected.
- The practice must comply with relevant Patient Safety Alerts issued from the Medicines and Healthcare products Agency (MHRA) and through the Central Alerting System (CAS).

Action the service SHOULD take to improve

- Improve confidentiality at the front desk and in the hallway at the St Ives location as well as for phone calls.
- Ensure thermometers used to record refrigerator and room temperatures where medicines are stored are validated before use to ensure their accuracy. In addition, the automated external defibrillator must be checked and serviced at regular intervals and at least annually.
- Ensure actions from the legionella assessment are undertaken.

Summary of findings

- Ensure effective control of substances hazardous to health is in place.
- Ensure blank prescription forms are kept securely at all times.
- Significant events, complaints, (medicines) audit results and the associated learning should be shared across practice staff teams to ensure that lessons are embedded and to prevent reoccurrence of errors.
- Ensure staff receive timely appraisals and support.
- Ensure chaperone training is available for all staff undertaking such duties.

Northcote House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and a CQC medicine optimisation inspector.

Background to Northcote House Surgery

Northcote House Surgery is situated in St Ives, Cambridgeshire and has a branch surgery in the nearby village of Fenstanton.The practice provides services for approximately 3800 patients across both sites. The practice dispenses medications to patients. The practice holds a General Medical Services contract with NHS Cambridgeshire and Peterborough CCG.

According to Public Health England, the patient population has a higher than average number of patients aged 45 to 69 compared to the practice average across England. It has a lower proportion of patients aged 35 and below compared to the practice average across England. Income deprivation affecting children and older people is lower than the practice and the England average. The overall level of deprivation is in the least deprived decile nationally.

The practice team consists of a sole GP lead who is male and one salaried female GP. The nursing team consists of three practice nurses and a health care assistant. The clinical staff is supported by a team of dispensary, secretarial and reception staff led by a practice manager.

The practice's opening times at the time of the inspection were 8am to 6pm Monday to Friday. Extended hours appointments were offered on Tuesday and Thursday morning between 7am and 8pm but were for nurse appointments only. During out-of-hours GP services were provided by Urgent Care Cambridge.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 20 April 2016. We:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised 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.

Detailed findings

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 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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice did not have a robust system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents, and there was a recording form available. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. However, we found that reporting was low with only three incidents reported in the previous 12 months. We saw evidence of, and were verbally told by staff about incidents that had occurred in the practice over the previous few months which had not been recorded as significant event but should have been. For example several incidents relating to security breaches in the dispensary. When we reviewed the practice's policy on significant event recording we found this was adequate and included appropriate criteria for incidents that were expected to be included. But we found that recordings did not reflect the policy. Significant events had not been reviewed on a regular basis; the practice explained that this was due to recent high staff turnover. This was in contradiction to the practice's policy and regulatory requirements. Any learning from significant events was not shared with the staff in the practice unless they had been directly involved. However due to the reduced number of recorded incidents this was difficult to establish.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) and guidance alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The information was monitored by designated members of staff and shared with other staff electronically. When we asked staff who was responsible for this we did not receive a consistent answer which indicated that the procedures and communication processes for alerts and updates were not robust.

We found gaps in the practice's records to demonstrate that alerts and updates had been actioned. For example the practice were unable to provide evidence to show that a recent alert relating to GPs undertaking home visits had been reviewed and actions taken. There was no record to show which staff had received relevant updates and alerts which meant that the practice could not reassure itself that adequate action was being taken to keep patients safe. We saw that the practice kept a library of hard copies of alerts and updates which were available to staff.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe but these were not clearly defined and embedded, they included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. The policies were available to all staff in the main practice but when we asked staff in the branch surgery they were not able to find them at short notice. They did have direct access to the CCG's safeguarding protocols and guidance. We saw that the safeguarding policy had not been reviewed since 2014 and could therefore not be assured that its content was up to date. Staff were able to show us safeguarding protocol cards that were present in the treatment and consultation rooms. There was a lead member of staff for safeguarding and staff we spoke with knew who it was. The GPs attended safeguarding meetings and worked with other agencies when required and staff demonstrated they understood their responsibilities. Evidence we reviewed did not assure us that all staff, both clinical and non-clinical, had received safeguarding training appropriate for their role. GPs were trained to Safeguarding Level 3 for children and vulnerable adults.
- Notices throughout the practice advised patients that chaperones were available. Nurses or health care assistants acted as chaperones if required. All member of staff who acted as chaperones were trained for the role but we saw that one clinical member of staff had not received a Disclosure and Barring Service 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 might have contact with children or adults who may be vulnerable).
- We observed the premises to be clean and tidy. We were informed by the practice manager that a practice nurse was the infection prevention and control (IPC) clinical lead but when asked, this member of staff was not aware of this. We saw no evidence that the practice liaised with the local IPC teams to keep up to date with best practice. There was an IPC protocol in place but

evidence indicated that only four members of staff had received up to date training. We saw evidence that an annual IPC audit was undertaken the day prior to our inspection and actions had been identified as a result but due to this audit being recent no actions were yet undertaken. We were informed that IPC audits were undertaken annually except for the previous year but there were no records available to support this. We saw that waste segregation and labelling took place appropriately and appropriate standards of cleanliness and hygiene were followed. The practice's branch surgery had recently been refurbished and we found this to be very clean and fit for purpose.

- Recruitment checks were mostly carried out and staff files we reviewed showed that most appropriate recruitment checks had been undertaken prior to staff's employment. For example, references, qualifications and registration with the appropriate professional body. However, we found that for one clinical member of staff there was no evidence of a DBS check being done. The practice manager explained that as a rule DBS checks were not carried out for non-clinical staff but there were no risk assessments in place to determine the need for these staff members having a DBS. The practice manager explained that they would undertake DBS checks or risk assessments immediately after the inspection.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had undergone an externally led risk assessment in October 2015 which had highlighted several areas that required attention. We saw evidence that some areas were addressed but not all. The practice manager explained the practice was still in the process of addressing some of the actions. The practice had a variety of other risk assessments in place to monitor safety of the premises, such as an infection control manual, but this dated back to 2011 and referred to out of date guidance. When we asked to see the documentation on the control of substances hazardous to health the practice was unable to provide these. The practice had undertaken an external risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) in 2013. The assessment had raised several recommendations that needed addressing for the practice to be able to be compliant, for example the need for a designated member of staff to be trained to be able to undertake water tests. The practice was unable to verify that the recommendations had been addressed.
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. Defibrillators and fridge thermometers in the dispensary had not been included in the calibration schedule. The practice informed us they would address this immediately.

Medicines management

- The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure dispensing processes were suitable and the quality of the service was maintained. The practice had carried out a dispensing review of patients (DRUMS) on 10% of their patients to ensure that medicines are being used safely and correctly. Dispensing staff were appropriately qualified, were provided some on-going training opportunities and had their competency annually reviewed.
- The practice had written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed. There were a variety of ways available to patients to order their repeat prescriptions and there were arrangements in place to provide medicines compliance aids. We were told that medicines were transported to the branch surgery at Fenstanton and stored securely there. These medicines included prescriptions for collection by patients registered with the practice in Fenstanton. We saw no evidence that this arrangement had been risk assessed to ensure the safety and security of the medicines, nor was there a protocol to cover this process. Prescriptions were reviewed and signed by GPs before they were given to patients, however, some repeat prescriptions and emergency prescription requests were dispensed to patients without being signed by the GP. Dispensary staff told us they always sought verbal approval when this occurred.

- Blank prescription forms were recorded and tracked through the practice but those used in printers were not always secured appropriately.
- Records showed medicine refrigerator temperature checks were carried out which ensured medicines requiring refrigeration were stored at appropriate temperatures. There was a policy for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a potential failure. The practice staff followed the policy. We noted that thermometers used to record room and refrigerator temperatures had not been calibrated to ensure their accuracy.
- Arrangements were in place to check medicines stored within the dispensary areas were within their expiry date and suitable for use.
- We observed that the practice had a number of Patients Group Directions (PGDs) in place and that these were in line with national guidelines and were being maintained and reviewed to a high standard by the lead practice nurse and that all PGDs had been signed by the lead GP.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the dispensary staff. For example, controlled drugs were stored in an appropriate cupboard and access to them was restricted and the keys held securely. However, we noted that security arrangements for access to the dispensary after working hours were unsatisfactory in that non-clinical staff including cleaners could enter the dispensary without being supervised by senior practice staff. We were told by the practice manager that security systems were being reviewed following two recent thefts from the dispensary and that the police had been informed and they were advising the practice on changes that need to be made to increase security.
- There was a system in place for the management of high risk medicines, which included an audit to ensure the practice operated in line with national guidance. We reviewed methotrexate (used in the treatment of rheumatoid arthritis or cancer) and lithium (used to treat and prevent episodes of mania) records and saw these were appropriately highlighted on the practice's system and that patients on these medications had undergone timely reviews and checks such as blood tests.
- Expired and unwanted medicines (including controlled drugs) were disposed of in line with waste regulations and protocols within the dispensary.
- We saw a positive culture in the dispensary for reporting and learning from medicine incidents and errors. Dispensing errors were logged, reviewed to monitor trends and appropriate actions were taken to prevent similar errors occurring but these were not shared with the rest of practice.

Arrangements to deal with 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.

All staff received annual basic life support training and there were emergency medicines available at both locations. Emergency medicines were easily accessible to staff near and all staff knew of their location. All the medicines we checked were in date and fit for use except at the branch location where we noticed that the atropine (a drug used in the treatment of bradycardia) had passed its expiry date of March 2016. Although it was clearly noted on the packaging that it was not to be used it had not yet been replaced. The practice informed us they could obtain this from the dispensary at the main location if required but said they would replace the atropine after we highlighted this.

The practice had a defibrillator available on the premises, along with oxygen with adult and children's masks. There was a first aid kit available.

The practice had a very comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place 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 people's needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF - is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2014/ 2015 the practice achieved 90.8% of the total number of points available, which was below the national average of 94.7% and the local average of 94.2%. The practice reported 3.4% exception reporting which was 7.1% below local, and 5.8% below national average (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):

- Performance for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, epilepsy, heart failure, hypertension, learning disability, mental health, palliative care, peripheral arterial disease, palliative care and rheumatoid arthritis, were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator. Except for chronic obstructive pulmonary disease (COPD) and heart failure, the exception reporting rates for these indicators were lower than, or in line with, the CCG and national averages.
  - Exception reporting for 'the percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register' was 36.4% compared to the CCG average of 13.3% and the national average of 9.8%.
  - Exception reporting for 'the percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which had been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register' was 9.1% compared to the CCG average of 6.1% and the national average of 4.6%.
- Performance for cancer related indicators was below the CCG and national average. With the practice achieving 77.3%, this was 21.3% below the CCG average and 20.6% below the national average. In response to the low score we reviewed the practice's performance for 2015/2106's QOF and noted that the practice had achieved all the points available. This data was not yet officially verified and was not yet publicly available at the time of this inspection.
- Performance for chronic kidney disease related indicators was higher compared to the CCG and national average. With the practice achieving 99.3%, this was 7.5% above the CCG average and 4.6% above the national average.
- Performance for dementia related indicators was lower compared to the CCG and national average. With the practice achieving 80.2%, this was 14.8% below the CCG average and 14.3% below the national average. In response to the low score we reviewed the practice's performance for 2015/2106's QOF and noted that the practice had achieved all the points available. This data was not yet officially verified and was not yet publicly available at the time of this inspection.
- Performance for depression related indicators was lower compared to the CCG and national average. With the practice achieving 0%, this was 90.6% below the CCG average and 92.3% below the national average. We asked the practice about their performance in this area and were informed that this related to eight patients and was due to incorrect coding on the practice's computer system. In response to the low score we reviewed the practice's performance for 2015/2106's QOF and noted that the practice had achieved all the points available. This data was not yet officially verified and was not yet publicly available at the time of this inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Performance for diabetes related indicators was lower compared to the CCG and national average. With the practice achieving 87.6%, this was 1.9% below the CCG average and 1.6% below the national average.
- Performance for osteoporosis: secondary prevention of fragility fractures related indicators was lower compared to the CCG and national average. With the practice achieving 66.7%, this was 15.4% below the CCG average and 14.7% below the national average. In response to the low score we reviewed the practice's performance for 2015/2106's QOF and noted that the practice had achieved all the points available. This data was not yet officially verified and was not yet publicly available at the time of this inspection.
- Performance for peripheral arterial disease, secondary prevention of coronary heart disease and stroke and transient ischaemic attack related indicators were lower compared to the CCG and national average.
- In response to some of the below average performances on the above indicators we reviewed the 2015/2016 QOF data for the practice. This data had not yet been validated by the Health and Social Care Information Centre and was not yet publicly available at the time of this inspection but indicated that the practice had achieved 532.2 points out of a potential 545. This was an improvement from 2014/2015.

The lead GP explained that clinical audits were carried out to demonstrate quality improvement and relevant staff were involved to improve care and treatment and people's outcomes. We discussed a number of clinical audits with the lead GP on the day of the inspection but we were not provided with written evidence until after the inspection. The audits included an audit on dementia patients being prescribed anti-psychotic medicines. The first audit had indicated three out of 17 patients were on this type of medication. Following actions from the practice, a second cycle of the audit indicated that nil out 17 patients were on anti-psychotic medicines.

Effective staffing

We could not consistently be assured that staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction program for newly appointed members of staff that covered topics such as health and safety, confidentiality and organisation rules.
- Staff had access to, and made use of, e-learning training modules, in-house and external training. However several members of staff told us they did not receive allocated time or resources to undertake mandatory training and undertook this in their own time. Records indicated that there were gaps in various topics including safeguarding adults, equality and diversity, manual handling, information governance, health and safety and infection control amongst others for various staff. We saw records that indicated all staff had received up to date basic life support training.
- We saw evidence that some staff had received support by means of one-to-one meetings, inductions, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of GPs but staff stated this support was not always timely or in-depth. Evidence we reviewed indicated five staff members' appraisals were overdue.

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 test results.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital.

We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were reviewed and updated.

Information such as NHS patient information leaflets were available in the patient waiting room.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, assessments of their capacity to consent were also carried out in line with relevant guidance. Where

Requires improvement

Are services effective?

(for example, treatment is effective)

a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Supporting patients to live healthier lives

Patients who might be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers and those at risk of developing a long-term condition. Patients were then signposted to the relevant service.

- The practice had a comprehensive cervical screening programme. The practice's percentage of patients receiving the intervention according to 2014-2015 data was 80.0%, which was in line with the England average of 81.8%. Patients who had not attended for a screening appointment were followed up with letters and via the telephone.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 82.1% to 100% compared to the local average of 52.1% to 95.7%, and for five year olds from 84.6% to 100% compared to the local average of 87.7% to 95.4%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and helpful to patients, and treated them with dignity and respect. We received mixed views from patients about how they were treated with some indicating the standard of caring they received was good. One patient said that they had not been satisfied with the service provided by one particular GP who, we were told, could be rude and dismissive to them and that they would not want to be seen by that GP again.

We discussed this with members of staff including the practice manager who told us they were aware that not all patients were happy with the service they received from the GP. The practice manager told us this would be discussed with the GP.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations but that conversations taking place in these rooms at the main location could potentially be overheard. We saw that at least one of the doors to the consultation rooms did not provide sufficient confidentiality.

The front desk did not provide sufficient confidentiality with limited queuing space and the waiting area being within earshot; phone calls were being answered at the front desk and could be overheard. The practice were aware of this but explained little could be changed as the building was listed and layout changes were not possible. Receptionists we spoke with were conscious of requesting patients to wait at a safe distance from the desk but this could prove difficult due to the size of the area.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection; we collected 14 completed cards. Nine of the comment cards we received contained positive and complimentary patient views about the service, one card contained negative comments regarding care and referrals received, two cards contained comments that a high staff turnover was evident but were positive about the care received, one card contained negative comments about one GP who they felt could be uncaring but also included positive comments about another GP. One card contained comments that the service was good but raised concerns that it was difficult to see a GP of choice.

We spoke with five patients who provided varying responses in being able to get an appointment with one stating it could be difficult and three stating it was easy. They told us they felt the practice offered a good service and that staff were polite, helpful, caring and treated them with dignity and respect, however one patient commented that a GP could be perceived as being rude.

Results from the National GP Patient Survey published in January 2016 were above or in line with CCG and national averages for patient satisfaction scores in most areas. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 91%.
- 99% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that 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.

Results from the National GP Patient Survey published in January 2016 showed patients responded positively and

Good

Are services caring?

generally above average to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 82%.
- 95% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 93% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Information in the patient waiting rooms told patients how to access a number of support groups and organisations, there was a designated carer's information board. The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers, 37 patients (approximately 1%) on the practice list had been identified as carers and were being supported, for example, by offering them health checks and referral for organisations such as social services for support. 42 patients were identified as being cared for. The practice manager informed us that the practice had hosted a Carer's Trust event approximately one year prior to our inspection.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with NHS England and the Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided through screening programmes and vaccination programmes.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care:

- Online appointment booking and prescription ordering was available for patients.
- Home visits were available for older patients or patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, a hearing loop and translation services available.
- All clinical rooms had space for wheelchairs and prams/ pushchairs to manoeuvre. Hallways were somewhat narrow in places but due to building restrictions the practice were unable to improve this Staff were aware of patients who had limited access and offered support when required.
- GPs visited a local care home at least once a week. When we spoke to the care home they stated that the care they received was of a good standard and responsive to the residents' needs. They specifically highlighted that the care given to palliative patients was of a good standard.
- The practice hosted external hearing help services to allow this treatment to be delivered to patients closer to their home and to eradicate the need to travel to the hospital for this. The practice provided facilities free of charge for these services.
- The lead GP provided sports medicine and musculo-skeletal clinics.
- Flexible appointments were available as well as set clinic times.
- The practice provided clinics for patients with long term conditions, which were nurse led.
- Midwives provided regular clinics from the practice's premises.

Access to the service

The practice's opening times at the time of the inspection were 08:00 to 18.00 Monday to Friday. Extended hours appointments were offered on Tuesday and Thursday morning between 07:00 and 08:00 but were for nurse appointments only.During out-of-hours GP services were provided by Urgent Care Cambridge.

Results from the National GP Patient Survey published in January 2016 showed that patients' satisfaction with how they could access care and treatment was in most cases higher than local and national averages:

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 96% patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average of 73%.
- 90% patients described their experience of making an appointment as good compared to the CCG average of 77% and national average of 73%.
- 76% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints, compliments and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Complaints were not discussed at practice and clinical meetings and we saw no evidence that learning from complaints had taken place.

Information about how to make a complaint was available at reception and there was reference to this being made on the website. Not all patients we spoke with were aware how to raise a complaint but those who didn't stated they wouldn't hesitate to ask staff. Reception staff showed a good understanding of the complaints' procedure.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to provide their patients with "personal health care of the highest quality and to strive to improve the health status of the practice population" with aims and objectives including "commitment to our patients' needs" and "ensuring effective management and governance systems" amongst others.

We found that, at the time of inspection, correlation between the practice's aims and objectives and our findings was inconsistent as governance systems were not robust and management was not always effective. The practice worked with the CCG and other local practices towards development of general practice in the area.

Governance arrangements

There were structures and procedures in place but these were not robust enough to ensure the practice had an effective governance framework to support the delivery of the strategy and good quality care.

- Communication across the practice was structured around key scheduled meetings. There were regular business meetings and staff told us that nurses' meetings took place on an ad-hoc basis, which worked well for the nursing team. Staff meetings involving all administrative staff took place monthly. We found that the quality of record keeping within the practice was inconsistent, with minutes and records required by regulation for the safety of patients being detailed, maintained, up to date and accurate for some meetings but not for others. For example, business meetings involving the lead GP and the practice manager were not minuted, which resulted in the practice not having robust evidence on the decision making processes and rationales. Clinical meetings were recorded and we saw evidence of this.
- Although the practice had procured an external health and safety risk assessment which had produced detailed findings there were no robust arrangements for addressing the outcomes and implementing mitigating actions. Some actions had been addressed where others had not been dealt with.
- There was a clear staffing structure and planning and staff were aware of their own roles and responsibilities. Some staff were multi-skilled and were able to cover each other's roles within their teams during leave or sickness.
- The practice used methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information. These methods did not always provide assurance that all staff had received and noted important information. For example, the practice's policies were available on the practice's computer system and in the staff room but we saw that not all staff had signed for confirmation to acknowledge they had read them.
- GPs were supported to address their professional development needs for revalidation.
- Learning from incidents and complaints was not consistently shared with staff unless they were directly involved, which limited the extent to which the practice could learn from errors. We saw evidence that the practice manager updated staff on practice matters on a regular basis.
- The practice did not have a robust system in place for reporting and recording significant events. We found that reporting was scarce with only three incidents reported in the previous 12 months. We saw evidence of, and were verbally told by staff about, incidents that had occurred in the practice over the previous few months which had not been recorded as significant event but should have been.
- A review of action points coming out of staff meetings, complaints and significant event recording did not provide assurance that information was used effectively to trigger improvement. For example, the practice was unable to verify that the recommendations from the legionella risk assessment in 2013 had been addressed.
- The practice had a number of policies and procedures to govern activity but we found that these had a review date of 2014 and had not been reviewed. The practice informed us they would immediately revise all their policies.
- The lead GP told us they had undertaken clinical audits which were used to monitor quality and systems to identify where action should be taken and drive improvements. We saw evidence that supported the GPs' revalidation process.

Are services well-led?

Inadequate

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

Leadership and culture

There was scope for the practice leadership to be improved. Staff we spoke with confirmed that the lead GP was not always visible in the practice and staff told us that they were not always approachable nor took the time to listen to all members of staff. Staff confirmed that they felt clinically supported by the lead GP. Staff also told us they felt the practice manager was visible in the practice and supported staff when needed. They explained that if there were any non-clinical concerns they would approach the practice manager.

One of the nurses confirmed that the lead GP supported them in undertaking a prescribing course which was due to start in September.

The practice had undergone a high turnover of staff over the previous year and made use of three regular locum GPs in addition to the full time lead GP and part time salaried GP. The lead GP explained that the practice had experienced recruitment challenges and had been exploring the option to extend to a partnership. We were told by management and staff that the practice had organised social events in the last year for all staff to attend.

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

The practice encouraged and valued feedback from patients by proactively engaging patients in the delivery of the service. There was an active patient participation group (PPG) which met formally on a regular basis, approximately every two months. These meetings were attended by the practice manager at all times and by a GP where possible. We spoke with one representative of the PPG which had six to seven active members at the time of our inspection. They commented that suggestions from the PPG were welcomed by the practice and that they had been consulted on their patients' viewpoint on a regular basis. For example, feedback on the waiting room had resulted in a change of chairs and information available.

Staff told us that various regular team meetings were held but that openness in the practice required improvement. They did not feel they always had the opportunity to raise issues at team meetings or in person and were not confident in doing so. Non-clinical staff said they felt respected and valued by the practice manager but not always by the lead GP. Some members of clinical staff confirmed they felt clinically supported by the GPs but not always personally.

We saw in minutes from meetings that a variety of topics were openly discussed with staff but that GPs did not always attend these meetings.

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 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users.(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (b) doing all that is reasonably practicable to mitigate any such risks (g) the proper and safe management of medicines. (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care related. Effective procedures to comply with relevant Patient Safety Alerts issued from the Medicines and Healthcare products Agency (MHRA) and the Central Alerting System (CAS) were not in place. Prescriptions were not always signed by GPs before they were given to the patient. Effective infection control procedures were not in place.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed (1) Persons employed for the purposes of carrying on a regulated activity must- (a) be of good character; (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. (2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in – (a) paragraph (1) (3) The following information must be available in relation to each such person employed- (a) the information specified in Schedule 3, and (b) such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(d) maintain securely such other records as are necessary to be kept in relation to—

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated activity.

Mandatory training was not up to date for all staff, including training for safeguarding.

Policies, procedures and guidance available in the practice was not always up to date. This hindered staff to operate in accordance with up to date procedures.

This section is primarily information for the provider

Requirement notices

Not all staff caring for patients and/or undertaking chaperone duties had received a Disclosure and Barring Service check (DBS).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment (1) All premises and equipment used by the service provider must be- (b) secure, Security arrangements must make sure that people are safe while receiving care, including Providing appropriate access to and exit from protected or controlled areas. Using the appropriate level of security needed in relation to the services being delivered. Appropriate dispensary access and security systems were not in place.

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 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	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (d) maintain securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity.