Manchester Road Surgery

Quality Report

Manchester Road Surgery
187-189 Manchester Road,
Burnley,
BB11 4HP
Tel: 01282 420680
Website: www.manchesterroadsurgery.co.uk

Date of inspection visit: 10 January 2018
Date of publication: 09/03/2018

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	Requires improvement
Are services safe?	Requires improvement
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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement overall. (Previous inspection May 2017 – Inadequate)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Requires Improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires Improvement

People with long-term conditions – Requires Improvement

Families, children and young people – Requires Improvement

Working age people (including those recently retired and students – Requires Improvement

People whose circumstances may make them vulnerable – Requires Improvement

People experiencing poor mental health (including people with dementia) - Requires Improvement

We undertook a comprehensive inspection of Manchester Road Surgery on 10 May 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and we issued warning notices for breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). The practice was placed into special measures following this visit.

We undertook a follow up focused inspection of Manchester Road Surgery on 10 October 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 had addressed concerns identified in the warning notices we issued. This inspection in October 2017 found the practice had complied with the regulation 12 and 17 warning notices. Both the full comprehensive and focussed follow up inspection reports relating to these previous inspections can be found on our website here: http://www.cqc.org.uk/location/1-550124196/reports.

Summary of findings

A further announced comprehensive inspection of Manchester Road Surgery was undertaken on 10 January 2018. This inspection was carried out following the period of special measures to ensure further improvements had been made.

Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- Improvements had been made to systems to monitor patients prescribed specific high risk medications.
- The practice was actively undertaking patients' medicines reviews to ensure appropriate care was being offered. However, we did find one example where the monitoring of high risk medicines had not been effective.
- There was improved coding of vulnerable patients on the practice's electronic record system which facilitated more thorough managerial oversight of this at risk group.
- Patients told us they felt positive about the care and treatment they were given.
- Audits had been undertaken which showed some evidence of quality improvement.
- We found complaints were handled well, with an appropriate apology offered and an explanation of any actions put in place as a result.
- While we saw the practice investigated incidents and identified learning outcomes as a result, the dissemination of this learning and any changes to practice was inconsistent.
- Some improvements had been made around risk management, but we found some examples where recommended mitigating actions had not been completed.
- Some policies and procedures lacked sufficient detail to adequately govern the activity to which they related.
- Documentary evidence of mandatory training completed by the GPs was not thorough.
- Recruitment checks for permanently employed staff members was found to be thorough, however there were gaps in documentation of pre-employment checks for a locum GP.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

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

In addition the provider should:

- Undertake the planned work to improve the practice premises.
- The infection prevention and control audit action plan should be updated to reflect work completed in order to ensure effective oversight of improvement activity.
- The practice's meeting structure should include all staff roles to facilitate effective communication and information flow.
- The process for disseminating learning outcomes following investigation of incidents should be formalised and embedded into practice.

I am taking this service out of special measures. This recognises the improvements made to the quality of care provided by the service.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General 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	**Requires improvement**
People with long term conditions	**Requires improvement**
Families, children and young people	**Requires improvement**
Working age people (including those recently retired and students)	**Requires improvement**
People whose circumstances may make them vulnerable	**Requires improvement**
People experiencing poor mental health (including people with dementia)	**Requires improvement**

Manchester Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and also included second CQC inspector and a GP specialist advisor.

Background to Manchester Road Surgery

Manchester Road Surgery, 187-189 Manchester Road, Burnley, BB11 4HP is part of the NHS East Lancashire Clinical Commissioning Group (CCG) and has approximately 4735 patients. The practice provides services under a General Medical Services contract, with NHS England.

Information published by Public Health England rates the level of deprivation within the practice population group as level two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

The numbers of patients in the different age groups on the GP practice register are generally similar to the average GP practice in England. The practice has 61% of its population with a long-standing health condition, which is higher that the local average of 56% and the England average of 53%. In addition, 14% of the practice population are unemployed compared to the CCG average of 5% and the England average of 4%.

The GP practice provides services to patients from a double fronted Victorian property that was originally two separate buildings. There is ramped access available both at the front and rear of the building, although automated opening of doors is not available upon entering the surgery. The practice has two GP consulting rooms and four treatment rooms, which are used by the practice nurse, the two health care assistants and the midwife who attends weekly.

The surgery is open Monday to Friday between 8am and 6.30pm with extensions on Tuesday evenings (open until 7.45pm) and Thursday mornings (open from 6.45am) for pre-bookable appointments. The practice provides a range of on the day, urgent and pre-bookable routine appointments and there is provision for children to be seen the same day. The practice provides online patient access that allows patients to book appointments and order prescriptions.

The service is led by two GP partners (one male, one female). They are supported by a practice manager, a full time practice nurse who is also a non medical prescriber, two part time health care assistants as well as an administration team including a deputy practice manager, secretary and reception staff.

The practice is a teaching practice for year four and year two medical students.

When the practice is closed patients are asked to contact NHS 111 for Out of Hours GP care.

Requires improvement

Are services safe?

Our findings

At our previous comprehensive inspection on 10 May 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of safeguarding, medicines management and infection control and risk management were not adequate.

These arrangements had improved when we undertook a full follow up inspection on 10 January 2018, although we found some gaps still remained. The practice is now rated as requires improvement for providing safe services and across all population groups.

Safety systems and processes

While the practice had made improvements to systems to keep patients safe and safeguarded from abuse, there remained some gaps in their implementation.

- The practice conducted safety risk assessments, such as for fire safety and lone working. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had improved its systems to safeguard children and vulnerable adults from abuse. We saw policies had been recently reviewed and updated and now contained practice specific information including appropriate contact numbers for onward referral of safeguarding concerns. They were accessible to all staff.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks on recruitment and on an ongoing basis. We saw that these were comprehensive for a new member of non-clinical staff who had commenced employment since our previous inspection and included references as evidence of conduct in previous employment and proof of identification. However, we found that evidence of pre-employment checks for a regular locum GP used by the practice since August 2017 were less thorough and lacked information demonstrating conduct in previous employment. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. However, evidence that GPs had completed appropriate training around safeguarding was not readily available during the inspection. We were told one of the GP partners had completed safeguarding children level 3 training on 20 December 2017, and we were shown an email confirming that a place had been booked on this course. However no evidence of attendance at the course was available. We were shown an email confirming that a course we were told was attended by the other GP partner in July 2017 included safeguarding children level 3 content. However, evidence of attendance was not held by the practice. Shortly after the inspection we were provided with evidence that one of the two GP partners had completed safeguarding adults training in December 2017. While a training certificates for both adult and child safeguarding was available for the locum GP, this certificate did not specify the level of the course content. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an improved system to manage infection prevention and control (IPC). An IPC audit had been completed, and an action plan produced. However, we found that the action plan had not been updated since October 2017 to document and record actions that had been completed. We saw evidence that the practice had obtained further quotes to replace flooring and have refurbishment work carried out since our previous focussed visit in October 2017. However, the timescale for the undertaking of this work was unclear. A building maintenance checklist dated 2 October 2017 acknowledged that the nurse's room, used for clinical activity, required new flooring, but stated the timescale for this work was within the 'next couple of years'. We also noted a lack of detail around the handling of urine samples in the practice's sample handling policy. Not all staff were aware of the need to wear gloves. The day after our inspection visit, the practice provided an updated sample handling protocol and advised that all staff had been made aware of the additional detail

around use of equipment such as gloves. The practice also supplied an updated IPC action plan documenting further actions completed, for example the wall mounting of liquid soap dispensers.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an appropriate induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients, although we found there was scope for the practice to make improvements around information flow in the practice to ensure clinician oversight that safe decisions were being made.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had a policy in place to govern the management of incoming correspondence such as test results and letters. However, this only acknowledged hospital letters, all of which were forwarded on to the relevant GP. The policy did not outline the procedure for management of correspondence from the out of hours GP service. The practice manager confirmed that this documentation was reviewed by a non-clinical staff member, who made decisions around which needed to be seen by the GPs. In addition to this not being covered in the practice's policy for results, electronic letters, paper letters and faxes, we were informed by the practice manager there was no system in place whereby the GPs audited this process to ensure they had sight of what they needed to.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had improved its systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- In the majority of cases patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. The practice's electronic patient record system indicated that 93% of patients prescribed four or more medicines had had a medication review undertaken in the previous 12 months, while this figure was 74% for patients on a repeat prescription.
- Registers were maintained of patients prescribed high risk medication such as Methotrexate (a medicine used to treat for example cancer and autoimmune diseases) and blood monitoring schedules were in place to ensure their blood tests were carried out at appropriate intervals (necessary to ensure medication dosage is correct). The practice manager monitored these registers on a monthly basis and took responsibility for contacting these patients a month in advance of their blood test being due in order to book an appointment. However, a similar system had not been implemented

for patients prescribed lithium. We found one of the three patients prescribed this medicine to have been issued with a prescription in January 2018, with the last documented blood results being dated August 2017 despite the need for tests every three months to ensure safe prescribing. We saw that the practice took immediate action on the day of inspection to ensure this patient was called for a blood test.

Track record on safety

The practice was working to improve safety systems.

- There were comprehensive risk assessments in relation to safety issues.
- However, the practice had not consistently undertaken mitigating activity to appropriately manage risk. For example, we saw a legionella risk assessment had been completed in January 2016 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). This risk assessment documented that the premises constituted a high potential risk of legionella, and recommended a control regime be implemented to mitigate this risk, including monthly monitoring of water temperatures. At the time of inspection, this control regime had not been implemented by the practice. However, we did see that the practice had tested the water system in March 2017, the outcome of which indicated that legionella was not present.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Most staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned lessons, identified themes and took action to improve safety in the practice. However, a system for effectively documenting how learning was disseminated to the broader team following analysis of a significant event was not sufficiently embedded. We saw for example that following an incident around urgent referrals to secondary care, the practice had modified the protocol for the management of such outbound correspondence, with tasks now being used via the practice's electronic record system in order to maintain an audit trail. We saw minutes documenting that this change was discussed at a practice meeting to inform all staff. However, we also reviewed a separate incident relating to documents not being scanned onto a patient's electronic record. We were told this had been discussed with individual staff members, but no documentation had been maintained to record the dissemination of learning from this event, meaning the practice did not have an audit trail of whom the information had been given to.
- There was a system for receiving and acting on safety alerts, although a log was not maintained to ensure effective oversight of any actions completed as a result. A pharmacist from the CCG attended the practice once per week, and we were told they would run any searches required on the patient record system following receipt of a safety alert. The practice was able to show us examples of searches that had been run as a result.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous comprehensive inspection on 10 May 2017, we rated the practice as inadequate for providing effective services as the arrangements in respect of timely medication reviews and health checks required by patients prescribed high risk medication were not adequate.

These arrangements had improved when we undertook a comprehensive follow up inspection on 10 January 2018. The practice is now rated as good for providing effective services and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance, although we did find one exception with regards to the monitoring of patients prescribed Lithium.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data for the practice for 01/07/2016 to 30/06/2017 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was better than local and national averages; 0.49, compared to 0.65 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was below local and national levels; 0.78 compared to 1.00 locally and 0.98 nationally.
- The percentage of antibiotic items prescribed by the practice that were Co-Amoxiclav, Cephalosporins or Quinolones (antibiotics which work against a wide range of disease-causing bacteria) was 5.7%, compared to the local average of 6.4% and national average of 8.9%.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed evidence of practice performance against results from the national Quality and Outcomes Framework (QOF) for 2016/17 and looked at how the practice provided care and treatment for patients (QOF is a system intended to improve the quality of general practice and reward good practice.)

Older people:

- The practice told us multidisciplinary meetings were held at the end of its monthly practice meetings, with representatives from other agencies invited to attend. We saw from meeting minutes that the Macmillan nurse had attended a meeting at the practice in August 2017 where three patients were discussed.
- The practice held a palliative care register for patients nearing the end of life. At the time of our visit, two patients were on this register. The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice nurse was trained to initiate diabetic patients on insulin, negating the need for a secondary care appointment. The practice nurse ran a monthly clinic along with one of the GPs for patients with poorly controlled diabetes.
- 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.
- Blood measurements for diabetic patients (HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 69% of patients had well controlled blood sugar levels compared with the CCG average of 82% and national average of 80%.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 79% compared to the CCG average of 85% and national average of 83%.
- The percentage of patients receiving appropriate anticoagulation (blood thinning) treatment was 85%, compared to the CCG average of 86% and national average of 88%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were lower than the target percentage of 90% or above according to data published for the period 1 April 2015 to 31 March 2016. However, we noted that data for 2016/17 indicated the practice had managed to increase uptake by approximately 10%.
- The practice had improved arrangements to ensure appropriate managerial oversight of vulnerable children. We saw that appropriate safeguarding registers were documented on the practice's electronic records system.
- The practice had emergency processes for acutely ill children and young people.

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

- The practice's uptake for cervical screening was 70%, which was in line with the local average of 73% and national average of 72%.
- The practice encouraged patients to attend national cancer screening programmes. The practice's uptake rates for these was either in line with or slightly higher than local and national averages. For example, 68% of females aged 50-70 had been screened for breast cancer within six months of being invited, compared to 61% locally and 62% nationally.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had identified 35 patients on its learning disability register and these patients were invited to attend for an annual review appointment with the practice nurse to ensure their health needs were being met. These patients were offered a longer appointment to ensure they had enough time with the clinician.
- The practice worked with other healthcare professionals in the case management of vulnerable patients. This included providing and supporting a substance misuse clinic.

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

- 85% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the local average of 88% and national average of 84%.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the local average of 93% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was comparable to local and national averages (practice 90%; CCG 92%; national 91%); as was the case with the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 99%; CCG 96%; national 95%).

Monitoring care and treatment

The practice had undertaken some quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. For example we saw the practice had engaged

Good

Are services effective?

(for example, treatment is effective)

with a local campaign to encourage uptake of cervical smear screening amongst young women; a nominated member of staff ran searches every three months to identify women who would be due their first screen in six months' time. These patients were then proactively sent an information pack to raise awareness and improve uptake.

The practice shared three audits with us which had been commenced since our previous comprehensive inspection. One of these was a completed two cycle clinical audit where changes made were revisited and evaluated for effectiveness. This audit examined whether the practice was utilising an appropriate risk calculation for patients with atrial fibrillation (a heart condition). The audit demonstrated that following implementation of an updated atrial fibrillation protocol, the practice improved appropriate recording of risk in this patient group from 82% to 88%. Between the first and second cycle of the audit, the practice had identified an additional 11 patients newly diagnosed with the condition, all of whom had an appropriate risk score documented to facilitate effective management of the condition.

Audits had also been commenced around the prescribing of antibiotics for patients with urinary tract infections and around whether patients with hypothyroidism (an underactive thyroid) were being monitored appropriately. While changes to practice had been identified following these pieces of work, the audits were yet to be repeated to monitor the impact of these changes.

The most recent published Quality Outcome Framework (QOF) results were 95.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.2% and national average of 96.5%. The overall exception reporting rate was 14.7% (improved from 16% the previous year) compared with a local average of 11.4 and national average of 9.6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). While the practice had lowered its overall exception reporting from the previous year, we noted the practice continued to report above average rates for some indicators. For example, while 77% of asthma patients had a review including appropriate assessment of their asthma control in the preceding 12 months (compared to 77% locally and 76% nationally), the practice's exception reporting rate was 29%, compared to the local average of 9% and national average of 8%. The practice demonstrated it was aware of this and felt it was due to coding issues on the electronic patient record system.

The practice manager informed us that patients would often be seen opportunistically after they had already been excepted. If the exception code was not then removed from the record this then skewed the data higher than it should be. The inspection team randomly selected a sample of patient records to review and we found evidence that corroborated the practice's explanation of its high exception reporting figures.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The practice informed us that other professionals were invited to the monthly practice meetings in order to discuss complex patients

Good

Are services effective?

(for example, treatment is effective)

and best coordinate their care. Staff expressed frustration that attendance was not consistent however, with the last documented attendance of an outside professional being at the practice meeting held in August 2017.

- The practice had made improvements to ensure patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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.

Helping patients to live healthier lives

Staff worked to help patients live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases who were referred under the two-week-wait referral pathway was lower than local and national averages (40% compared to 54% locally and 52% nationally). Clinical staff we spoke to demonstrated awareness of relevant best practice guidance and care pathways around urgent cancer referrals.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, by referring patients to a local wellbeing clinic to support smoking cessation and tackling obesity.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

At our previous inspection on 10 May 2017, we rated the practice as good for providing caring services.

At this comprehensive follow up inspection on 10 January 2018 the practice is still rated as good for providing caring services and across all the population groups.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- All of the three patients we spoke with during the visit were positive about the service experienced. However, we did not receive any completed CQC patient comment cards to further review patient feedback.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 315 surveys were sent out and 100 were returned. This represented a response rate of 32% and about 2% of the practice population. The practice was generally below average for its satisfaction scores on consultations with GPs, but in line with local and national averages regarding consultations with nurses. For example:

- 81% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 80% of patients who responded said the GP gave them enough time; CCG - 86%; national average - 86%.
- 92% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 77% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 95% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 94% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 87% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care:

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 73 patients as carers (1.5% of the practice list). A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. They took responsibility for monitoring and validating the practice's carers list as well as contacting carers to invite them to attend for a health check.

Staff told us that if families had experienced bereavement, their usual GP sent them a condolence letter. Patients were then offered a consultation at a flexible time and location to meet the family's needs and given advice on how to find a support service as required.

Good

Are services caring?

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. However, results were again lower than local and national averages for consultations with GPs and in line with local and national averages for nurses:

- 74% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.
- 75% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 81%; national average - 82%.
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 10 May 2017, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints needed improving.

These arrangements had improved when we undertook a comprehensive follow up inspection on 10 January 2018. The practice is now rated as good for providing responsive services and across all population groups.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended hours appointments were offered on Tuesday evenings and Thursday mornings.
- The practice improved services where possible in response to unmet needs. For example
- The practice was in the process of obtaining quotes for improvement works to ensure facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice offered longer appointments to patients with complex needs, used interpretation services for patients with English as an additional language and a hearing loop was available for those patients with hearing difficulties.
- The practice made efforts to ensure care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Home visits and urgent appointments for those with enhanced needs were offered when required.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- Consultation times were flexible to meet each patient's specific needs.
- Other professionals were invited to the monthly practice meetings in an effort to best coordinate the care and treatment of patients with complex health needs.

Families, children and young people:

- 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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were available two days each week.
- The practice offered online services such as booking appointments and ordering prescriptions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Patients with complex needs were offered longer appointments.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice proactively signposted patients to support organisations for those with mental health needs and those who had recently suffered bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or higher than local and national averages, with the exception of telephone access, where the practice scored below average.

- 76% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 62% of patients who responded said they could get through easily to the practice by phone; CCG – 72%; national average - 71%.
- 82% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 83%; national average - 84%.
- 89% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 70% of patients who responded described their experience of making an appointment as good; CCG - 72%; national average - 73%.
- 77% of patients who responded said they don't normally have to wait too long to be seen; CCG - 61%; national average - 58%.

Two of the three patients we spoke to as part of the inspection visit reported they sometimes had to wait to be offered an appointment. The third patient told us they were happy they were able to access appointments in a timely manner when needed.

Listening and learning from concerns and complaints

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

- The practice had improved the availability of information about how to make a complaint or raise concerns and this process was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. One complaint had been received since our previous comprehensive inspection. We reviewed this in details and found that it was satisfactorily handled in a timely way, with a clear apology offered and explanation of what action the practice had taken to minimise the chances of the situation reoccurring.
- The practice learned lessons from individual concerns and complaints and acted as a result to improve the quality of care, for example ensuring targeted staff training was put in place to ensure patient's needs were met in an appropriate manner.

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 previous inspection on 10 May 2017, we rated the practice as inadequate for providing well-led services as sufficient governance arrangements were lacking and systems to monitor the safety and effectiveness of treatment had not been established.

While we found the leadership had improved when we undertook a follow up inspection of the service on 10 January 2018, there remained some areas of concern. The practice is now rated as requires improvement for being well-led and across all the population groups.

Leadership capacity and capability

Leaders were working to make further improvements towards delivering high-quality, sustainable care.

- Leaders were putting measures in place to deliver the practice strategy and address risks to it. We were told how the practice had engaged with external support from other agencies in order to make sustainable improvements.
- They had an improved understanding of issues and priorities relating to the quality and future of services. They were developing an understanding of the challenges and were beginning to address them.
- Most staff told us leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However, we did note that the practice's meeting structure was not fully inclusive for all staff roles.
- The practice was implementing processes to plan for the future leadership of the practice.

Vision and strategy

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

- Staff we spoke with were able to articulate this ethos and were aware of their role in relation to it.
- There was a vision and set of values documented in the practice's statement of purpose and business plan. The partners and practice manager informed us of a proposal for the practice to merge with two other local practices in the near future in order to better cater for patient needs. The practice shared its business plan document which was dated November 2017. The title of the plan indicated this covered a two year timescale. While this document acknowledged the intention for this merger to happen, it did not document clear timescales for completion.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- The strategy was in line with health and social priorities across the region.The practice planned its services to meet the needs of the practice population.

Culture

The practice was working to develop a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud of the work completed to make improvements at the practice.
- The practice focused on the needs of patients and improving their outcomes.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour and we saw evidence of full explanations and apologies being offered to patients.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. However we noted that not all staff were fully familiar with mechanisms in place to formally document this, for example not all were aware of the existence of forms to log significant events and their investigations.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Are services well-led?

Requires improvement

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

- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- The practice had begun to place an increased emphasis on the safety and well-being of all staff.
- The practice promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Further improvement was required around the clarity of responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management had been set out, but were not yet fully embedded, understood or effective. For example, while notable improvements had been made around the monitoring of patients on specific high risk medication, such as disease-modifying ant-rheumatic drugs, these systems had not been extrapolated to encompass patients taking other high risk medication, such as Lithium.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- While practice leaders had established appropriate policies, procedures and activities, these were not always in sufficient detail to ensure safety and to assure themselves that they were operating as intended. For example the protocol documented for managing incoming correspondence was not sufficiently detailed and processes followed for filing and distribution of discharge letters from the out of hours service presented risk.
- While regular practice and staff meetings had been established and were held on a monthly and three-monthly basis respectively, we saw that this meeting structure did not incorporate all staff roles to ensure effective communication channels. Some staff we spoke to were not aware of recent examples of incidents.

Managing risks, issues and performance

While there were improvements in processes for managing risks, issues and performance, some gaps remained.

- The processes to identify, understand, monitor and address current and future risks including risks to patient safety were not fully effective. For example, the recommended control regime following the completion of a legionella risk assessment in January 2016 had not been implemented. Some staff who worked alone did not have an awareness of the practice's lone-worker risk assessment.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had some awareness of patient safety alerts, however there was no clear documented audit trail to demonstrate necessary actions had been completed.
- We saw some evidence that clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- We saw some evidence that quality and sustainability were discussed in relevant meetings where most staff had sufficient access to information. However, further work was necessary to ensure communication channels and information flow within the practice were consistently utilised to ensure they were effective.
- The practice used performance information which was reported and monitored and management and staff were held to account.

Are services well-led?

Requires improvement

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

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support improvements to the quality and sustainability of services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG). A recent meeting with the PPG was attended by four patients in December. The practice had undertaken a patient survey in May 2017 to gauge patient feedback, and we were told the PPG had been supporting the practice to complete an updated survey in December 2017. At the time of inspection we were told the practice was still in the process of collating and analysing the results.

Continuous improvement and innovation

Practice staff had worked hard to implement changes resulting in improved management of patients prescribed high risk medications. The practice leadership demonstrated an awareness of the needs of the patient population and were moving forward with plans to merge with two local practices. It was envisaged this would facilitate a greater degree of flexibility in offering services to patients and ensure the organisation was resilient at a time of increasing demand on the local healthcare economy.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** 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: • Evidence of safeguarding training completed by the GPs was not available. • We found one example of a patient prescribed a high risk medicine without appropriate health checks being completed in a timely manner. • Some policies and procedures lacked sufficient detail, for example the policy for managing incoming correspondence did not include how out of hours discharge letters were disseminated and filed. Decisions regarding whether GPs needed sight of this correspondence were being made by an untrained non-clinical member of staff. • There were some gaps in risk management. For example, the recommended legionella control regime had not been implemented. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to maintain 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: • There were gaps in pre-employment check documentation relating to the long term locum GP. **Regulation 17(1)**