Care Quality Commission

Shakespeare Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	8
What people who use the service say	13
Areas for improvement	13

Detailed findings from this inspection

Our inspection team	15
Background to Shakespeare Medical Practice	15
Why we carried out this inspection	15
How we carried out this inspection	15
Detailed findings	17
Action we have told the provider to take	29

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Shakespeare Medical Practice on 18 April 2017. Overall the practice is rated as requires improvement.

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

- There was a system in place for reporting and recording significant events. We saw that significant events were not recorded in a timely way in all cases.
- There were a number of risk assessments in place completed by the landlord of the premises. In addition, the practice had developed a risk register to identify and track known risks affecting the practice and walk in centre.
- Staff had access to current evidence based guidance on the internal intranet. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- We saw that Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were not always acted upon in a timely way. Following our inspection the practice provided evidence to demonstrate that they had improved their processes in relation to this.
- Results from the national GP patient survey (published July 2016), were lower than average in some respects. These results were collected before the current provider took over the contract.
- Information about services and how to complain was available. At the time of our visit we saw that the process for patients to make verbal complaints was unclear. Following our inspection the practice provided evidence that this had been improved. We saw examples of where the practice had responded to complaints in order to improve the quality of service provided to patients.
- Patients we spoke with said they were able to access appointments with a GP in most cases. Urgent

Summary of findings

appointments were available on the same day. In addition patients were able to access appointments with an Advanced Nurse Practitioner via the Walk in Centre service on site.

- The practice had acknowledged the needs of their patient group and had appointed patient advisors to provide additional social and emotional health support.
- The practice facilities were cramped and space was limited. However we saw that the practice was making good use of the space available. We saw that there were several outstanding maintenance issues in the premises. The practice provided evidence that they were proactively addressing these with the landlord of the premises.
- The senior leadership team at One Medical Group were accessible to staff. Leadership was provided on site by a practice manager and salaried GP. Staff told us management was accessible and supportive.
- The practice had recently established a patient participation group. They described further plans for increasing patient involvement in planning services for the practice population.
- The provider was aware of the requirements of the duty of candour.
- We saw evidence that patients were not always fully informed when they were affected by a significant event.

The areas where the provider must make improvement are:

- The provider must do all that is reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. Safety alerts must be acted on, and notifications of incidents must be made in a timely manner. Processes for keeping patients informed when they are affected by internal incidents must also be improved.

  In addition the provider should:

- Take steps to improve uptake of bowel and breast screening amongst the practice population.
- Continue to develop and maintain a carers' register, and offer additional support to this group of people.
- Continue to support patients wishing to make complaints, verbal or written.
- Continue to improve systems and processes for monitoring patient outcomes.
- Establish a clear safeguarding lead within the practice, ensure all staff are aware of who this is; and develop systems for multidisciplinary meetings to be held in house.

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?

Requires improvement 

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

- There was a system for reporting and recording significant events. We viewed a sample of three significant events. We saw that lessons were learned and disseminated to staff. However the practice did not have a clear process in place for informing patients who were affected by significant events.
- We found that not all incidents were reported in a timely way. We saw that, following an occasion when one of the vaccine fridges went out of the recommended temperature range, the correct procedures were followed. However it was not recorded as a significant event at the time. This was pointed out during the inspection and a significant incident form was completed before we left the premises.
- The practice had systems, processes and practices in place to minimise risks to patient safety. However we saw that not all MHRA alerts were dealt with in a timely way. This could lead to a patient receiving inappropriate or unsafe medicines. Following on from the inspection the practice provided evidence that this had been addressed.
- Staff demonstrated that they understood their responsibilities and all had received, or were booked to receive, training on safeguarding children and vulnerable adults relevant to their role. Not all staff were clear who the lead for safeguarding was within the practice.
- The practice had good arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement 

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

- Data from the Quality and Outcomes Framework (QOF) 2015/16 showed patient outcomes were lower than local and national averages. These figures related to a period prior to the current provider taking over the contract for the practice. The practice showed us they were working to improve QOF results for the current year.
- We saw that the Walk in Centre was operating at 143% of contracted capacity in terms of numbers of patients seen.

Summary of findings

- Staff had access to, and acted in accordance with current evidence based guidance on the internal intranet.
- Prescribing audits demonstrated quality monitoring.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There were systems for staff appraisal and personal development plans in place. One staff member had not received an appraisal at the time of our visit. We were assured, following the inspection, that all staff would receive an appraisal in a timely way.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. At the time of our visit formal multidisciplinary meetings did not take place on site; however regular communication occurred on an 'ad hoc' or informal basis.
- End of life care was coordinated with other services involved.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey (which was carried out before the current provider took control of the practice) showed patients rated the practice below others for some aspects of care.
- At the time of our visit a formal carers' register had not been developed. Following our inspection the practice provided evidence that they were continuing to develop and maintain a register. All patients had been contacted to establish whether they were carrying out an unpaid caring role.
- Patient feedback we reviewed showed that patients said they were treated with compassion, dignity and respect.
- Information was available in several different languages in line with the needs of the patient group.

We saw staff treated patients with kindness and respect. Conversations at the reception area could be overheard by patients in the waiting room. However, we saw that staff were aware of this, and took reasonable steps to improve this and maintain patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

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

Summary of findings

Two patient advisors had recently been appointed. Their role was to offer additional support and signposting for patients experiencing social or emotional difficulties, and provide support for patients to maintain their own health.They provided this service for all practices within the One Medical Group Ltd in Leeds.

- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they usually found it easy to make an appointment with a GP. Urgent appointments were available on the same day. In addition same day appointments were available at the Walk in Centre with an Advanced Nurse Practitioner.
- The Walk in Centre achieved 100% of the key performance indicator for patients to be seen and treated within four hours.
- The practice facilities were cramped and space was limited. However we saw that the practice was making good use of the space available. We saw that there were several outstanding maintenance issues in the premises. The practice provided evidence that they were proactively addressing these with the landlord of the premises.
- Information about how to complain was available. At the time of our visit the practice did not have a clear process for patients to make verbal complaints. Following our inspection the practice provided evidence to show that this had been addressed.Evidence from three written complaint examples we reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

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

- The practice and walk in centre were part of One Medical Group Limited. Before the inspection the practice provided a Statement of Purpose which described their aims to improve the health and quality of life for all in the community they served; and to provide a positive and safe experience for all patient care. Staff we spoke with understood the ethos of the organisation, and were clear about their responsibilities in relation to it.

Summary of findings

- There was a leadership structure and staff felt supported by the practice manager and senior leadership team. The practice had policies and procedures to govern activity. One Medical Group Integrated Governance Committee met regularly, addressing clinical, operational and clinical governance issues.
- A daily 'huddle' was held in the practice, to which all staff were invited. This enabled staff to discuss immediate operational or professional concerns. Staff told us issues raised in this way were taken seriously and actions taken to address concerns.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings. One member of staff had not received an appraisal at the time of our visit. We were assured, following the inspection, that all staff would receive an annual appraisal in a timely way. We saw evidence that staff were encouraged to develop and progress within their roles.

- The provider was aware of the requirements of the duty of candour.
- We found that patients were not routinely informed when they were affected by a significant incident.
- The leadership team encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff. The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice had recently established a patient participation group. They described further plans for increasing patient involvement in planning services for the practice population.
- There were opportunities for continuous learning and improvement at all levels. Staff were provided with 'administration time' to enable them to keep up to date with training and administrative duties.

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 

The practice is rated as requires improvement for providing safe, effective, caring responsive and well led to the population it serves. These ratings affect all population groups, including older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients. Home visits and longer appointments were available when required.
- The practice liaised closely with district nurses and palliative care staff when patients were identified as approaching the end of life. The practice encouraged patient involvement in contributing to their end of life care plan. Multidisciplinary meetings were not held on site with district nurses and palliative care nurses; however patients from the practice were discussed and their needs reviewed at a meeting held at another site within One Medical Group.
- Where older patients had complex needs, the practice shared summary care records with local care services, such as out of hours services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. Patient advisors were available to provide individualised support, guidance and signposting to additional local support services.

The practice participated in the 'Proactive Care Programme' which involved the development of a register of patients with severe and moderate frailty, in order to provide appropriate support.

People with long term conditions

Requires improvement 

The practice is rated as requires improvement for providing safe, effective, caring, responsive and well led to the population it serves. These ratings affect all population groups, including people with long term conditions.

- Recently appointed nursing staff had lead roles in long term disease management. The practice participated in the 'Collaborative Care Planning' initiative which involved patients in setting their own goals to manage their condition.

Summary of findings

- The practice participated in the 'Avoiding Unplanned Admissions' enhanced service, which involved monitoring the 2% of patients at higher risk of unplanned admission; and offering intervention and treatment in a timely way.
- 71% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months, compared to the CCG average of 86% and national average of 92%.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients were offered a structured annual review with the practice nurse, in the month of their birthday; to check their health and medicines needs were being met. For those patients with the most complex needs, the GP and practice nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for providing safe, effective, caring responsive and well led to the population it serves. These ratings affect all population groups, including families, children and young people.

- Children who were subject to a child protection plan were identified on the electronic patient record. Staff were able to describe examples from practice which demonstrated their understanding of safeguarding issues. There were systems in place to liaise with patients' own GPs if families registered at another practice attended for treatment at the Walk In Centre. Formal multidisciplinary meetings with the health visitor were not held on site; however families with additional needs were discussed, and their care reviewed, at a meeting held at another site within One Medical Group.
- Immunisation rates were in line with national averages for all standard childhood immunisations. Data showed that immunisations for 2 year olds were 87% (national average 91%) in 2016/17 and 81% (national average 88%) for 5 year olds in the same period.
- The practice and Walk In Centre prioritised appointments for children and young people.
- The practice hosted a midwife clinic weekly, providing support and monitoring for pregnant women. In addition, six week checks and post-natal checks were provided for new babies and their mothers.
- Appointments were available from 8am until 6.30pm each weekday. In addition, patients were able to access

Summary of findings

appointments at the Walk in Centre between 8am and 8pm each day, including weekends and bank holidays. Although space was limited, the practice had made efforts to accommodate children and babies. Baby changing facilities and space for breast feeding mothers was available if required.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for providing safe, effective, caring responsive and well led to the population it serves. These ratings affect all population groups, including working age people (including those recently retired and students).

- The practice offered appointments from 8am until 6.30 pm Monday to Friday. In addition patients were able to access appointments at the walk in centre which was open between 8am and 8pm seven days a week.
- Appointments could be booked in advance or on the day. Telephone consultations were also available to those patients who needed them.
- The practice made use of text reminders to advise patients of appointment times.
- The practice encouraged patients to register for online services. At the time of our inspection 265 patients (6% of the patient group).were registered for this service.
- New patient screening was offered. This included blood borne virus screening (BBV) to those patients who gave permission; to screen for hepatitis B and C, and HIV.
- Patient advisors were available to provide lifestyle advice or assist with researching further information relating to medical conditions to support patients in managing their own health needs.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for providing safe, effective, caring responsive and well led to the population it serves. These ratings affect all population groups, including people whose circumstances may make them vulnerable.

- At the time of our visit the practice did not hold a formal register of unpaid carers. However they had identified 21 people as carers. Following our inspection the practice provided evidence that they were continuing to maintain and develop a register and had written to all patients to request they inform the practice if they were acting in a caring role for family members, neighbours or friends. An initial Carers' coffee morning had

been held in the weeks prior to our inspection, supported by the patient advisors. Although this session did not attract any attendees, the practice told us they were keen to develop this service, particularly in relation to young carers.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered double appointments for patients with additional needs. Routine appointments were ten minute appointments. We were told these would be increased to fifteen minutes within the next few weeks, in order to better meet the complex needs of their patients.
- Patients with learning disability were offered an annual health care review.
- The practice liaised with other health care professionals to manage the care of vulnerable patients.
- The practice patient advisors acted as a resource to provide information for vulnerable patients in relation to local support groups and additional resources available.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for providing safe, effective, caring responsive and well led to the population it serves. These ratings affect all population groups, including people experiencing poor mental health (including people with dementia).

- The practice carried out assessments to identify patients at risk of dementia, and liaised with relevant agencies to support advance care planning for patients living with dementia.
- 100% of patients, diagnosed with dementia, had had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG average of 87% and the national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. The practice recognised a high proportion of their patients were at risk of minor to moderate mental health difficulties. Patient advisors

Summary of findings

provided a link between services and these patients. A 'Crisis Café' had been set up in close proximity to the practice, run by a voluntary organisation. Patients were able to attend there to support them in avoiding unnecessary hospital admission.

- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 70% of patients diagnosed with schizophrenia or other psychoses had a record of their blood pressure completed in the preceding 12 months compared to the CCG average of 80% and the national average of 81%.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing below local and national averages. 361 survey forms were distributed and 80 were returned. This represented 22% of the surveyed population, and 2% of the patient list as a whole. These survey results were collated before the current provider took over the contract for the practice.

- 71% of patients described the overall experience of this GP practice as good compared with the CCG average of 82% and the national average of 85%.
- 69% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 63% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 75% and the national average of 78%.

We discussed the lower than average patient satisfaction results for the practice. One Medical Group Ltd had taken over responsibility for the practice in May 2016. The most recent patient satisfaction survey pre-dated this. The management team were aware of the current results. Patient feedback was sought on a daily basis via the Friends and Family Test.We saw the results from the most recent Friends and Family test, in April 2017. Of 60 respondents 87% of people said they were likely or extremely likely to recommend the practice to friends and family.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received six comment cards, four of which were completed by patients attending the Walk In Centre, and two by registered patients. All but one of the cards contained positive comments, citing staff as 'respectful' 'polite' and 'caring'. One card completed by a walk in centre patient described the wait to be seen as 'unacceptable'.

We spoke with five patients during the inspection, all of whom were attending the walk in centre. One of these patients was a registered patient, but had chosen to access an appointment at the Walk In Centre. All five patients said they were satisfied with the care they received and thought staff were friendly and helpful.

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Areas for improvement

Action the service MUST take to improve

- The provider must do all that is reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. Safety alerts must be acted on,and notifications of incidents must be made in a timely manner. Processes for keeping patients informed when they are affected by internal incidents must also be improved.

Summary of findings

Action the service SHOULD take to improve

- Take steps to improve uptake of bowel and breast screening amongst the practice population.
- Continue to develop and maintain a carers' register, and offer additional support to this group of people.
- Continue to support patients wishing to make complaints, verbal or written.
- Continue to improve systems and processes for monitoring patient outcomes.
- Establish a clear safeguarding lead within the practice, ensure all staff are aware of who this is; and develop systems for multidisciplinary meetings to be held in house.

Care Quality Commission

Shakespeare Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Shakespeare Medical Practice

Shakespeare Medical Practice is part of One Medical Group Ltd. It is one of five practices operated by One Medical Group Ltd in the Leeds area. Shakespeare Medical Practice is located in Burmantofts, Leeds LS9 7TA. The practice offers General Practice services to a registered patient group of around 4,700 patients. In addition the practice provides a Walk In Centre service accessible to patients who are registered with any GP throughout the country. The practice has Alternative Provider for Medical Services (APMS) contracts with two Leeds Clinical Commissioning Groups (CCGs). The contract to deliver General Practice services is with Leeds South and East CCG, and the Walk In Centre contract is with Leeds North CCG. The practice had been taken over by One Medical Group Ltd in May 2016. The premises housed Shakespeare Medical Practice and Shakespeare Walk in Centre. The premises were leased from the Community Health Trust, and was co-located with another general practice. Community Health Staff were also based on site.

The National General Practice Profile data shows a significantly higher than average number of people within the 0-4 and the 25-44 year age group. The data relating to deprivation shows the practice is rated at one, on a scale of one to ten. Level one represents the highest level of deprivation, and level ten the lowest. People who live in more deprived areas tend to have greater need for health services.

43% of the practice population are of a non-white ethnicity; 16% of the practice population are of Asian origin, 16% are black, with 6% mixed and 5% other non-white ethnic groups.

Shakespeare Medical Practice is open between 8am and 6.30pm Monday to Friday for General Practice services, and the Walk In Centre is open between 8am and 8pm every day including bank holidays.

The General Practice service is staffed by one male salaried GP. GP cover is supplemented by regular locums. Additional clinical cover is provided by one male practice nurse, one female nurse practitioner and one female health care assistant. The Walk In Centre service is staffed by four Advanced Nurse Practitioners (ANPs), three female and one male. An on call GP is available each day to support the ANPs working within the walk in centre, by providing additional medical expertise for clinical queries which arise. We saw examples of rotas which showed that GP and nurse appointments were available each day for the GP practice; and that appointments with advanced nurse practitioners were available each day for the Walk in Centre. The clinical team is supported by a practice manager and a range of reception and administrative staff, who work across both services. The practice has developed a 'One Leeds' model, which enables the service to access clinical and non-clinical resources from within any of the Leeds practices operated by One Medical Group Ltd. The

Detailed findings

on-site clinicians receive additional support from the lead GP and lead Nurse within One Medical Group Ltd. An operations manager, with responsibility for all practices within the group of Leeds practices provides further managerial support to the practice.

The practice has limited parking spaces on site. A pay and display car park is available adjacent to the practice for patient and staff use. The practice has disabled access, with use of ramps, enabling patients in wheelchairs to access all areas.

When the service is closed care is provided by Local Care Direct, which can be accessed by calling the surgery telephone number, or by contacting NHS 111 service.

Why we carried out this inspection

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 the provider we reviewed a range of information we hold about the practice and asked the Clinical Commissioning Group (CCG) and NHS England to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection.

We reviewed the latest data available to us from the Quality and Outcomes Framework (QOF) and the national GP patient survey results.

We carried out an announced visit on 18 April 2017. During our visit we:

- Spoke with a range of staff including the practice manager, locum GP, practice nurse and health care assistant for the practice and locum advanced nurse practitioner for the walk in centre. We also spoke with the practice manager and one receptionist, and both patient advisors. In addition we spoke with the operations manager and lead GP for the organisation.
- We spoke with one member of the patient participation group (PPG) over the telephone before the inspection.
- We spoke with five patients on site; all who were attending the Walk in Centre.
- We observed communication and interaction between staff and patients, both face to face in the reception area and on the telephone.
- We reviewed six comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would complete the incident form on the practice intranet, and inform the practice manager of any incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw that one incident when a vaccine refrigerator had gone out of the recommended temperature range in November 2016; although the correct procedure had been followed in dealing with the event, an incident report form had not been completed at the time. Following our feedback this was completed whilst we were on the premises.
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were not routinely informed of the incident. For example, a patient referral had been delayed by five months due to an internal administrative error. The patient had not been informed of the delay or the reason for this.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The provider's Integrated Governance Committee (IGC) discussed safety incidents within the organisation as a whole. In addition weekly clinical meetings and daily 'huddles' were held in the practice where incidents, patient safety alerts and other operational issues were discussed. However we saw that Medicines and Healthcare products Regulatory Agency (MHRA) alerts were not always acted upon in a timely way within the practice. This could lead to a patient receiving inappropriate or unsafe medicines. The organisation received support from a clinical pharmacist who took responsibility for taking any necessary actions. However at the time of our inspection we found there were outstanding issues in relation to medicines alerts.Following our inspection the practice provided evidence that all affected patients had been reviewed to ensure their care had not been impaired.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a locum member of staff did not turn up as expected for duty. This was discussed at the daily huddle, and a decision was made to always clarify with any staff expected on duty which hours they understood they were working. The organisation had recently begun directly employing their own locums, to improve communication, consistency and reliability.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Not all staff were clear about the lead staff member for safeguarding. The provider told us the salaried GP was nominated as the safeguarding lead for the practice,with One Medical Group clinical lead providing additional support as needed. The practice told us that the clinical lead for the organisation attended safeguarding meetings when invited; and also represented the practice at regional safeguarding meetings. In addition, staff liaised with the health visitor as necessary to provide information for other agencies as required.Regular multidisciplinary meetings were held at another site within One Medical Group, however formal meetings were not held on site at the practice at the time of our visit.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received, or were booked to receive, training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level three. Other staff received training to level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.

Requires improvement

Are services safe?

(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).

There were some issues in relation to maintenance of the premises, for example one of the patient toilets had flooded due to blockages on several occasions. We saw the practice had identified this issue on the risk register, had taken remedial steps in the first instance, and made contact with the landlord of the premises to address the issue. Despite this we saw the practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. Equipment we saw on the day appeared visibly clean, however we saw that some equipment cleaning schedules were not completed at the time of our inspection. Following our visit the practice provided evidence that their processes had been updated to provide evidence that equipment was cleaned after use.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice had additional support from the clinical pharmacist within One Medical Group. Blank prescription forms and pads were securely stored and there were systems to monitor their use. The ANPs were qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the clinical lead for the organisation for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions (PSDs) from a prescriber were produced appropriately. PSDs are written instructions, signed by a doctor; dentist or non-medical prescriber for medicines to be supplied and /or administered to a named patient after the prescriber has assessed the patient on an individual basis.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the shared building. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The shared premises had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The organisation recognised that staff cover in relation to clinicians, was challenging at times. Immediate staffing or operational issues were discussed at the daily 'huddle' and additional staff sourced from within the wider organisation if required. A recent decision had been made to employ a second salaried

Requires improvement

Are services safe?

GP for the practice. In addition the organisation made use of the 'One Leeds' approach to provide access to additional clinical staff when needed from within the pool of all One Medical Group practices within the Leeds area.

Arrangements to deal with emergencies and major incidents

The practice had good arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there was a comprehensive range of emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises, oxygen and nitrous oxide, with adult and children's masks. Nitrous oxide is an analgesic which is inhaled through a mask. It was principally for use by Walk in Centre patients. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan 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

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

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recently published results, relating to the period before One Medical Group took over the practice, showed the practice had achieved 88% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. The exception reporting rate was 15% which was higher than the CCG and national exception reporting rates of 9% and 10% respectively. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting, or where certain medicines cannot be prescribed due to side effects. These figures represented a time before the current provider was delivering the service from the practice. The practice provided evidence to show that QOF results for 2016/17 had reached 94%, although this data has not been published and verified.

Data from 2015/16 showed:

- Performance for diabetes related indicators was lower than local and national averages. For examples 71% of patients with diabetes had a record of a foot examination and risk classification completed in the preceding 12 months, compared to the local average of 88% and the national average of 89%. The exception reporting rate was 1% compared to the CCG and national average exception reporting rates of 7% and 8% respectively.
- Performance for mental health related indicators was significantly lower than local and national averages. For example 19% of patients with schizophrenia or other psychoses had a comprehensive care place documented in the preceding 12 months compared to the local average of 80% and the national average of 78%. The exception reporting rate was 5% compared to the CCG and national average exception reporting rates of 12% and 13% respectively.

Unpublished and unverified data for 2016/17 showed:

- 76% of patients with diabetes had a record of a foot examination and risk classification completed in the preceding 12 months.
- 90% of patients with schizophrenia or other psychoses had a comprehensive care plan documented in the preceding 12 months.

The practice told us their relatively low performance in QOF was a result of being without a practice nurse for a period of time in the previous year. A practice nurse had been recruited in the past few months who had expertise in management of long term conditions, and was working to improve results, and this was partly attributed to the improved QOF results for 2016/17. The practice told us they offered three appointments for reviews, by telephone or in writing.

The contracted target for the number of patients to be seen at the Walk in Centre was 18,375 from 1 May 2016 to 31 May 2017. We saw that as of 31 March 2017 the service had seen a total number of 24,914 patients, or 143% of contracted capacity in the year to date. The provider acknowledged the pressure this placed on existing resources for the service. They informed us they planned to introduce a 'meet and greet' streaming process; whereby patients were assessed by a health care assistant within 30 minutes of arrival (15 minutes for children), and then allocated an appointment in relation to the urgency of the presenting symptoms. This was in order to prioritise and triage patients more efficiently to make best use of available staff resources. After the inspection, the provider informed us this model had been trialled over a weekend.

Requires improvement

Are services effective?

(for example, treatment is effective)

There was evidence of quality improvement including clinical audit:

- There had been three medicines audits commenced in the period since the current provider began running the practice; all of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included updating the process for monitoring the prescribing of amber drugs within the practice. This included tracking who was responsible for monitoring of patients taking these medicines, and ensuring that any necessary tests were collated and results stored. Amber drugs are medicines, usually initiated by a hospital consultant, which require additional monitoring by the practice before repeat prescribing, due to the risk of side effects.

Information about patients' outcomes was used to make improvements such as standardising clinical recording and prescribing patterns for antibiotic prescribing.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at clinical meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings when required, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All, apart from one member of staff, had received an appraisal within the last 12 months. We were assured, following our inspection, that all staff would receive an annual appraisal in a timely way.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From discussion with staff, we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. We found that information relating to patients attending the Walk in Centre was communicated with their own GP in a timely way.

We saw that the key performance indicators for March 2017 for the Walk in Centre showed:

- 100% of referrals to accident and emergency had been deemed appropriate
- 100% telephone access by other providers within 90 seconds had been achieved.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. With patient consent, staff were able to access to part of the clinical record for patients who attended the Walk in Centre for treatment. The organisation held and minuted a range of multi-disciplinary meetings including meetings with district nurses and palliative care nurses. These were held centrally

Requires improvement

Are services effective?

(for example, treatment is effective)

at another practice site. Patients from the practice were discussed at these meetings. At the time of our inspection multidisciplinary meetings were not held on site at Shakespeare Medical Centre. Staff told us they communicated on an 'ad hoc' basis when needed by telephone or internal 'task'.

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.

Consent to care and treatment

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

- < >taff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored to ensure it met the practice's responsibilities within legislation, and followed national guidance.

Supporting patients to live healthier lives

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

- Patients were able to access support with weight management, smoking cessation and emotional well-being from the in-house patient advisors.
- A local Crisis Café was available, provided by local mental health services, to provide support for those patients experiencing mental health crises, to avoid unnecessary hospital admission.
- The practice had recently established a carers' coffee morning, and at the time of our inspection this had been held once. The practice were keen to improve patient take up of this service, particularly in relation to young carers.

The practice's uptake for the cervical screening programme was 79%, which was lower than the CCG average of 83% and the national average of 82%. National Public Health Profiles (NPH) information showed that 39% of eligible people had received bowel cancer screening in the preceding 30 months compared to the CCG average of 57% and national average of 58%. NPH profiles showed that 36% of eligible women had received screening for breast cancer in the preceding five years compared to the CCG average of 67% and national average of 73%.

The practice acknowledged their lower than average performance in relation to cancer screening. These figures pre-dated the current provider having the contract for the practice. They told us they had appointed a 'cancer champion' to encourage patients to take up breast and bowel screening opportunities. In addition they had recruited an additional female practice nurse who was able to carry out cervical screening, in an attempt to improve uptake. The practice offered telephone or written reminders for patients who did not attend for their cervical screening test. Women who were referred as a result of abnormal results were followed up by the practice.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given in 2016/17 were in line with national averages. For example, rates for the vaccines given to under two year olds stood at 87% (national average 91%), and five year olds stood at 81% (national average 81%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40 to 74. New patient checks included blood borne virus screening for hepatitis and HIV. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff told us that if patients wanted to discuss sensitive issues or appeared distressed they would locate a private room to enable them to discuss their needs.
- Staff made efforts to accommodate patients who requested they be treated by a clinician of the same sex.

Five of the six patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a 'wonderful' service and staff were helpful, caring and treated them with dignity and respect. One card, completed by a patient attending the walk in centre commented that the wait to be seen was unacceptable.

We spoke with five patients in the waiting room. In addition we spoke with one member of the recently formed patient participation group (PPG) over the telephone before the inspection day. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed not all patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 78% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 75% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 81% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 76% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 90% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 86% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 94% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The practice was aware of these relatively low satisfaction results in relation to patient feedback. The survey had been completed prior to the current provider taking over the practice. They told us they were working hard to engage with patients to improve satisfaction scores for the forthcoming year.

We saw the results from the most recent Friends and Family test, in April 2017. Of 60 respondents 87% of people said they were likely or extremely likely to recommend the practice to friends and family.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed

Requires improvement

Are services caring?

decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also generally positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patient responses were mixed in relation to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages. For example:

- 74% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 81% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

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

- Staff told us that telephone interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets could be printed in larger format for patients who were visually impaired.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- A hearing loop was available in the practice for hearing impaired patients.
- One member of staff was able to use sign language for these patients, and was teaching a number of other staff to do so.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. The patient advisors had created a comprehensive information board which provided detailed information for patients.

The practice had identified 21 patients (less than half of one percent of the patient list) as carers. At the time of our inspection a formal carers' register had not been developed. Following the inspection the practice provided evidence that they were continuing to maintain and develop a carers' register. They told us they had contacted all registered patients asking whether or not they carried out caring responsibilities. Written information was available to direct carers to the various avenues of support available to them. The practice had set up a carers' coffee morning in order to improve communication and support for this group of people. At the time of our inspection one coffee morning had been held, but had not attracted any attendees. The patient advisors were continuing to promote this service, and the practice told us they were particularly keen to identify younger carers, in light of the age range of their patient group.

Staff told us that if families had experienced bereavement, they were contacted by telephone if appropriate. Staff were aware of cultural practices in relation to bereavement. The practice told us they planned to begin sending condolence cards in addition to this. Practice staff were able to direct patients to local bereavement support groups if required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice had a range of information in different languages appropriate to their patient group available within the premises.
- All appointments for the General Practice were 10 minutes in length; the practice had plans to increase all appointments to 15 minutes in length, although this system was not in place at the time of our inspection.
- Home visits and telephone triage were available for those patients who were unable to access the practice.
- Same day appointments were available in the practice and at the Walk in Centre. Children and patients with additional vulnerability were given priority.
- In the previous year, the Walk in Centre achieved 100% of the key performance indicator for patients to be seen and treated within four hours.
- The practice made use of text messaging services for appointment reminders.
- Patients were able to receive travel vaccines available on the NHS within the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressing conditions. They maintained conversations with these patients about their care planning needs, including end of life care.
- There was a hearing loop in the practice. Telephone interpreters were available. One member of staff was able to provide sign language for hearing impaired patients, and other staff were being taught to provide this service.
- Information could be printed off in larger print for those patients with visual impairment.
- As part of the 'One Leeds' model, patients registered at the practice were able to access appointments at any of the One Medical Group practices within the Leeds area.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday for GP services. The walk in centre was open 8am to 8pm each day; including weekends and bank holidays.

Appointments were from:

- 8am -11.30am for morning appointments.
- 11.30am – 1pm for telephone triage and home visits.
- 2.30pm -6.30pm for afternoon/evening appointments.
- Appointments were available to book on the day, or could be booked in advance.
- The Walk in Centre was open between 8am and 8pm each day. Patients were seen in accordance with level of urgency, judged by the clinician on duty.

Results from the national GP patient survey (completed before current provider took over the practice) showed that patient's satisfaction with how they could access care and treatment was lower, in some cases, than local and national averages.

- 94% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 70% of patients said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 73%.
- 77% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 83% and the national average of 85%.
- 89% of patients said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 69% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 50% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

This was established by telephoning the patient in advance to enable clinicians to prioritise home visits in accordance with medical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The 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. One Medical Group Performance Improvement Meeting (PIM) met regularly to review all performance issues, including patient experience.
- We saw that there was a poster on site providing information to help patients to make a complaint. At the time of our visit the poster was not easily visible. The practice told us they would re-site the poster.

There had been 12 complaints received in the previous 12 months. We looked at a sample of three of these, and found they were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, the practice had responded to complaints in relation to lack of access to appointments with doctors and nurses. As a result they had employed an additional practice nurse, and had arranged access to additional consulting rooms within the premises, on a sessional basis, in order to accommodate additional staff. A decision had also been made to employ a second salaried GP to help meet patient need. At the time of our visit this recruitment was in process. At the time of our visit not all staff were aware of the process for dealing with verbal complaints. Following our inspection the practice provided evidence that processes had been improved in relation to this.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

One Medical Group, had a clear vision to improve the health and quality of life of all individuals in the communities they served; and to provide a safe and positive experience for patients.

- Staff we spoke with on the day described many recent changes in organisational and staffing structure, however they felt they were beginning to understand the organisation's ethos, and their responsibilities within that.
- One Medical Group had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice was part of One Medical Group's overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was an organisational and staffing structure. However not all staff were able to identify the safeguarding lead for the practice.
- The practice had access to organisational wide protocols and policies via the internal intranet system.
- The performance of the practice was monitored and maintained by weekly clinical meetings within the practice, and regular Performance Information Meetings which included leadership teams from all the Leeds practices in the group, and focussed on performance issues, incorporating operational, workforce, clinical and patient experience.
- The One Medical Group Integrated Governance Committee took place within the Executive Board meetings, and addressed clinical, operational and clinical governance arrangements.
- The practice made use of prescribing and internal audit, such as appointment audit, to monitor quality and make improvements.
- There were arrangements in place for identifying, recording and managing risks, and implementing mitigating actions. For example a risk register had been created which identified and tracked identified risks, detailing actions taken to address and mitigate risks. Risks were given a RAG rating to help provide an overview of overall risk and status of progress. (Red, Amber Green ratings provide status reports based on the Red, Amber and Green colours used in a traffic light system.)

Leadership and culture

On the day of inspection the leadership team demonstrated they had the experience, capacity and capability to run the practice and strove to provide high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the on-site practice manager was approachable. Staff were involved in the daily 'huddle' which enabled staff of any grade to raise issues or concerns.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The leadership team encouraged a culture of openness and honesty. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice did not always give affected people reasonable support, truthful information and a verbal and written apology. We found that patients were not routinely informed when they were affected by a significant incident.
- At the time of our visit the process for patients to make a verbal complaint were not clear to all staff. Following the inspection the practice provided evidence that systems had been improved in this regard.

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

- The organisation held and minuted a range of multi-disciplinary meetings including meetings with district nurses and palliative care nurses. These were held centrally at another practice site, and minutes were accessible on the internal intranet system. Formal multidisciplinary meetings did not take place within the practice. Staff communicated with other services on an

Are services well-led?

Requires improvement

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

'ad hoc' basis by telephone or electronic task when required. A link health visitor was available to the practice; and liaised with staff to monitor vulnerable families and safeguarding concerns.

- A monthly staff meeting was held for all staff, and clinical meetings were held weekly in house. We saw evidence of minutes to support this. Staff told us they were able to access minutes if they had been unable to attend meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings or daily huddles, and felt confident and supported in doing so. Minutes were available for practice staff to view on the internal intranet system.
- Staff said they felt respected, valued and supported, by the organisation as a whole, and by management in the practice. Staff told us they were able to contribute to discussions about how to run and develop the practice.

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

The practice encouraged and valued feedback from patients and staff.

- A patient participation group (PPG) had recently been formed. At the time of our inspection one meeting had been held. We spoke with a member of the PPG over the telephone before the inspection day, and were told the practice was open to patient suggestions to improve the service delivered. We were given examples of suggested improvements which the practice had said they would consider implementing. These included re-siting of the water dispenser in the waiting area, and providing a play area for children in the waiting room. Further feedback was obtained by complaints and compliments received from patients, and from the Friends and Family Test.
- Staff told us they were able to give feedback informally via the practice manager, or more formally through staff meetings or the daily staff 'huddle'. Staff told us they felt proud to work for the practice and felt involved in how the service was delivered.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. A 'meet and greet' system of triaging and prioritising patients to be seen was planned for the Walk in Centre to improve clinical safety and enhance patient experience. Closer working through the 'One Leeds' approach provided additional resource for clinical and non-clinical staff to increase capacity.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. In particular: • Processes for receiving and acting on MHRA alerts were not embedded. • Patients were not always informed when they were affected by an internal significant event. • Significant event notifications were not always completed in a timely way following untoward incidents within the practice. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.