Dr Samuel Levenson

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?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement overall. (Previous inspection August 2016 – Requires Improvement)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Requires Improvement

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 previously inspected Dr Samuel Levenson at a previous location on 11 August 2016. At this inspection the service was rated as requires improvement. Since this inspection the provider had moved into a new purpose built location. We carried out an announced comprehensive inspection at Dr Samuel Levenson on 9 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had made improvements since their last inspection in particular around safety processes and governance within the practice. However, there were still further improvements needed.
- The practice had some systems to manage risk so that safety incidents were less likely to happen but some improvements were still needed. When incidents did happen, the practice learned from them and improved their processes but incidents were not always discussed at team meetings.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Staff did not always receive the training or supervision required in order to carry out their role.
- The practice was underperforming in the Quality Outcome Framework results.

Summary of findings

- Patients did not find the appointment system easy to use and reported that they often had long waits to be seen by the doctor.
- There was a strong focus on improving within the practice and the practice had acknowledged there were still improvements to be made in order to become compliant with the regulations.

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

- Persons employed by the service must receive appropriate training and supervision.
- Ensure systems or processes are established and operated effectively to ensure good governance of the service.

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

- The practice should review patient feedback relating to waiting times and access.
- The practice should review their QOF scores.
- The practice should attend local neighbourhood safeguarding meetings.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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**

Dr Samuel Levenson

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 a practice nurse specialist adviser.

Background to Dr Samuel Levenson

Dr Samuel Levenson provides primary medical services at Newbury Place Health Centre, 55 Rigby Street, Salford, M7 4NX.

The practice has a single handed lead GP (male) and uses regular locum GPs, two practice nurses (female), and two prescribing pharmacists. The clinical staff are supported by an administration team made up of a practice manager and reception staff.

Dr Samuel Levenson provides care to 5400 patients under a General Medical Services contract. The age population is significantly different to the national average. The practice has less patients over the age of 35 compared to local and national averages and a large number of patients under the age of 14.

Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is higher than the national average. The practice is open Monday to Friday from 8am to 6.30pm with extended openening on a Wednesday until 9pm. Appointments are offered at the same times.

Outside of normal opening hours, patients would be diverted to the NHS 111 service.

Requires improvement

Are services safe?

Our findings

We rated the practice, and all of the population groups, as Requires Improvement for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse but not all staff were up to date with safeguarding training.

- The practice conducted safety risk assessments. 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. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- 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. Local neighbourhood safeguarding meetings were not always attended by the practice.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. 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).
- Not all staff had received up-to-date safeguarding and safety training appropriate to their role including mental capacity act training, but we saw that staff were booked on to attend safeguarding courses. Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- 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 and a policy was in place.

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 effective 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.

- 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 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 made improvements to 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, however, we found that Patient Group Directions were not always signed by the authorised person. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Requires improvement

Are services safe?

- Patient's 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.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice told us they learned and made improvements when things went wrong.

- There was now a system in place for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Significant events were not always discussed within practice meetings so it was difficult to identify that learning was shared within the practice, but we did see evidence that significant events would be discussed at neighbourhood meetings.
- There were adequate systems for reviewing and investigating when things went wrong but learning was not always shared.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as requires improvement for providing effective services overall 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 supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- 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.
- The practice was aware that they were underperforming for their QOF targets and they told us that they found it difficult to recall patients for reviews. During the inspection we identified instances where patients had attended a review but this had not been read-coded correctly. This meant that some QOF targets appeared lower than they actually were.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed 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 percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 74% which was below the CCG average of 92% and the national average of 92%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions was 49% which was below the CCG average of 74% and the national average of 76%.
- The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register was 50% which was below the CCG average of 91% and the national average of 89%.

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 in below the target percentage of 90% or above for both children aged 12 months and 24 months. The practice informed us that they felt this was a cultural challenge and would oppourtunistically attempt to vaccinate children.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 66%, which was below the CCG average of 90% and the national average of 96%. The practice was aware this result was low and informed us that they struggled with encouraging patients to attend their review.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Requires improvement

Are services effective?

(for example, treatment is effective)

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.

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months which was above the CCG average of 84% and the national average of 84%.
- 22% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months which was significantly below the CCG average of 87% and the 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 (practice 79%; CCG 90%; national 91%).

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 66% of the total number of points available compared with the clinical commissioning group (CCG) average of 91% and national average of 94%. The overall exception reporting rate was 2% compared with a national average of 10%. (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.)

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 informally ensured the clinical supervision of staff employed in advanced roles by discussion, but there was no system in place to audit 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.
- 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 were consistent and proactive in helping patients to 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.
- 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.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, 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.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

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.
- We received 40 patient Care Quality Commission comment cards and 25 were positive about the service experienced. 13 comment cards were negative about the access to the service. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 379 surveys were sent out and 100 were returned. This represented about 4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% 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%.
- 92% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 94%; national average - 95%.
- 96% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 85%; national average - 86%.
- 85% of patients who responded said the nurse was good at listening to them; (CCG) - 92%; national average - 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 87% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 83% of patients who responded said they found the receptionists at the practice helpful; CCG - 85%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice attempted to identify patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 30 patients as carers (less than 1% of the practice list). The reason for the low number of carers was due to the age of the patient population. The practice had a significantly large percentage of patients under the age of 14 and a significantly low percentage of patinets over the age of 60 when compared to the local and national average.

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent

them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 94% 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 85% and the national average of 86%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 87% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 86%; 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services 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 opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- 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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

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

Families, children and young people:

- 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. Records we looked at confirmed this.
- 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 on a Wednesday evening.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

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 held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

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.
- Patients told us that waiting times were often excessive.
- Patients with the most urgent needs had their care and treatment prioritised.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Patients told us the appointment system was not easy to use and often struggled to get through on the phone as they would often get cut off before speaking to someone. The practice told us that they are having this issue investigated to have this issue resolved.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were low compared to local and national averages.

- 86% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 32% of patients who responded said they could get through easily to the practice by phone; CCG – 70%; national average - 71%.
- 67% 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 - 82%; national average - 84%.
- 67% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 81%.
- 45% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.
- 6% of patients who responded said they don't normally have to wait too long to be seen; CCG - 57%; national average - 58%.

The practice had scored significantly low on appointment waiting times. Patients told us that although waiting times were long they were happy to wait to be seen by the doctor as they were satisfied with the medical care provided. The practice told us that waiting times are sometimes long as the doctor will not rush appointments. The practice should consider feedback in relation to this and try to make improvements.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care.

Are services well-led?

Requires improvement

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

Our findings

We rated the practice as requires improvement for providing a well-led service.

Leadership capacity and capability

- Leaders were aware that governance within the practice required improvement and were working towards gaining the experience and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, safe care and promote good outcomes for patients but it was not yet fully embedded.

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

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need, however these processes were not effective enough as we found that staff had not always completed the required training relevant to their role. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- 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.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively 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

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management had been recently implemented but were not yet fully effective. For example, prescribing pharmacists did not have formal supervision.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety but improvements were still needed. For example, significant events were not always discussed

Are services well-led?

Requires improvement

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

at team meetings to ensure learning and improvement was disseminated throughout the practice, and local neighbourhood safeguarding meetings were not always attended by the practice.

- 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 oversight of MHRA alerts, incidents, and complaints.
- Improvement was needed to manage performance of the practice. During the inspection we identified incorrect read coding which meant that the practice's QOF data was inaccurate.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was not always accurate.
- The practice submitted data or notifications to external organisations as required.
- There were robust 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 high-quality sustainable 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.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. With the main focus on becoming compliant with the regulations.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure that systems or processes are established and operated effectively to ensure good governance of the service. This was because: • The practice did not discuss significant events at team meetings and significant events did not contain information relating to patients affected. • Patient group directions were not always signed before administering medicines. • Clinical staff did not always read code correctly when patients attend reviews.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure that persons employed by the service received appropriate training and supervision. This was because: • Clinical staff were not receiving formal supervision and their prescribing audited. • Staff did not always receive training relevant to their role.