The Highfield Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of The Highfield Medical Centre on 1 December 2016. The practice was rated as requires improvement overall, as they were not providing safe and well-led care. We asked them to submit an action plan setting out how they would improve systems and processes within the practice and the date by which these improvements would be implemented. The full comprehensive report on the December 2016 inspection can be found by selecting the 'all reports' link for The Highfield Medical Centre on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of The Highfield Medical Centre on 31 August 2017. This inspection was carried out following confirmation from the practice that all actions had been carried out and improvements had been made following our December 2016 inspection. At this inspection we found that some areas from the last inspection had not been addressed. For example; we found there were still issues with infection prevention and control and significant event recording. We also identified further areas of concern and the practice is now rated as inadequate overall.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example; we saw no evidence that Medicines and Health Regulatory (MHRA), or other patient safety alerts were discussed by the clinical team. An annual Infection Prevention and Control audit had taken place in October 2016; however the provider had not taken steps to ensure that all actions had been addressed. We also found that patient referrals to other services were not always being carried out in a timely way.
- The reporting and actioning of significant events was inconsistent and lessons learned were not always clear or documented.

Summary of findings

- Some of the staff we spoke with told us there was a shortage of staff or that the workload was too high in order to carry out their role safely.
- There was little or no evidence of audits or quality improvement activity within the practice.
- There was limited evidence of governance oversight or a clear lead for governance areas. Some of the staff we spoke with were aware of the whistleblowing policy but were reluctant to invoke it due to the dynamics within the leadership team.
- We saw no evidence of partners within the practice working together to improve the service provided.
- We were not assured that appropriate recruitment processes were followed in all cases.
- There had only been limited progress made with regard to the areas identified as requiring improvement during the inspection carried out in December 2016.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvement are:

- The provider should review their agenda structure for the meetings which are currently taking place to encourage full staff participation and act as a prompt to cover relevant topics (such as complaints) on a regular basis.
- The practice should establish a clear lead for reviewing and updating practice policies.
- The provider should look at ways to increase uptake of breast and bowel screening within the practice.

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

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated inadequate for providing safe services and improvements must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However; the recording of these events and incidents was inconsistent and lessons learned were not always clear, documented or implemented.
- An annual Infection Prevention and Control audit had taken place in October 2016; however the provider had not taken steps to ensure that all the required actions had been addressed.
- We saw that Medicines and Health Regulatory (MHRA) and other patient safety alerts were received and acted upon appropriately. However; we saw no evidence that these had been discussed by the clinical team to share learning and action taken. There was no clear lead within the clinical team to review and take any necessary action from updated National Institute for Health and Care Excellence (NICE) guidance. We did not see evidence that this information was disseminated and shared with the wider team.
- We were informed the practice had recruited two new members of staff into the roles of receptionist and secretary, who were due to start work within two weeks following our inspection. However; we were unable to view any evidence that a recruitment process had been followed or that relevant checks had been carried out.
- On the day of our inspection we found that patient referrals to other services were not always being carried out in a timely way. We saw a number of referrals, dating back to July 2017 which had not been actioned.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Some of the staff we spoke with told us there was a shortage of staff or that their workload was too high to enable them to carry out their role safely. They also told us they did not feel supported by all members of the management team.

Summary of findings

- Not all staff had received an annual appraisal in the last 12 months and there was no current system in place to monitor the uptake of staff training.
- Not all patients who had a learning disability or mental health need had a date for their next review.
- There was little or no evidence of audits or quality improvement activity within the practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP survey showed that patients rated the practice in line with or above others for some aspects of care. For example:
- 90% of patients said the last GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91% and national average of (89%).
- 86% of patients said the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89% and the national average of 86%.
- The practice had identified 248 patients (over 5% of their practice list) as carers.
- We spoke with two patients on the day of our inspection who told us they were able to get an appointment when they needed one; and that they were happy with the service they received.
- We received 25 comment cards which were positive about the care and treatment received. However; one comment card also raised concerns around staffing levels and contained less positive comments regarding staff being overworked.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example; the practice were involved in a local improvement scheme looking at early diagnosis of asthma in children.
- The practice nurse had developed guidance on type 2 diabetes to support other practice nurses in the local area.
- The practice had a system in place to follow up all hospital admissions and discharges to recall patients if necessary.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally comparable to local and national averages although the practice was an outlier in relation to mental health and depression indicators.
- As a result of our previous inspection, the practice had made improvements to the repeat prescription process and medication reviews were being monitored by prescribers.
- The practice was part of the 'C-card' scheme offering people aged 25 years and under access to free contraception.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded to issues raised. However, we were unable to see any evidence of learning from complaints being shared with staff and other stakeholders.
- The practice had introduced a telephone triage service where patients could speak to a GP or nurse and access a same day appointment if deemed clinically necessary.
- The practice offered extended hours from 7.45am until 8.30am on Monday mornings and from 6.30pm until 8.15pm on Monday evenings.
- In addition, the practice worked with three other local practices to provide weekend access from 8am until 4pm on Saturday and 8am until 12pm on Sunday.

Are services well-led?

Inadequate

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

- There was limited evidence of governance oversight or a clear lead for governance areas.
- The practice had not undertaken any two-cycle audits to review the effectiveness and appropriateness of care provided.
- We reviewed a number of practice policies and saw that these had no review dates. We received conflicting information from different staff members about who was responsible for reviewing and updating practice policies.
- A schedule of meetings had been introduced by the practice but not all had set agendas to ensure relevant topics were covered and to encourage full staff participation.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded to issues raised. However, we were unable to see any evidence of learning from complaints being shared with staff and other stakeholders.
- Clinical meetings were not always minuted due to lack of secretarial support. This meant there was a risk of important information being missed by some members of the team.

Summary of findings

- The practice duplicated work in some areas by running electronic systems alongside paper systems. For example, incident reporting and policies and procedures.
- There had been improvements, since our December 2016 inspection, made to some practice processes. For example; high risk medicine monitoring; however we learned that the changes had only been made in the two weeks leading up to this CQC inspection.
- Some of the staff we spoke with were aware of the whistleblowing policy but were reluctant to invoke it due to the dynamics within the leadership team.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served. This affected all patients including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- All patients over the age of 75 had a named GP to offer continuity of care.

People with long term conditions

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served. This affected all patients including this population group

- The practice nurse worked with a GP partner to run chronic disease management clinics and patients at high risk of hospital admission were identified as a priority.
- A GP partner in the practice was the lead for diabetes and offered insulin initiation for patients. Non-insulin injectable and oral treatments were also initiated by the practice nurse.
- Performance against diabetes related indicators was better than the CCG and national averages. For example, 100% of patients newly diagnosed with diabetes, on the register, had a record of being referred to a structured education programme. This was better than the CCG average of 89% and national average of 92%.

Families, children and young people

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served. This affected all patients including this population group.

- There were systems in place 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.

Summary of findings

- The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 79% and national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served. This affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered a telephone triage service for patients who were unable to attend the surgery due to work or study commitments.
- Appointments were available outside of normal working hours.

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served. This affected all patients including this population group.

- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- Not all patients with a learning disability or mental health need had a date for their next review.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice informed vulnerable patients about how to access various support groups and organisations.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for providing safe, effective and well led services to the population it served.

- The practice carried out advanced care planning for patients with dementia.
- 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 87% and national average of 84%.
- The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally comparable to local and national averages although the practice was an outlier in relation to mental health and depression indicators.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice had varied performance. A total of 332 survey forms were distributed and 92 (28%) were returned. This represented less than 2% of the practice's patient population.

- 90% of patients found it easy to get through to this practice by phone compared to the CCG average of 83% and national average of 71%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and national average of 84%.
- 88% of patients describe their overall experience of this surgery as good compared to the CCG average of 90% and national average of 85%.
- 69% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 84% and national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards, 24 of which were positive about the standard of care received. One card contained mixed feedback regarding the practice and raised issues regarding workload of staff causing too much stress and unprofessionalism.

We spoke with two patients during the inspection. Both patients were satisfied with the care they received.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Action the service SHOULD take to improve

- The provider should review their agenda structure for the meetings which are currently taking place to encourage full staff participation and act as a prompt to cover relevant topics (such as complaints) on a regular basis.
- The practice should establish a clear lead for reviewing and updating practice policies.
- The provider should look at ways to increase uptake of breast and bowel screening within the practice.

The Highfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was supported by a second CQC inspector, a GP specialist advisor and a pharmacist specialist advisor.

Background to The Highfield Medical Centre

The Highfield Medical Centre is located on Highfield Road, Bramley, Leeds, West Yorkshire, LS13 2BL. The practice operates from a two storey, purpose built building with car parking available for staff and patients.

The practice is situated within the Leeds Clinical Commissioning Group (CCG) and provides primary medical services under the terms of a Personal Medical Services (PMS) contract. This is a contract between general practices and NHS England for delivering services to the local community.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. The practice is situated in one of the more deprived areas of Leeds. People in more deprived areas usually have a higher need for medical intervention.

The practice age profile shows that 21% of patients are under 18 years of age (compared to CCG average of 19% and national average of 21%). Only 12% of patients are over 65 years of age, this is lower than the CCG average of 14% and national average of 17%. Average life expectancy for the practice population is 79 years for males and 83 years for females.

The service is provided by three GP partners (two male and one female), a salaried GP (female) a part time practice nurse (female) and two part time health care assistants (one male and one female). The clinical team is supported by a practice manager and a team of administrative and reception staff.

The practice serves a population of 4,775 patients who can access a number of clinics for example; asthma, diabetes and childhood immunisations.

The practice is open between the hours of 7.45am and 8.15pm on Monday and 8.30am until 6.30 pm Tuesday to Friday.

Appointments are available between the following hours:

Monday: 7.45am until 12.40pm and 3pm until 8pm

Tuesday: 8am until 12.40pm and 4pm until 5.50pm

Wednesday: 8am until 11.45pm and 4pm until 5.50pm

Thursday: 9.15am until 12.40pm and 4pm until 5.50pm

Friday: 9.15am until 12.40pm and 4pm until 5.50pm

The practice works with other local practices to provide an extended hours service from 8am until 4pm on Saturday and 8am until 12pm on Sunday.

When the practice is closed out of hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of The Highfield Medical Centre on 1 December 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement overall and for providing safe and well led services. We asked them to submit an action plan setting out how they would improve systems and processes within the practice and the date by which these improvements would be implemented. The full comprehensive report on the December 2016 inspection can be found by selecting the 'all reports' link for The Highfield medical Centre on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of The Highfield Medical Centre on 31 August 2017. This inspection was carried out following confirmation from the practice that all actions had been carried out and improvements had been made.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Leeds West Clinical Commissioning Group and NHS England to share what they knew. We carried out an announced visit on 31 August 2017. During our visit we:

- Spoke with a range of staff including a GP partner, the practice manager, the practice nurse and two members of the administrative and reception team.
- We spoke with two patients.
- Observed how patients were being cared for in the reception area.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

At our previous inspection on 1 December 2016, we rated the practice as requires improvement for providing safe services as there was no evidence of lessons learned from significant events and no evidence of learning from these being shared with relevant practice staff.

When we returned we found there were still some issues with the significant event process. We also found issues with patient safety alerts, infection control, the recruitment of staff and arrangements to deal with emergencies and major incidents.

Safe track record and learning

The practice had two systems in place for reporting and recording significant events. There was a paper book which incidents and events could be logged in and also an electronic system.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However; reporting was inconsistent and lessons learned were not always clear, documented or implemented. For example, an incident had occurred when a patient's 'fit note' was recorded in the wrong patient record. The significant event analysis did not outline the steps the practice would take to avoid a similar incident happening again. We also noted that incidents of a similar nature, for example relating to prescribing errors, were recurring without any evidence that the practice had taken steps to change processes to reduce the likelihood of any such recurrences.

We saw that Medicines and Health Regulatory (MHRA) and other patient safety alerts were received and acted upon appropriately. However; we saw no evidence that these had been discussed by the clinical team to share learning and action taken. There was no clear lead within the clinical team to review and take any necessary action from updated National Institute for Health and Care Excellence (NICE) guidance. We did not see evidence that this information was disseminated and shared with the wider team.

Overview of safety systems and process

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, however; we saw areas where the practice needed to improve:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements 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.
- There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- 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. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The provider had not taken steps to ensure that all the required actions identified in the infection prevention and control audit, carried out in October 2016, had been addressed. There were immediate actions still outstanding on the audit, for example; daily cleaning tasks and high level cleaning. The cleaner employed by the practice only worked four days per week and did not clean at a high level.
- There was no evidence of weekly water checks being carried out as part of the legionella action plan and it was unclear who was responsible for carrying out these checks.
- The practice nurse was the infection prevention and control lead; however they had not received any specific training to support this.
- There was no cleaning schedule for clinical equipment such as ear syringing and the spirometer. At the time of the inspection the member of staff responsible for this was absent.
- As a result of our previous inspection, the practice had made improvements to the repeat prescription process and medicine reviews were being monitored by prescribers.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, recording, handling, storing, securing and disposal).

Inadequate

Are services safe?

- Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions.
- The Health Care Assistants were trained to administer vaccines and medicines against a Patient Specific Direction (PSD). A PSD is an instruction to administer vaccines and medicine to a list of individually named patients where each patient on the list has been individually assessed by a prescriber.

We reviewed two personal files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references from previous employers and registration with the appropriate professional body. However; the practice had issued two offers of employment letters to administrative staff that were due to start shortly after our inspection. In these cases we were unable to see evidence that a recruitment process had been followed or that relevant checks had been carried out.

Monitoring risks to patients

There were some procedures for assessing, monitoring and managing risks to patient and staff safety. However, we saw areas where the practice needed to improve:

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and there were designated fire marshals within the practice.
- All electrical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as a general building risk assessment and legionella risk assessment (legionella is a term for a bacterium which can contaminate water systems in buildings). However; there was no evidence that actions outlined in the legionella action plan had been adhered to and it was not clear who had overall responsibility for overseeing this.
- There was no evidence of a control of substances hazardous to health (COSHH) risk assessment. This meant that staff may be unsure what action to take in cases of contact with skin or eyes.
- There were arrangements in place for planning and monitoring the number of staff and skill mix needed to meet patients' needs. However the staff members we spoke with felt the service was understaffed and they did not have enough time to carry out all aspects of their role safely in all instances.

Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. 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 medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place. However; this focused more on areas for improvement within the practice and did not make reference to what action to take in the event of a major incident. For example the business continuity plan did not contain numbers for emergency contractors to be contacted in the event of an unforeseen event of accident.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 1 December 2016, we rated the practice as good for providing effective services. When we returned we identified concerns around staffing levels, staff workload and the training and support staff received. The practice is now rated as inadequate for providing effective services.

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. However we did not see evidence of a system to ensure all clinical staff were kept up to date. The practice had no system in place to monitor that guidelines were followed.

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 general quality of general practice and reward good practice). The most recently verified and published results referred to data from 2016/17. The practice had achieved 97% of the total number of points available, compared with the Clinical Commissioning group (CCG) average of 96% and national average of 95%.

The overall exception reporting rate at the practice was 10% which comparable to the CCG average of 9% and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally comparable to local and national averages although the practice was an outlier in relation to mental health and depression indicators.

- Performance against the diabetes related indicators was better than the CCG and national averages. For example 94% of patients with diabetes, on the register had a record of a foot examination and risk clarification. Compared to the CCG average of 88% and national average of 89%.
- Performance against the mental health related indicators was significantly lower than the CCG and national average. For example 72% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months compared to the CCG average of 85% and national average of 89%.

Not all patients with a learning disability or mental health need had a date for their next review. There were no alerts or reminders in place to prompt reception staff to opportunistically book a review when communicating with patients.

There was limited quality improvement including clinical audit:

- We saw evidence of one clinical audit having been commenced in the last 12 months. This was to look at monitoring of high risk medicines within the practice as a result of concerns raised by Leeds West CCG. However this was not a completed audit and there was no evidence of improvements being identified, implemented and monitored.

Effective staffing

The staff we spoke with demonstrated they had the skills, knowledge and experience to deliver effective care and treatment. However we found issues relating to staffing within the practice:

- The practice could not demonstrate that they ensured role-specific training for all staff. For example the practice nurse was the infection prevention and control (IPC) lead however they had not received IPC training to the appropriate standard to support them in this role.
- We saw evidence that staff had received safeguarding training to the appropriate level and basic life support training. However there were no records in place to monitor and ensure training in other areas was in date.
- The provider told us that the learning needs of staff were identified through a system of appraisals. However not all staff members had received an appraisal within the last 12 months. The practice had implemented staff meetings, although we saw no evidence of ongoing support or one to one meetings.

Inadequate

Are services effective?

(for example, treatment is effective)

- We were told that staff were not always able to access training opportunities during working hours and instead were accessing opportunities in their own time. For instance during the evening and at weekends.
- Some of the staff we spoke with told us there was a shortage of staff or that the workload was too high to enable them to carry out their role safely. They also told us they did not feel supported by all members of the management team.

Coordinating patient care and information sharing

Some 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. However the practice did not always share information with other services in a timely way. For example, during the inspection we saw there was a back log of five referrals of patients, to community services or secondary care, dating back to July 2017.

Staff worked together 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 or after they were discharged from hospital.

Meetings took place with other health care professionals on a monthly basis when care plans could be reviewed and updated for patients with complex needs.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example;

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, weight, smoking cessation and alcohol consumption. Patients were either offered support within the practice or signposted/referred to the relevant externally provided service.
- The practice was involved in a local improvement scheme looking at early diagnosis of asthma in children.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 79% and national average of 81%. The practice also encouraged patients to attend national screening programmes for bowel and breast cancer screening.

The practice achievement for breast screening for women aged between 50 and 70 years in the previous 36 months was 61%, compared to the CCG average of 70% and national average of 73%.

The practice uptake for bowel cancer screening in the last 30 months for all patients aged between 60 and 69 years was 50%, compared to the CCG average of 60% and national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to national averages. For example childhood immunisations rates for the vaccinations given to under two year olds ranged from 91% to 98% (national average 90%) and five year olds from 93% to 100% (national average 91%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74.

Good

Are services caring?

Our findings

At our previous inspection on 1 December 2016, we rated the practice as good for providing a caring service. At this inspection we found staff continued to be courteous and helpful to patients. We observed reception staff treating patients with dignity and respect.

Kindness, dignity, respect and compassion

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 25 CQC comment cards which were positive about the care and treatment received. Patients used words such as 'excellent' and 'fantastic' to describe the service. However one comment card also raised concerns around staffing levels and contained less positive comments regarding staff being overworked.

We spoke with two patients who told us they were happy with the care provided by the practice.

Results from the national GP patient survey published in July 2017 showed the majority of respondents felt they were treated with compassion, dignity and respect.

- 90% of patients said the GP was good at listening to them compared with the clinical commissioning (CCG) group average of 91% and national average of 89%.
- 86% of patients said the GP was good at giving them enough time compared with the CCG average of 89% and national average of 86%.
- 97% of patients said they had confidence and trust in the last GP they saw or spoke to, compared with the CCG average of 96% and national average of 95%.
- 81% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 86%.
- 80% of patients said the nurse they saw or spoke to was good at listening to them compared with the CCG average of 93% and national average of 91%
- 85% of patients said the nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 94% and national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw or spoke to, compared to the CCG average of 98% and national average of 97%.
- 86% of patients said the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 91%
- 94% of patients told us they found the receptionist at the practice helpful compared to the CCG average of 89% and national average of 87%.

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. Patient feedback from the CQC comment cards we received was also positive and aligned with these views.

Results from the national GP 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 in most areas. For example;

- 86% of patients said the last GP they saw or spoke to was good at explaining tests and treatments, compared to with the CCG average of 88% and national average of 86%.
- 81% said the last GP they saw or spoke to was good at involving them in decisions about their care, compared to the CCG average of 84% and national average of 82%.
- 82% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments, compared with the CCG and national averages of 90%.
- 76% of patients said the last nurse they saw or spoke to was good at involving them in decision about their care, compared to the CCG average of 89% and national average of 85%.

Good

Are services caring?

During the inspection we learned that the nursing staffing levels were low as only one practice nurse was employed on a part time basis. The national GP survey figures were reflective of these findings.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. GPs within the practice also spoke a number of languages compatible with their patient group.
- Information leaflets were available in easy to read formats.
- The NHS e-Referral Service was used with patients as appropriate. (The NHE e-Referral Service is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 248 patients as carers (over 5% of the practice list). Written information was available to direct carers to the various avenues of support available to them.
- Staff told us that if families had suffered bereavement their usual GP contacted them. This call was followed by a patient consultation at a flexible time and location to meet the family's needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 1 December 2016, we rated the practice as good for providing responsive services. At this inspection we found the practice continued to respond to patient needs and rated them as good.

Responding to and meeting people's needs

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

- The practice was involved in a local improvement scheme looking at early diagnosis of asthma in children.
- The practice nurse had developed guidance on type 2 diabetes to support other practice nurses in the local area.
- The practice had a system in place to follow up all hospital admissions and discharges to recall patients if necessary.
- The practice were part of the 'C-card' scheme offering people offering people aged 25 years and under access to free contraception.
- The practice had introduced a telephone triage service where patients could speak to a GP or nurse and access a same day appointment if deemed clinically necessary.
- The practice offered extended hours from 7.45am until 8.30am on Monday mornings and from 6.30pm until 8.15pm on Monday evenings.
- In addition, the practice worked with three other local practices to provide weekend access from 8am until 4pm on Saturday and 8am until 12pm on Sunday.

Access to the service

The practice was open between the hours of 7.45am and 8.15pm on Monday and 8.30am until 6.30pm Tuesday to Friday.

Appointments were available between the following hours:

Monday: 7.45am until 12.40pm and 3pm until 8pm

Tuesday: 8am until 12.40pm and 4pm until 5.50pm

Wednesday: 8am until 11.45am and 4pm until 5.50pm

Thursday: 9.15am until 12.40pm and 4pm until 5.50pm

Friday: 9.15am until 12.40pm and 4pm until 5.50pm

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey published in July 2017 showed that patients satisfaction with how they could access care and treatment was comparable to local and national averages.

- 83% of patients were satisfied with the practice's opening hours compared with the Clinical Commissioning Group (CCG) average of 86% and national average of 76%.
- 90% of patients said they could get through easily to the practice by phone compared to the CCG average of 83% and national average of 71%.
- 84% of patients said they were able to get an appointment to see or speak to someone the last time they tried, compared to the CCG average of 89% and national average of 84%.
- 85% of patients said the last appointment they got was convenient, compared to the CCG average of 86% and national average of 81%.
- 78% of patients described their experience of making an appointment as good compared with the CCG average of 79% and national average of 73%.
- 66% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and 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.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system and a leaflet was available to support patients when making a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We looked at two complaints received in the last 12 months and found these had been handled appropriately showing openness and transparency. However; one complaint was not responded to within timescales. We discussed this with the practice manager who advised us this was due to the practice seeking legal indemnity input. We were unable to see any evidence of learning from complaints being shared with staff and other stakeholders.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 1 December 2016, we rated the practice as requires improvement for providing well-led services as systems and processes were not in place to enable the provider to maintain securely an accurate, complete and contemporaneous record of each patient.

When we returned we identified concerns around the leadership and management of the practice and governance arrangements to support the service. The practice is now rated as inadequate for providing well-led services.

Vision and strategy

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

- The practice had a mission statement which outlined a number of aims and objectives. However; at the time of our inspection we found that the practice was not meeting all of these.

We saw no evidence of partners and management at the practice working together to improve the service provided.

Governance arrangements

There was limited evidence of governance oversight or a clear lead for governance areas. Not all staff were clear who took the lead on systems and processes within the practice. For example we were informed by the practice manager that one of the partners dealt with MHRA alerts, however the GPs we spoke with advised that the practice manager was responsible for disseminating this information.

- The practice had not undertaken any two-cycle audits to review the effectiveness and appropriateness of care provided.
- We reviewed a number of practice policies and saw that these had no review dates. We received conflicting information from different staff members about who was responsible for reviewing these.
- A schedule of meetings had been introduced by the practice but not all had standard agendas to ensure relevant topics were covered and to encourage full staff participation.
- Clinical meetings were not always minuted due to lack of secretarial support. This meant there was a risk of important information being missed by some members of the team.
- The practice duplicated work in some areas by running electronic systems alongside paper systems. For example for incident reporting and policies and procedures.
- There had been improvements made to some practice processes. For example Disease Modifying Ant-Rheumatic Drugs (DMARDS) monitoring. DMARDS are a range of medicines used to reduce pain, swelling and stiffness associated with rheumatoid arthritis. They can have side effects which may affect the liver or blood; and patients taking these medicines need regular blood tests. However, we learned that these improved processes had only been implemented in the two weeks prior to our inspection.

Leadership and culture

There was limited evidence of effective management, leadership and oversight within the practice.

On the day of the inspection we learned that the actions identified as completed by the practice following our last inspection in December 2016 had only begun to be implemented in the two weeks prior to our inspection.

Some of the staff we spoke with told us they did not feel supported by all members of the management team. They told us that there was a shortage of staff or that their workload was too high to enable them to carry out their role safely.

Not all staff had received an annual appraisal in the last 12 months and there was no current system to monitor the uptake of staff training.

Some of the staff told us they were aware of the whistleblowing policy but were reluctant to invoke it due to the dynamics within the leadership team.

We found that the practice had systems to ensure that when things went wrong with care and treatment;

- The practice gave affected people reasonable support, truthful information and a written apology.
- The practice kept written records of both formal and verbal complaints.

Are services well-led?

Inadequate

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

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

The practice gathered feedback from patients through the patient reference group (PRG) and through surveys and complaints received. The PRG met regularly and were encouraged to submit proposals for improvements to the practice management team. We did not see any recent changes made as a result of patient feedback.

The practice gathered feedback from staff through appraisals. However at the time of the inspection, not all staff members had received an appraisal in the previous 12 months.

Continuous improvement

At the time of our inspection there was only limited evidence that the practice had a focus on continuous learning and improvement at all levels, as evidence by the limited approach to clinical audit and learning from past incidents.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. This was because: · There was no evidence that Medicines and Health Regulatory (MHRA), or other patient safety alerts were discussed by the clinical team. There was no clear lead within the clinical team to review and take necessary action from updated National Institute for Health and Care Excellence (NICE) guidance, or patient safety alerts. We did not see evidence that this information was disseminated and shared with the wider team. · The process for recording significant events and incidents was inconsistent and lessons learned were not always clear or documented. · Not all findings from an Infection Prevention and Control audit carried out in October 2016 had been actioned. · Patient referrals to other services were not always being carried out in a timely way. We saw a number of referrals, dating back to July 2017 which had not been actioned. This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems in place to ensure that adequate governance and monitoring systems were in place. This was because: · There was limited evidence of governance oversight or a clear lead for governance areas. · There was little evidence of quality improvement planning or activity being carried out within the practice. · There was no system in place to ensure practice policies were reviewed and updated. · The practice duplicated work in some areas by running electronic systems alongside paper systems. For example; incident reporting and policies and procedures. · There was no evidence of a formal recruitment process being followed during the recruitment of two potential new staff members into the role of receptionist and secretary. We saw no evidence of relevant checks had been undertaken. · There was limited evidence of learning from complaints being shared with staff and other stakeholders. · Some of the staff we spoke with did not feel supported by partners and management within the practice.

This section is primarily information for the provider

Enforcement actions

· There was limited evidence of progress being made with regard to breaches in regulations identified during an inspection carried out by the CQC in December 2016.

· We saw no evidence of partners and management at the practice working together to improve the service provided.

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not do all that was reasonably practicable to ensure that persons employed received appropriate support, training, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. This was because: · Not all staff had received an annual appraisal. · Staff did not feel they could manage their workload safely. · Not all staff felt supported by the management team. · The provider did not maintain records to monitor and ensure appropriate training had been accessed by staff. · There was no documented evidence of learning from complaints being shared with staff and other stakeholders.

This section is primarily information for the provider

Enforcement actions

· The Infection Prevention and Control (IPC) lead had not received IPC training to the appropriate standard to support them in this role.

This was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.