Central Dales Practice

Quality Report

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Central Dales Practice on 1 June 2015. Overall the rating for the practice was requires improvement (The domains of safe, effective and well led were rated as requires improvement, and caring and responsive as good).

In particular, on 1 June 2015, we found the following areas of concern:

- Systems, processes and practices were not always reliable or appropriate to ensure patients were kept safe, in particular in respect of the management of medicines and ensuring that non-clinical staff who acted as a chaperone had a DBS check in place.
- Not all staff had completed mandatory training such as safeguarding and infection control. There were some gaps in the management and support arrangements for staff.
- The outcome of patients care and treatment was not always monitored regularly or robustly. Few completed clinical audits were carried out and participation in local audits and benchmarking was limited. The results of monitoring were not always used effectively to improve quality.
- The vision and values for the practice were not well developed.
- The governance arrangements were not always effective resulting in risks and issues not being identified and or addressed.
- We had some concern regarding the leadership at the practice. There were concerns with the culture and governance at the practice.

As a result of our findings at this inspection we issued the provider with a requirement notice for the proper and safe management of medicines.

Following the inspection on 1 June 2015 the practice sent us an action plan that explained what actions they would take to meet the regulation in relation to the breach of regulation we identified.

We carried out a further comprehensive inspection at Central Dales Practice on 31 March 2017 to check whether

Summary of findings

the practice had made the required improvements. We found that some but not all improvements had been made in respect of medicines management. However, we identified further concerns in respect of medicines management. We also found that some areas we identified at the previous inspection that should be improved had not been addressed.

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

- The practice had failed to ensure that risks to patients were minimised. Areas of concern related to the reporting and investigation of significant events, medicine management, infection prevention and control (IPC) management, safe storage of patient records and medicines within the dispensary and the safe recruitment of staff.
- Data showed that the practice was performing highly when compared to practices nationally. Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice demonstrated innovative community engagement.
- Staff had completed a wide range of qualifications to support them in their role. However, the practice could not demonstrate how they always ensured mandatory training and updating for relevant staff. For example, we reviewed the training record made available to us which showed not all staff were up to date with mandatory training such as infection control, information governance and basic life support.
- Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care. Patients told us they were treated with kindness and respect. Patients described being well cared for by an excellent staff team.
- The practice understood its population profile and had used this understanding to meet the needs of its population.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients.
- Staff were supported and encouraged to develop new skills and into new roles.
- The practice encouraged and valued feedback from patients and staff
- Although the practice had a wide ranging governance framework and staff were, in the majority of cases, aware of roles and responsibilities within the practice; there was insufficient attention paid to identifying, recording and managing risks. The governance arrangements were ineffective which undermined the practice's aim to provide consistently high quality safe care.
- The practice's approach to continuous improvement was mixed. We saw evidence of a focus on continuous learning and improvement in some but not in all areas of the practice. A comprehensive understanding of the performance of the practice was not maintained in all areas and the practice had not addressed all the areas we identified at the previous inspection.

The areas where the provider must make improvement are:

- Ensure medicines are always managed safely.
- Introduce reliable processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements always include all necessary employment checks for all staff.
- Ensure all staff are aware of their responsibilities to raise safeguarding concerns.
- Ensure patient records are securely stored.
- Take action to address gaps in the mandatory training completed by staff.
- Review the arrangements for managing concerns regarding staff competence.
- Implement and embed stronger governance arrangements to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Patients were at risk of harm because systems and processes were not in place and when they were in place they had weaknesses in them and were not implemented in a way to keep patients safe. Areas of concern related to the reporting and investigation of significant events, medicine management, infection prevention and control (IPC) management, safe storage of patient records and medicines within the dispensary and the safe recruitment of staff.
- Arrangements for safeguarding reflected relevant legislation and local requirements. However not all staff were aware of their responsibilities to raise safeguarding concerns
- There were enough staff to keep patients safe.

Are services effective?

Requires improvement

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

- Data showed that the practice was performing highly when compared to practices nationally.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- The practice demonstrated innovative community engagement. For example the practice had run a healthy eating session at the local Brownies club and had offered this to other newly established groups for children such as Beavers and Cubs. They had also attended a local farming community network to promote health services.
- Staff had completed a wide range of qualifications to support them in their role. For example training in wound management, advanced care planning and dementia awareness. However the practice could not demonstrate how they always ensured mandatory training and updating for relevant staff. For example, we reviewed the training record made available to us which showed not all staff were up to date with mandatory training such as infection control, information governance and basic life support. The requirement for staff to complete

Summary of findings

training in a timely way was not appropriate with training planned for completion in one staff record we viewed for 2018. The lack of mandatory training was also highlighted at the previous inspection as being an area in which the practice should improve

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- Patients told us they were treated with kindness and respect. Patients described being well cared for by an excellent staff team.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

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. The practice led a pilot within the CCG for a Step up Step down Bed at local extra care housing scheme. This pilot had allowed patients to rest and be rehabilitated in a local bed once the patient no longer needed extensive medical care in a hospital setting but was not quite ready to go home, under the supervision of the GPs. In addition GPs could step a patient up into the bed rather than admit to hospital, where appropriate. This was particularly beneficial due to the nearest hospital being over an hour away and no local residential or nursing homes in the area.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led and improvements must be made.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients.
- Staff were supported and encouraged to develop new skills and into new roles.
- The practice encouraged and valued feedback from patients and staff
- Staff told us the partners were approachable and always took the time to listen to all members of staff. Staff told us there had been a significant amount of change in recent years to develop a more supportive, cohesive and open culture at the practice.
- A programme of continuous clinical audit was used to monitor quality and to make improvements.
- Although the practice had a wide ranging governance framework and staff were, in the majority of cases, aware of roles and responsibilities within the practice; there was insufficient attention paid to identifying, recording and managing risks. The governance arrangements were ineffective which undermined the practice's aim to provide consistently high quality safe care.
- The practices approach to continuous improvement was mixed. We saw evidence of a focus on continuous learning and improvement in some but not all areas of the practice. A comprehensive understanding of the performance of the practice was not maintained in all areas and the practice had not addressed all the areas we identified at the previous inspection.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people.

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits, medicine delivery service and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Performance for diabetes related indicators was similar to the CCG and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 87% compared to the England average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 89% compared to the national average of 80%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- From the sample of documented examples we reviewed 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.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. For example young patients could request appointments via secure social media if they felt uneasy about contacting the main reception.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal and post-natal care.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- The practice demonstrated innovative community engagement. For example the practice had run a healthy eating session at the local Brownies club and had offered this to other similar groups.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students).

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- The needs of these populations 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.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including housebound patients and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. All these patients had had a review at the practice within the last year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

The provider was rated as inadequate for safety and requires improvement for being effective and well-led and good for being caring and responsive. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice carried out advance care planning for patients living with dementia.
- 89% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
- Performance for mental health related indicators was higher than the CCG and national averages in two out of the three indicators and similar in the other. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 100% compared to the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. For example the practice held quarterly GP/psychiatry liaison meetings at the practice.
- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations. Patients could access external counselling at both practices once a fortnight.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. Clinical staff had completed Mental Capacity Act training.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with local and national averages. 215 survey forms were distributed and 130 were returned. This represented 3% of the practice's patient list.

- 100% of patients described the overall experience of this GP practice as good compared with the CCG average of 94% and the national average of 85%.
- 96% of patients described their experience of making an appointment as good compared with the CCG average of 89% and the national average of 73%.
- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 90% and the national average of 78%.

As part of our inspection we also asked for patient feedback prior to and on the day of our inspection. We received feedback from 54 patients which included CQC comment cards which patients completed prior to the inspection and questionnaires that patients completed on the day of our visit. Almost all of the feedback was positive about the care and treatment patients received. A small number of negative comments related to waiting times which may have been attributed to the sit and wait service. A small number of patients told us they were not aware of the chaperone service.

Results from the Friends and Family Test showed that of the six responses that 100% would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines are always managed safely.
- Introduce reliable processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements always include all necessary employment checks for all staff.
- Ensure all staff are aware of their responsibilities to raise safeguarding concerns.
- Ensure patient records are securely stored.
- Take action to address gaps in the mandatory training completed by staff.
- Implement and embed stronger governance arrangements to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and staff.

Central Dales Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a CQC Specialist Pharmacist and a CQC Inspection Manager.

Background to Central Dales Practice

The Central Dales Practice (main practice), The Health Centre, Hawes, North Yorkshire, DL8 3QR and Aysgarth Surgery (branch practice), Aysgarth, Leyburn, North Yorkshire DL8 3AA are rural practices covering approximately 500 geographical square miles and has a patient list of approximately 4, 260 patients across the two practices (Hawes and Aysgarth). The registered patient list size is 96% white British background. The practice is ranked in the eighth least deprived decile, (one being the most deprived and 10 being the least deprived). The practice age profile differs from the England average with the highest age range being 65 years plus and the lowest being zero to four year olds and patients 85 years plus. The practice is a dispensing practice and dispenses to approximately 73.5% of their patients across the two practices. This means the practice can dispense prescribed medication to registered patients who live more than a mile from a Pharmacy/ Chemist.

The practice is run by five partners (three male and two female) made up of four GPs and one practice manager. There are two practice nurses (female) and a health care assistant (female). There is a team of reception/dispensing staff. Hambleton, Richmondshire and Whitby CCG funds a Pharmacist to work at the branch practice one day a fortnight until June 2017.

The practice is open at Hawes on a Monday, Wednesday, Thursday and Friday between 8.45am to 6.00pm (phone lines open from 8.30am to 6.00pm) and a Tuesday 8.45am to 4.00pm (phone lines open from 8.30am to 4.00pm then switch to Aysgarth 4.00pm to 6.00pm). The branch practice at Aysgarth is open Monday to Friday 9.00am to 6.00pm (phone lines open 8.30am to 6.00pm).

The practice offers a mixture of open access appointments and booked appointments daily at both practices. Open access appointments are available every weekday morning at the main practice from 8.45am to 10.15am and Tuesday until 10.45am and at the branch practice from 9am to 10.30am. These appointments are on a first come first serve basis. Pre-booked appointments are available every weekday afternoon at the main practice from 5pm to 6pm and at the branch practice from 4pm to 5.30pm. Additional pre-booked appointments are also available on Tuesdays at the main practice from 1.30pm to 4pm. The practice does not provide extended hours after a previous trial period with zero take up.

The practice has opted out of providing out-of-hours services to its own patients. Out of hours patients are directed to Harrogate District Foundation Trust (the contracted out-of-hours provider) via the 111 service. They can offer self-help advice and treatment or refer you into the GP Out of Hours service (based at Harewood Medical Practice, 42 Richmond Road, Catterick Garrison, North Yorkshire DL9 3JD).

The practice holds a General Medical Services (GMS) contract to provide GP services which is commissioned by NHS England.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice had previously been inspected on 1 June 2015 and was rated as requiring improvement and issued with a requirement notice in respect of the proper and safe management of medicines. The latest inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

- Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. The practice had provided us with an action plan which outlined the work and actions they would take to comply with the regulation breach stated in the requirement notice we had given them.
- Spoke with or received feedback from a range of staff including GP's, practice nurse, health care assistant, practice manager, dispensing and administration staff.
- Received feedback from members of the Patient Participation Group.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

What we found at our previous inspection in June 2015

The practice was rated as requires improvement for providing safe services. Systems, processes and practices were not always reliable or appropriate to ensure patients were kept safe. Medicines were not always safely managed in line with current legislation and guidance. Non-clinical staff who acted as a chaperone did not have a DBS check in place.

What we found at this inspection in March 2017

Safe track record and learning

There was a system in place for reporting, recording and reviewing significant events. However we identified concerns regarding adherence to this system.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Despite this we saw that incidents were not being appropriately recognised as significant events. We identified eight incidents related to medicines in the dispensary 'near miss' record that should have been reported and reviewed as significant events. For example medicines administered to the wrong patient and medicines going missing at one of the delivery drop off points. No action had been taken to record these as significant events in order that they could be investigated. The practice management was not aware of these entries and confirmed the 'near miss' log record was not reviewed as part of the significant event reviewing process.
- From the sample of recorded significant events we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out an investigation and put in place mitigating actions to prevent reoccurrence. However, the practice did not have a process for re-visiting changes introduced over time to see if they had been embedded into practice. This was evident in one example we looked at where patients with the same or similar name were supposed to be highlighted. Our record checks confirmed that this was not the case and further significant events of the same nature had occurred.
- The practice carried out an annual review to identify trends and completed audits when trends were identified. However the review was not thorough enough to identify whether changes introduced had been sustained over time.

Overview of safety systems and processes

The practice did not always have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding although not all staff were clear who the lead was. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Most staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to level 2.
- 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. Non-clinical staff who acted as a chaperone did not have 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). A risk assessment as to why a DBS for these staff was not required was in place, but this was not appropriate.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol. Most staff had not completed annual IPC training (two GPs, one practice nurse, one health care assistant and five non-clinical staff). Annual IPC audits were not undertaken. The last audit was completed prior to our last inspection in 2015. The actions identified in the action plan made available to us in the June 2015 inspection had not all been actioned. For example there remained inappropriate methods of disposing of sanitary waste.
- Arrangements for managing medicines were checked at the practice. Medicines were dispensed at the main surgery and branch surgery for people who did not live near a pharmacy. Dispensary staff showed us standard operating procedures (SOPs) which covered the dispensing process (these are written instructions about how to safely dispense medicines). There was a system in place to ensure staff had read and understood these. Prescriptions were signed before being dispensed and there was a process in place to ensure this occurred. We saw that staff did not always follow the procedure for handing out prescriptions as the paper prescription was sent to administration before the medicines were collected. We brought this to the attention of the practice and this was rectified during our visit.
- There was a named GP responsible for providing leadership to the dispensary team who had recently taken on this role. We saw records showing all members of staff involved in the dispensing process had received appropriate training and regular checks of their competency. Dispensary staff responded appropriately to national patient safety alerts and medicines recalls.
- Staff kept a record of incidents which had occurred from the dispensary. The dispensary at Aysgarth kept a near miss log (a record of errors that have been identified before medicines had left the dispensary). However this was limited in scope as errors highlighted when the barcoder identified an error, were not recorded. The main surgery had a different recording system and when we reviewed the incidents recorded between November 2016 and March 2017 we found that eight of the near misses recorded were significant events which had not been escalated in the appropriate manner. We also found that although the practice used a barcode scanning system to provide a second check on dispensing, two of the significant events which had been recorded as near misses were in relation to the wrong medicine being dispensed. We reviewed documents relating to significant events, which had been correctly identified, and found these had been recorded in detail and actions had been taken to prevent reoccurrence.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were appropriate arrangements in place for their destruction. However balance checks of controlled drugs had not been carried out regularly.
- Expired and unwanted medicines were disposed of according to waste regulations. There was a procedure in place to check dispensary stock was within expiry date, and staff recorded when checks were made. There was a system in place for the management of repeat prescriptions, including those for high risk medicines, and we saw how this worked to keep patients safe. Staff routinely monitored prescriptions which had not been collected and described what they would do in the event of medicines not been collected.
- The practice provided a delivery service to people's homes and there was a procedure in place to ensure deliveries were completed safely and the receipt of medicines recorded. The practice also delivered medicines to locations in the community for patients to collect from. The practice had not risk assessed this service and had not put a formalised system in place to ensure medicines where stored securely and safely when delivered in the community.
- Vaccines and injections were administered by nurses using Patient Group Directions (PGDs). PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We found that these were not effectively managed as 21 out

of the 32 PGDs we were shown were out of date. Of the 11 in date, not all were signed or authorised for use by a manager. This had also been identified through appraisals but no actions had been taken. The healthcare assistant (HCA) at the practice administered medicines regularly using Patient Specific Directions (PSDs). PSDs are written instructions for a specific patient allowing a specified professional to supply or administer a medicine. This was effectively managed by the practice.

- Blank computer prescription forms and pads were not stored securely in line with national guidance. However, there was a system in place to track their use through the practice.

We reviewed two personnel files for the most recently recruited members of staff. We found appropriate recruitment checks had not always been undertaken prior to employment. Recruitment records showed proof of identification, qualifications, registration with the appropriate professional body. However there was no evidence of satisfactory conduct in previous employments in the form of references. Appropriate checks through the Disclosure and Barring Service (DBS) for clinical staff were in place for all clinical staff. 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). Non-clinical staff including dispensing staff did not have DBS checks. A risk assessment dated June 2015 was in place in respect of the decision not to DBS check non-clinical staff. We noted the risk assessment stated new members of dispensing staff would be DBS checked. This was not the case for the most recent dispensary recruit. We received confirmation from the provider following the inspection that DBS checks had been requested for all staff including those staff who had had one completed previously.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments in respect of the safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However the practice did not routinely carry out formal checks of the environment, infection control and health and safety.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. For example the practice used a team of bank administration/dispensing staff to cover absences and had secured the services of a previous partner to act as a locum.
- Patient records were not always stored securely.
- Access to the dispensary was not secure.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All clinical staff had received annual basic life support training. Six out of the nine non-clinical staff had not received training in the last 12 months.
- The practice had a defibrillator available at both premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were available. However not all these were easily accessible to staff in the branch practice. All staff knew of their location. All clinical staff had received anaphylaxis training. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

What we found at our previous inspection in June 2015

The practice was rated as requires improvement for providing effective services. Not all staff had completed mandatory training such as safeguarding and infection control. There were some gaps in the management and support arrangements for staff.

What we found at this inspection in March 2017

Effective needs assessment

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

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 95%.

The practice's overall exception reporting rate was 4%, lower than the England average of 6%. 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 NHS Business Services Authority (NHSBSA) - electronic Prescribing Analysis and Costs (ePACT) showed the practice was an outlier in one area. This related to the percentage of antibiotic items prescribed that were Cephalosporins or Quinolones (01/07/2015 to 30/06/2016). Prescribing at the practice was 10% compared to the local CCG of 7% and the England average of 5%. With the support of the CCG pharmacist the practice was working on reducing this figure.

Data from QOF 2015/2016 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 87% compared to the England average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less (01/04/2015 to 31/03/2016) was 89% compared to the national average of 80%.
- Performance for mental health related indicators was higher than the CCG and national averages in two out of the three indicators and similar in the other. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 100% compared to the national average of 89%.

There was evidence of quality improvement including clinical audit:

- There had been at least six clinical audits commenced in the last two years, all of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included implementing a new recall system and improved coding for patients with using a particular contraceptive.

Effective staffing

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality. The most recent recruits were in 2015 so we were unable to view any recent records to confirm this was being used.
- Staff had completed a wide range of qualifications to support them in their role. For example training in wound management, advanced care planning and

Requires improvement

Are services effective?

(for example, treatment is effective)

dementia awareness. However the practice could not demonstrate how they always ensured mandatory training and updating for relevant staff. For example, we reviewed the training record made available to us which showed not all staff were up to date with mandatory training such as IPC, information governance and basic life support. The requirement for staff to complete training in a timely way was not appropriate with training planned for completion in one staff record we viewed for 2018.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Where concerns regarding staff performance were identified the practice did not always revisit concerns in a timely way in order for them to assess if improvement had been made. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work although this was not always completed or completed in a timely way. The nursing staff had informal meetings with the GPs at the practice. More formal support was obtained from local clinical nurse meetings with other practices. The HCA was supported by the practice nurse. Dispensing staff were appraised by the practice manager who had no dispensary experience and not the lead GP for the dispensary. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinical staff had completed mental capacity training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

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, smoking and alcohol cessation.
- The practice demonstrated innovative community engagement. The practice had supported the local Brownies group to achieve their healthy eating badge. Two representatives from the practice attended the group and ran a healthy eating session. Due to the success of the session the practice had offered the same session to a newly established Beavers and Cubs group in the Hawes area. The practice nurse had attended a

Requires improvement

Are services effective?

(for example, treatment is effective)

local school and trained the teachers and staff how to use an Epi-Pen in the case of an emergency. This offer had been extended to other local practices, playgroups and a local child-care setting free of charge.

- The practice used the practice social media site to raise awareness of healthy living and the range of support services available to patients.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 83% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. Childhood immunisation rates for the vaccinations given up to age two was above the 90% national target at 96% scoring 9.6 out of 10 compared to the national average of 9.1. Vaccinations for five year olds ranged from 82% to 100% compared to the England average of 88% to 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer through health promotion within the practice, the practice website and their social media site. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

What we found at our previous inspection in June 2015

The practice was rated as good for providing caring services.

What we found at this inspection in March 2017

Kindness, dignity, respect and compassion

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

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

Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comments highlighted that staff responded compassionately when they needed help and provided support when required. The practice had put in place a number of initiatives which demonstrated their caring approach to both their patients and patients from other practices. For example patients from other practices could see the external counsellor at both practices if they wished to be seen out of the area they lived. The practice had also arranged for newly pregnant women to collect their pregnancy packs in a discreet envelope in order to protect their privacy.

We received feedback from the PPG. They told us they were extremely satisfied with the care provided by the practice.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 89%.
- 98% of patients said the GP gave them enough time compared to the CCG average of 92% and the national average of 87%.

99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 92%97% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 85%.

- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 95% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 96% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 99% and the national average of 97%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 95% and the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared with the CCG average of 93% and the 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 and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. For example young patients could request appointments via secure social media if they felt uneasy about contacting the main reception.

Good

Are services caring?

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

- 98% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 86%.
- 96% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 82%.
- 96% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 94% and the national average of 90%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 91% and the national average of 85%.

The GP patient survey and Friends and Family results were representative of the practice's' commitment to being a caring practice.

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

- We were told interpretation services were available for the very small number of patients whose first language was not English. However, not all staff were clear about this service. Despite this we observed positive interaction between a staff member and a person whose first language was not English.
- If requested information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

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. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 56 patients as carers. This had increased from 31 when compared to the previous year. (1% of the practice list). The practice told us they were using patient annual reviews to enquire about whether the patient was a carer or was cared for to try and identify other carers within the practice. Written information was available to direct carers to the various avenues of support available to them.

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 and/or by giving them advice on how to find a support service. A palliative care post-death questionnaire had been developed and was being used by the GPs to collect feedback on how the practice supported the family during the palliative care period.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

What we found at our previous inspection in June 2015

The practice was rated as good for providing responsive services.

What we found at this inspection in March 2017

Responding to and meeting people's needs

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

- The practice offered a mixture of open access appointments and booked appointments daily at both practices. Appointments on a Tuesday were coordinated to coincide with the local events in the area.
- The practice list increased from 4200 to approximately 6000 patients in the summer months through temporary residents (due to rural location) for which the practice did not receive additional funding. The practice planned in advance for this increase to ensure patients visiting the practice could be seen in a timely way.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for all patients through the sit and wait service. Children and those patients with medical problems that required same day consultation were prioritised.
- The practice did not currently send text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- There were accessible facilities, which included a hearing loop.
- The practice worked collaboratively with Leyburn Medical Practice, HRWCCG and South Tees NHS Foundation Trust to create the 'Nursing Project' in which Practice Nurses were developed to undertake home visits to reduce burden on community nursing whilst improving equality in services for patients. This project also included improved support and training for practice and community nurses with training between these staff taking place bi-monthly.
- The practice led a pilot within the CCG for a Step up Step down Bed at a local extra care housing scheme. This pilot had allowed patients to rest and be rehabilitated in a local bed once the patient no longer needed extensive medical care in a hospital setting but was not quite ready to go home, under the supervision of the GPs. In addition GPs could step a patient up into the bed rather than admit to hospital, where appropriate.
- The practice provided numerous in house services and tests that in some practices would need to be undertaken in hospital. For example, warfarin monitoring, acute retention catheterisation and Deep Vein Thrombosis diagnosis management. These services meant patients could be treated closer to home and this was of significant benefit due to the population of the area in their rural location and the nearest hospital being 34 miles away and nearest hospital with specialist services being 54 miles away. The practice also provided other in house services including minor surgery and minor injury assessment and treatment which were particularly useful as the practice saw transient patients during certain times of the year.
- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. The practice offered an unfunded service to a local extra care housing scheme by visiting most days. Counselling services were offered at both practices once a fortnight. Patients were able to see the counsellor at neighbouring practices and vice versa for patients who preferred to be seen outside of the area they lived within.
- The practice worked jointly with the paramedic service whereby if a person was assessed by the paramedic as not needing admission to hospital they contacted the GP direct who then took over the care of the patient.
- The practice was not aware of the NHS England Accessible Information Standard to ensure that disabled patients received information in formats that they could understand and receive appropriate support to help them to communicate.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open at Hawes on a Monday, Wednesday, Thursday and Friday between 8.45am to 6.00pm (phone lines open from 8.30am to 6.00pm) and a Tuesday 8.45am to 4.00pm (phone lines open from 8.30am to 4.00pm then switch to Aysgarth 4.00pm to 6.00pm). The branch practice at Aysgarth was open Monday to Friday 9.00am to 6.00pm (phone lines open 8.30am to 6.00pm). The practice was engaged with the CCG regarding reviewing their opening times.

The practice offered a mixture of open access appointments and booked appointments daily at both practices. Open access appointments were available every weekday morning at the main practice from 8.45am to 10.15am and Tuesday until 10.45am and at the branch practice from 9am to 10.30am. These appointments were on a first come first serve basis. Pre-booked appointments were available every weekday afternoon at the main practice from 5pm to 6pm and at the branch practice from 4pm to 5.30pm. Additional pre-booked appointments were also available on Tuesdays at the main practice from 1.30pm to 4pm. The practice did not provide extended opening hours. This had previously been trialled with a zero uptake. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages.

- 93% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 76%.
- 98% of patients said they could get through easily to the practice by phone compared with the CCG average of 90% and the national average of 73%.
- 98% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 92% and the national average of 85%.
- 99% of patients said their last appointment was convenient compared with the CCG average of 97% and the national average of 92%.
- 96% of patients described their experience of making an appointment as good compared with the CCG average of 89% and the national average of 73%.
- 79% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 70% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. Records showed a book in advance appointment (i.e. not sit and wait) were available the next working day.

The practice had a system to assess:

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

All requests for a home visit were passed to the GP who contacted the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- 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. For example information on the practice website and displayed within the practice.

We looked at seven complaints received in the last 12 months and found these were dealt with in a timely, open and transparent way. Lessons were learned from individual concerns and complaints. The practice demonstrated they completed an annual review of the complaints although there was little evidence to show the practice was revisiting changes introduced to see whether the changes introduced were embedded into practice over time. Information was not easily maintained to allow the practice to easily monitor complaints and identify trends. Shortly after the inspection the practice sent us an enhanced recording tool they had implemented.

Are services well-led?

Requires improvement

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

Our findings

What we found at our previous inspection in June 2015

The practice was rated as requires improvement for being well-led. The vision and values were not well developed. The practice demonstrated, in some areas, that they were on a positive journey of improvement – although evidence of the impact of the improvement to support this was minimal at this time. The practice had a number of policies and procedures to govern activity although we were unable to confirm when they were last reviewed as some were not dated. Not all staff had received regular performance reviews. The arrangements for governance and performance did not always operate effectively. We found the lack of governance arrangements had resulted in areas such as medicines management not being identified as a risk. There was limited evidence to demonstrate an ongoing programme of clinical audit or re-audit. We had some concern regarding the leadership at the practice. The risks and issues we identified did not always correspond with what we were told nor were the issues understood by some leaders. We received some conflicting information from the management team. During feedback to the practice we experienced varying levels of acknowledgement regarding the areas we identified as requiring improvement.

What we found at this inspection in March 2017

Vision and strategy

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

- The practice had a mission statement which was available for patients to see. Staff had been involved in creating the mission statement and knew and understood the values.

The practice had a recently established business plan. This did not contain information of owners of the plan and how it was going to be achieved and by when.

Governance arrangements

Although the practice had a wide ranging governance framework and staff were, in the majority of cases, aware of roles and responsibilities within the practice; there was insufficient attention paid to identified and unidentified risk. The governance arrangements were ineffective which undermined the practice's aim to provide consistently high quality safe care:

- A comprehensive understanding of the performance of the practice was not maintained in all areas.
- The arrangements in place for identifying, recording and managing risks were not always effective. For example, the arrangements for managing medicines were not sufficiently robust and there was a clear lack of oversight by the partners in respect of the dispensary.
- Whilst the practice had taken steps to raise the awareness, understanding and importance of reporting significant events we identified such events were not always being recorded and therefore investigated as such. The partners at the practice were not aware of this.
- Staff were not always recruited safely. The practice could not evidence they had undertaken audits for the two most recent recruits. We also identified that staff who acted as a chaperone did not have a DBS check in place.
- In most cases there was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- Practice specific policies were available to all staff. However the policies and procedures in place did not always identify lead roles. Shortly prior to the inspection the practice had put in place a list of lead roles for staff to refer to. We found not all staff were clear on specific lead roles. The policies and procedures were mostly dated, updated and reviewed regularly. A small number of the policies required review.
- Staff were supported and encouraged to develop new skills and into new roles. For example the HCA was taking a lead in diabetes care.
- Poor performance was not always managed in a timely way.
- A programme of continuous clinical audit was used to monitor quality and to make improvements. There was no programme of non-clinical audit in place.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Are services well-led?

Requires improvement

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

Leadership and culture

Staff told us the partners were approachable and always took the time to listen to all members of staff. Staff told us there had been a significant amount of change in recent years to develop a more supportive, cohesive and open culture at the main and branch practice. We saw evidence of this. We were told there had been vast changes in the culture at the practice in recent years and that a significant amount of time had been invested to bring the two practices together to function as one.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. From the sample of significant events we reviewed 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 verbal and written apology.

Despite this we identified incidents that were not recorded as significant events and therefore this transparency was not always applied.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Quarterly staff meetings were held in the evenings so that all staff could attend. Staff were paid to attend these meetings to encourage attendance. Minutes were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. The practice had recently introduced an initiative where staff provided feedback about members of staff and the person with the most amount of feedback each month received a gift from the practice.
- The partners encouraged staff to be involved in discussions about how to run and develop the practice

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. The PPG was part of the Upper Dales Area Partnership which was a collaboration of North Yorkshire County Council, Richmondshire District Council (organisers), local businesses, HRWCCG, local press, transport representatives and local medical practices who met regularly to discuss challenges being faced in the area. The PPG had an action plan in place which showed recorded actions had been taken forward. For example adding the PPG details to the practice website and including a synopsis from the UDAP meetings on the practice website.
- the NHS Friends and Family test, complaints and compliments received.
- staff through staff social events and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practices approach to continuous improvement was mixed. We saw evidence of a focus on continuous learning and improvement in some but not all areas of the practice. The practice clearly demonstrated they had made improvements in a range of areas ranging from improvements to the physical buildings, putting in place a programme of appraisal, introducing a programme of clinical audit, implementing a new meeting structure and supporting staff to access training. The practice also demonstrated a commitment to improving the services available to the community they served. For example the practice had been involved in a range of CCG pilots the most recent being a 20 week pilot running from May to September 2017 to improve safety in prescribing in the frail elderly. A new system had been created and was about to be piloted in relation to improving the patient experience

Are services well-led?

Requires improvement

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

when visiting the practice to discuss contraception. They monitored their performance against other practices and took action where necessary. However, we also identified areas where continuous improvement and learning was not being appropriately managed resulting in the risks and issues we identified. For example responding to all the issues identified at the previous inspection, medicines management, significant event management and training of staff.

Following the inspection the practice provided us with a range of evidence to demonstrate their commitment to addressing the issues we identified at this inspection. For example an enhanced business plan had been written which referred to the introduction of governance meetings and upskilling of dispensing staff. The practice also provided other information such as updated policies and tools for recording near misses in the dispensary and confirmation that DBS checks were in progress for all staff.

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
Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** **How the regulation was not being met:** **Governance systems and processes were not in place to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk including staff. Specifically in respect of arrangements to respond effectively in an emergency, medicines management, recruitment, training and monitoring procedures, infection prevention and control, significant event management and risk management.** **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** **How the regulation was not being met:** **Not all staff had received essential training including infection control, information governance and basic life support.** **The provider did not always revisit concerns regarding staff competence in a timely way in order for them to assess if improvement had been made.**

This section is primarily information for the provider

Requirement notices

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

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
Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** How the regulation was not being met: The provider was not assessing the risks to the health and safety of service users in regards to receiving the care or treatment and not doing all that is reasonably practicable to mitigate any such risks. Specifically, the arrangements for managing medicines were not always safe. Controlled drugs were not audited regularly, risk assessments were not appropriate for the medicines third party collection service, systems and processes were not in place to ensure Patient Group Directions (PGDs) were reviewed and updated, prescriptions were being sent for pricing before medicines were collected and blank prescription forms were not always stored in line with national guidance. The system in place for reporting, recording and reviewing significant events was not effective resulting in incidents not always being recorded and subsequently investigated as significant events. Changes introduced following such events were not revisited over time to assure the practice the changes were embedded into practice which resulted in a recurrence of similar events. Not all staff demonstrated they understood their responsibilities to raise safeguarding concerns.

This section is primarily information for the provider

Enforcement actions

Appropriate recruitment checks had not always been undertaken prior to employment. There was no evidence of satisfactory conduct in previous employment in the form of references for the two most recent recruits; one clinical and one non-clinical.

Staff who acted as a chaperone did not have a DBS check in place.

Infection control audits were not carried out. The arrangements for disposing of sanitary waste were inappropriate.

The arrangements for responding to an emergency were not always appropriate with emergency medicines not always being easily accessible and not all staff being trained in basic life support.

Patient records were not always securely stored.

Medicines in the dispensary were not securely stored.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.