Wilmslow Road Surgery

Quality Report

Wilmslow Road Surgery
Wilmslow Road Medical 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	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
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 carried out an announced comprehensive inspection at Wilmslow Road Surgery on the 14 April 2016. The overall rating for the practice was requires improvement, with key question Safe rated as inadequate, and Responsive and Well led rated as requires improvement. We issued three requirement notices for breaches of regulation and the practice submitted an action plan detailing how they intended to improve the service they provided. The full comprehensive report on the April 2016 inspection can be found by selecting the 'all reports' link for Wilmslow Road Surgery on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection on 25 April 2017. Overall the practice is now rated as Inadequate.

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

- Since the last inspection the practice had improved the system for reporting and recording significant events and ensuring all staff were made aware of any learning and improvement from incidents.
- Actions undertaken by the practice to ensure health care risks for patients were minimised were inadequate. For example safeguarding registers and carer's registers were not available.
- Systems to ensure patient pathology results were checked in a timely manner were not implemented, recorded care plans were not available and checks to monitor patients referred on the two week pathway were reactive.
- Some improvement had been made to recruitment checks since the last inspection. Recruitment records included Disclosure and Barring Service checks (DBS) for staff employed at the practice. However we observed that one employee's recruitment file was missing information about their employment status and professional and character references.
- Some improvements had been made in the environment at Wilmslow Road, however further refurbishment was required.

Summary of findings

- Risk assessments for fire safety at both the practice main location (Wilmslow Road) and the branch location in Sale had been undertaken but no action had been taken to address the key risks areas identified. A Legionella risk assessment for Wilmslow Road had been undertaken but no action had been implemented in response to the areas identified.
- Governance arrangements to monitor and review the service provided were not supported by clear objectives and actions plans. This had resulted in gaps in service delivery and performance.
- Some policies including the Duty of Candour or (Being Open policy), Consent and the Mental Capacity Act were not available and the complaints policy was available upon request and was not in a user friendly format.
- Staff confirmed they attended weekly team meetings which they found useful.
- The practice had reviewed its patient access to appointments and provided open surgeries four mornings each week.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice website needed updating.

The areas where the provider must make improvements are:

- Implement action to mitigate any risks to patients and to ensure care and treatment is provided in a safe way. This includes:
  - Ensuring patient pathology laboratory results are responded to in a timely manner,
  - Ensuring the practice safeguarding leads have oversight and knowledge of children and young people with a child protection plan in place or designated at 'risk'.
  - Ensuring there are appropriate emergency medicines available to respond quickly and effectively to medical emergencies such as severe asthma, pain, and nausea.
  - Ensuring patients prescribed high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs have received the correct healthcare monitoring
  - Ensuring the written care plans are maintained and copies provided to patients.
- Implement immediate action to improve the practice environment by undertaking a planned programme of improvement to minimise the identified risks in the fire and Legionella risk assessments.
- Implement comprehensive systems of governance to monitor and review the practice performance and implement strategies to improve, including:
  - Ensuring policy and procedures are available including The Duty of Candour, Consent and the Mental Capacity Act.
  - Implementing systems to monitor actions taken in response to NICE guidance and updates from the Medicines & Healthcare products Regulatory Agency (MHRA).
  - Ensuring the complaints policy is readily available to patients in a readable format.
  - Ensure systems to monitor patients two week secondary care referrals are proactive and systems to monitor patients on high risk medicines such as DMARDS are implemented.
  - Ensure all staff have access to essential information including team meeting minutes, guidance and alerts.

In addition the provider should:

- Improve systems to demonstrate the receipt of all the necessary pre-employment checks for all staff including agency /self-employed staff.
- Take proactive action to improve cancer screening of patients including cytology
- Implement a system of regular checks for the oxygen and the practice defibrillator.
- Improve the monitoring of all prescription paper used at the practice.
- Implement a planned programme of refurbishment.
- Develop a carer's list in order to support patients who are also carers.
- Update the practice website to reflect the actual services provided including changes in the appointment system, staffing and medical students.

I am placing this service in special measures. Where a service is rated as inadequate for one of the five key questions or one of the six population groups and after re-inspection has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we place it into special measures.

Summary of findings

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as 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 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.

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

At our previous inspection on 14 April 2016, we rated the practice as requires improvement overall and inadequate for providing safe services. We found that staff were not always clear about reporting incidents and lessons learned from these were not communicated and so safety was not improved. Recruitment checks were not always carried out, infection control audits were not undertaken and the appropriate building checks were not in place such as gas and electrical safety certificates.

Some arrangements had partially improved when we undertook a follow up comprehensive inspection on 25 April 2017. However, other gaps in service provision were identified. The practice remains as inadequate for providing safe services.

- Since the last inspection the practice had improved the system for reporting and recording significant events and ensuring all staff were made aware of any learning and improvement from these investigations. Meeting minutes demonstrated learning was shared and staff confirmed their attendance at these meetings.
- Although risks to patients were now assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example fire and Legionella risk assessments had been undertaken and several areas of concern identified as requiring immediate action. No action had been taken or was planned.
- Staff were trained and action was taken by the practice in relation to safeguarding children and adults however the practice did not have oversight and knowledge of children and young people with a child protection plan in place or designated at 'risk'. Registers to provide an overview and to monitor children and vulnerable adults were not available.
- Recruitment procedures had improved although comprehensive records for one worker were not available.
- Some risks to patients were assessed and managed, however some medicines that maybe required to respond to a medical emergency were not available; systems to monitor patients prescribed high risk medicines, monitoring of the use of prescription paper, and regular checks on the oxygen and defibrillator were not implemented.

Summary of findings

Are services effective?

Requires improvement

The practice was rated as good for providing effective services at our previous inspection on 14 April 2016.

The practice is now rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework showed patient outcomes reflected the local and the national average.
- A clinical audit plan was in place and the practice monitored and benchmarked its progress with others in the clinical commissioning group.
- Pathology laboratory results were not checked in a timely manner, recorded care plans were not available and checks to monitor patients referred on the two week pathway were reactive.
- Staff assessed needs and delivered care in line with current evidence based guidance, although a system to ensure clinicians had read and responded to guidance such as Medicines & Healthcare products Regulatory Agency (MHRA) were not monitored.
- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However policies on consent and the Mental Capacity Act were not available.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. At our previous inspection on 14 April 2016 we rated the practice as good for providing caring services as data showed patients were generally satisfied with the service they received.

The practice is now rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the national GP patient survey from July 2016 showed patients rated the practice at a comparable level to other practices in the locality.
- 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 easy to understand and accessible. Staff members were able to speak a number of languages which reflected the diversity of the patient population.

Summary of findings

- The practice staff team including GPs were unable to confirm that a carer's list of patients was maintained.
- Feedback from CQC patient comment cards was positive.

Are services responsive to people's needs?

Good

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing responsive services. Feedback from patients reported that access to a named GP and continuity of care was not always available. The complaints procedure did not reflect recognised guidance and there was no evidence that learning from verbal complaints had been shared with staff.

These arrangements had improved when we undertook a follow up inspection on 25 April 2017. The practice is rated as good for providing responsive services

- The practice had reviewed its patient appointment availability since the last inspection and now provided open access appointments four mornings per week.
- The practice was in the process of closing the branch surgery in Sale to ensure sufficient staff were available at the main Wilmslow Road location.
- The practice was equipped to treat patients and meet their needs. However the Wilmslow Road surgery building and equipment were showing evidence of wear and tear.
- Systems to allow patients to complain proactively needed improving as the complaint procedure was provided upon request from the practice manager. The written complaint procedure format was formal and a patient friendly version was not available.

Are services well-led?

Inadequate

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing well led services. The governance arrangements were not fully embedded and this had led to gaps in the safe management of the service. For example, staff did not have access to job descriptions and the policies and procedures were not always reviewed on time. There were gaps in recruitment checks, infection control audits, clinical auditing and building checks.

Although some of these arrangements had improved when we undertook a follow up inspection on 25 April 2017, we found other areas of significant concern. The practice is rated as inadequate for being well-led.

Summary of findings

- The GP partners were the practice owners and clinical care providers and following our last inspection they brought in a consultancy agency to support the practice. However evidence suggested that the guidance and advice from the consulting agency had not always been followed. For example key policies such as the Duty of Candour or Being Open policy and Consent were not available and systems promoting information sharing of, for example team meeting minutes, and health professional contact information, were not available to staff in the absence of the practice manager.
- Governance arrangements to monitor the provision of safe services to patients were not in place. Gaps in monitoring included lack of oversight of patients on the safeguarding registers and lengthy waits before patient pathology results were reviewed. In addition the practice staff including GPs were unable to provide evidence that they responded to patient safety alerts.
- The practice website contained out of date information.
- The practice team was small and there was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues on a day to day basis and felt confident and supported in doing so.
- A patient participation group (PPG) or patient forum was established, and meeting minutes from August 2016 were available.

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 is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

However:

- 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 and urgent appointments for those with enhanced needs.
- Regular multidisciplinary meetings were held to discuss patients nearing the end of life in order to ensure their needs were being met.
- The practice followed up on older patients discharged from hospital, however recorded care plans were not available.

People with long term conditions

Inadequate

The provider is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

However:

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Data from 2015/16 indicated the practice's performance was similar to local and national averages when monitoring and supporting patients with diabetes. For example the percentage of diabetic patients with a blood pressure reading 140/80mmHG or less recorded within the preceding 12 months was 83%, which was higher than the CCG and England average of 78%.
- The percentage of diabetic patients whose last measured total cholesterol was 5mmol/l or less within the preceding 12 months was 86%, which was above the CCG average of 82%, and the England average of 80%.

Summary of findings

- However evidence that patients with a long term condition received a written care plan to assist them to self manage their condition was not available.

Families, children and young people

Inadequate

The provider is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

- There was a lack of oversight and knowledge of children and young people with a child living in disadvantaged circumstances and who were at risk. Registers to provide an overview and to monitor children and vulnerable adults were not available.

However:

- Immunisation rates for the vaccines given to children were comparable to the CCG and national averages.
- Quality and Outcome Framework (QOF) 2015/16 data showed that 65% of patients with asthma, on the register had an asthma review in the preceding 12 months compared to the CCG and the England average of 75%. The practice had a lower rate of exception reporting at 3% compared to the CCG average of 6% and the England average 8%.
- The practice's uptake for the cervical screening programme was 71%, which was lower than the CCG average of 78% and the national average of 82%. However the practice's clinical exception reporting rate was also lower at 6% compared to the CCG average of 13%.
- The practice had emergency processes for acutely ill children and young people.

Working age people (including those recently retired and students)

Inadequate

The provider is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

However:

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these

Summary of findings

were accessible, flexible and offered continuity of care, for example, extended opening hours were available and were offered on Tuesday and Thursday evenings between 6.30pm until 8pm.
- The practice offered 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

Inadequate

The provider is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

However:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- 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. However the practice did have an oversight or maintain a register of patients living in vulnerable circumstances or considered at risk from abuse.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider is rated as inadequate for two key questions safe and well-led and requires improvement for providing effective and caring services. The concerns identified overall affected all patients including this population group.

However:

- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was higher than the CCG average of 89% and the England average of 84%.
- 74% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was lower than the CCG average and England average of 89%. The practice had a lower rate of exception reporting at 3% compared to the CCG average of 12% and the England average 13%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP Patient Survey results were published on 7 July 2016. The results showed the practice was performing similarly to the local and national averages. A total of 363 surveys were sent out, 74 surveys were returned. This was a return rate of 20% and represented just over 1% of the practice's patient list.

- 81% of patients found it easy to get through to this practice by phone, compared to the Clinical Commissioning Group (CCG) average of 74%. The national average was 73%.
- 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 80% and the national average of 85%.
- 79% of patients described the overall experience of this GP practice as good compared to the CCG average of 82% and the national average of 85%.
- 68% 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 75% and the national average of 78%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 40 comment cards, all but two of which were positive about the standard of care received. Comment cards described the practice, GPs and reception staff as being responsive, caring and willing to listen. Comments cards repeatedly stated the practice was 'helpful'.

We spoke with one patient on the day and one patient the day after the inspection. Both were complimentary about the quality of care they received from the GPs and their comments reflected the information we received from the CQC comment cards. Patients told us they liked the open surgeries and knew they would see a GP on the day they needed or wanted to. Patients confirmed that they did have to wait to see a GP but accepted this.

The practice had a patient forum or patient participation group (PPG) and one patient we spoke with was a member of this group. They told us that they attended meetings which the GPs attended and they discussed issues such as appointments and parking.

Areas for improvement

Action the service MUST take to improve

- Implement action to mitigate any risks to patients and to ensure care and treatment is provided in a safe way. This includes:
  - Ensuring patient pathology laboratory results are responded to in a timely manner,
  - Ensuring the practice safeguarding leads have oversight and knowledge of children and young people with a child protection plan in place or designated at 'risk'.
  - Ensuring there are appropriate emergency medicines available to respond quickly and effectively to medical emergencies such as severe asthma, pain, and nausea.
  - Ensuring patients prescribed high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs have received the correct healthcare monitoring
  - Ensuring the written care plans are maintained and copies provided to patients.
- Implement immediate action to improve the practice environment by undertaking a planned programme of improvement to minimise the identified risks in the fire and Legionella risk assessments.
- Implement comprehensive systems of governance to monitor and review the practice performance and implement strategies to improve, including:
  - Ensuring policy and procedures are available including The Duty of Candour, Consent and the Mental Capacity Act.
  - Implementing systems to monitor actions taken in response to NICE guidance and updates from the Medicines & Healthcare products Regulatory Agency (MHRA).
  - Ensuring the complaints policy is readily available to patients in a readable format.

Summary of findings

- Ensure systems to monitor patients two week secondary care referrals are proactive and systems to monitor patients on high risk medicines such as DMARDS are implemented.
- Ensure all staff have access to essential information including team meeting minutes, guidance and alerts.

Action the service SHOULD take to improve

- Improve systems to demonstrate the receipt of all the necessary pre-employment checks for all staff including agency /self-employed staff.
- Take proactive action to improve cancer screening of patients including cytology
- Implement a system of regular checks for the oxygen and the practice defibrillator.
- Improve the monitoring of all prescription paper used at the practice.
- Implement a planned programme of refurbishment.
- Develop a carer's list in order to support patients who are also carers.
- Update the practice website to reflect the actual services provided including changes in the appointment system, staffing and medical students.

Wilmslow Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Wilmslow Road Surgery

Wilmslow Road Surgery provides services from two sites. The main site is located at Wilmslow Road Medical Centre, 156 Wilmslow Rd, Manchester M14 5LQ. The branch surgery is located at 79 Washway Road, Sale, Cheshire, M33 7TQ. The practice is part of the NHS Central Manchester Clinical Commissioning Group (CCG) and has approximately 4703 patients. The practice provides services under a General Medical Services contract, with NHS England.

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

The numbers of patients in the different age groups on the GP practice register are generally similar to the average GP practice in England. There is a higher number of patients aged 15 to 44 years. The practice has 54% of its population with a long-standing health condition, which is similar to the England average of 53% but higher than the local average of 50%.

The services from Wilmslow Road are provided from a purpose built building with disabled access and off street parking. The practice has three consulting rooms and one treatment room. The services from the practice in Sale are provided from a converted shop on the main road. We did not visit the Sale branch of the GP practice because we were informed that a process of patient consultation to close this branch had begun.

The service is led by two GP partners (one male, one female) who are supported by a female salaried GP. We were informed that the salaried GP was about to be added to the NHS England contract to become a partner. Once this was confirmed we were advised that an application to add this GP to the registered partnership would be submitted to the CQC.

The GPs are supported by a practice manager and a phlebotomist as well as an administration team including a number of reception / administrative staff who also cover other duties such as dealing with samples and drafting prescriptions. The practice is recruiting a practice nurse and in the interim was using a regular agency/ self-employed practice nurse one day per week. Following the last inspection the GP partners brought in a consultancy agency to support the practice.

The Wilmslow Road practice is open between 8.00am to 6.30pm on Mondays, Tuesdays, Thursdays and Fridays. Open access or walk in surgeries are offered in the morning on these days. Patients arriving between 9am and 11am are seen on that day. Routine bookable appointments are offered on Wednesday s until 2pm. Extended hours are offered on Tuesday and Thursday evenings between 6.30pm until 8pm.

The Sale practice is open between 9am and 10am and 5pm to 6pm on Mondays, Tuesdays,Wednesdays and Fridays. Patients can walk in during these times with no pre-booked appointments.

Telephone consultations and home visits are also provided daily as required.

Detailed findings

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

The practice provides online access that allows patients to book appointments and order prescriptions.

Why we carried out this inspection

We undertook a comprehensive inspection of Wilmslow Road Surgery on 14 April 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe service and requires improvement for responsive and and well led services.

We issued three requirement notices to the provider in respect of, safe care and treatment, good governance and fit and proper persons employed. The practice supplied an action plan which detailed how and when the practice would become compliant with the law by the end of September 2016. We undertook a follow up inspection on 25 April 2017 to check that action had been taken to comply with legal requirements. The full comprehensive report on the April 2016 inspection can be found by selecting the 'all reports' link for Wilmslow Road Surgery on our website at www.cqc.org.uk.

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. We carried out an announced visit on 25 April 2017.

During our visit we:

- Spoke with a range of staff including both GP partners, and the salaried GP (new partner). We spoke with the lead business consultant engaged by the practice following the last inspection, the practice phlebotomist, three reception/admin staff and the agency practice nurse by telephone after the inspection visit.
- Spoke with one patient and telephoned one patient the day after the inspection.
- Observed how reception staff communicated with patients.
- Reviewed an anonymised sample of patients' personal care or treatment records.
- Reviewed comment cards where patients shared their views and experiences of the service.

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 14 April 2016, we rated the practice as inadequate for providing safe services. We found that staff were not always clear about reporting incidents, near misses and concerns, and lessons learned from these were not communicated and so safety was not improved. Recruitment checks were not always carried out, infection control audits were not undertaken and the appropriate building checks were not in place such as gas and electrical safety certificates. Some staff had not received training in safeguarding and at times there were insufficient staff available at both the main surgery and the branch surgery.

Despite some improvement in the above areas we found other areas of concern at our follow up comprehensive inspection on 25 April 2017. The practice remains rated as inadequate for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- 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 practice did not have a policy for the Duty of Candour or a 'Being Open' policy therefore we could not assure ourselves that the incident recording form supported the recording of notifiable incidents under the legislation for 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 practice carried out investigations of the significant events identified, and staff confirmed they were informed of any improvements to practice or systems. At the previous inspection, evidence that learning from significant event investigations was shared was not available. However, at this inspection recorded evidence in the form of team meeting minutes demonstrated that staff were kept informed of the outcome of significant event investigations.

Overview of safety systems and processes

The practice had processes and practices in place to minimise risks to patient safety. However these required further development.

- 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. However the practice safeguarding leads were unable to demonstrate that they had oversight and knowledge of children and young people with a child protection plan in place or designated at 'risk'. Safeguarding registers of patients identified at risk which would provide an overview were not in place. (Safeguarding registers facilitate active management including, review and monitoring of those children and vulnerable adults assessed at risk from abuse.)
- There was a lead member of staff for safeguarding. GPs were trained to child protection or child safeguarding level three. The practice phlebotomist and the agency practice nurse were trained to safeguarding level 2. Staff were also trained in recognising and responding to domestic abuse.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.
- 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 practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. Since the last inspection the practice had employed a cleaning company. There were cleaning schedules and monitoring systems in place. Risk assessment such as the control of substances hazardous to health were available.
- A GP partner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams. A recent IPC audit and risk assessment had been undertaken and several areas requiring improvement had been identified. Evidence

was available that demonstrated the practice had implemented some of the required actions and further improvements were planned. There was an IPC protocol and staff had received up to date training.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised some of the risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being given to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. However we noted that the practice provided prescriptions to patients prescribed disease-modifying anti-rheumatic drugs (DMARDs). Secondary care services carried out the monitoring of these patients bloods, however the practice did not routinely check with the secondary care service to ensure the prescriptions provided were appropriate. Blank prescription forms and pads were securely stored and there were records of the boxes prescription paper entering the practice. However records monitoring the use and traceability of prescription paper in the practice were not available. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

At the previous inspection, we found that a recruitment policy was not available and there were gaps in the staff recruitment files we reviewed. At this inspection, a recruitment policy was available. We reviewed five personnel files including one for an agency worker and an additional four records for locum GPs. We noted improvements including DBS checks, proof of identification, references, qualifications, and registrations with the appropriate professional body. One staff file for one staff member did not identify what the employee's status was. There was no application or contract in place nor were references available. The employee confirmed to us their status as being an agency /self-employed worker having previously been employed by the practice for a number of years.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety. Action had been taken since the previous inspection to improve the health and safety of the building and equipment however significant gaps were identified at this inspection.

- There was a health and safety policy available.
- Fire risk assessments had been undertaken at the beginning of March at both Wilmslow Road Surgery and the branch surgery at Sale. Both risk assessments identified several areas requiring action. For example at the Wilmslow Road Surgery seven out of the ten areas identified were rated as level one actions requiring action within one month. One area identified included the premises back door which was designated as a fire exit but which was kept locked and the key was not readily accessible. At the branch surgery in Sale, 21 actions were identified 14 of which were rated level one requiring action within one month. The GPs confirmed that no action had been taken in response to the areas identified and that a plan to respond to these areas was not in place.
- The practice carried out regular fire drills. There were designated fire marshals within the practice.
- All electrical and clinical equipment was checked and calibrated at the Wilmslow Road Surgery to ensure it was safe to use and was in good working order. We were told that records of calibration were not available for the branch surgery. Gas and electrical safety certificates were available.
- The practice had a Legionella risk assessment undertaken in January 2017(Legionella is a term for a particular bacterium which can contaminate water systems in buildings). This identified a number actions required to reduce the risk of Legionella developing. These included replacing the boiler, reducing the hot water temperature and undertaking a scalding risk assessment. A plan of action to implement these actions was not in place. The risk assessment also identified three key personnel as requiring training in the management of risk and Legionella. This training had not been undertaken.
- The practice had recognised that the Wilmslow Road Surgery needed up dating and refurbishment. The practice had submitted plans previously to NHS England and the forerunner to the clinical commissioning group (primary care trust) to pursue funding to develop and

upgrade the practice building. However the funding support had not materialised and the practice confirmed they continued to pursue this. Evidence was available that the practice had obtained some quotes for some improvement work to be undertaken. However an improvement plan with timescales had not been developed.

- 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.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there 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. However systems to regularly check these were not in place. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. Not all medicines that may be required in an emergency (including antihistamine, antiemetic, analgesic or hydrocortisone) were available and this potentially put patients at risk.
- The practice had a 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

The practice was rated as good for providing effective services at our previous inspection on 14 April 2016.

Evidence reviewed at the follow up comprehensive inspection on 25 April 2017 identified some areas of concern and the practice is now rated as requires improvement.

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.

- GPs told us that they kept up to date with NICE guidelines and used this information to deliver care and treatment that met patients' needs. However it was unclear if the practice manager maintained a separate log of NICE guidance and actions taken by the practice in response to these. A folder of updates from the Medicines & Healthcare products Regulatory Agency (MHRA) was available but evidence demonstrating action taken in response to these was not available.

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 (2015/16) results were 92% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 95%. Clinical exception reporting overall was 5% which was lower than the CCG average of 11% and the England rate 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).

Unverified QOF data supplied by the practice had achieved 94.6% of the total points available for 2016/17.

Data from 2015/16 showed:

- The percentage of patients with diabetes on the register in whom the last blood test (HbA1c) was 64 mmol/mol or less in the preceding 12 months was 69%, compared to the CCG average of 75% and the England average of 78%. The practice had a lower rate of exception reporting at 5% compared to the CCG average of 14% and the England average 12.5%.
- The percentage of diabetic patients with a blood pressure reading 140/80mmHG or less recorded within the preceding 12 months was 83%, which was higher than the CCG and England average of 78%. The practice had a lower rate of exception reporting at 4% compared to the CCG average of 11% and the England average 9%.
- The percentage of diabetic patients whose last measured total cholesterol was 5mmol/l or less within the preceding 12 months was 86%, which was above the CCG average of 82%, and the England average of 80%. The practice had a lower rate of exception reporting at 5% compared to the CCG average of 12% and the England average 13%.
- 92% of patients with diabetes registered at the practice received a diabetic foot check compared with the CCG average and the England average of 88%. The practice had a lower rate of exception reporting at 4% compared to the CCG average of 10% and the England average 8%.

Other data from 2015/16 showed the practice performance was similar or better than the local and England averages. For example:

- 82% of patients with hypertension had their blood pressure measured as less than 150/90 mmHg in the preceding 12 months compared to the CCG average of 81% and the England average of 83%.
- 65% of patients with asthma, on the register had an asthma review in the preceding 12 months compared to the CCG and the England average of 75%. The practice had a lower rate of exception reporting at 3% compared to the CCG average of 6% and the England average 8%.
- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was higher than the CCG average of 89% and the England average of 84%.
- 74% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the preceding 12 months, which was lower than the CCG average and England average of 89%. The practice had a lower rate of exception reporting at 3% compared to the CCG average of 12% and the England average 13%.

Requires improvement

Are services effective?

(for example, treatment is effective)

There was evidence of quality improvement including clinical audit:

Since the last inspection in April 2016 we observed that the practice had developed a clinical audit plan, which detailed audits already undertaken and scheduled the planned re-audits.

Examples of these included two audit cycles for the prescribing of 300mg aspirin tablets. The initial audit undertaken in 2015 identified patients prescribed this dose of medicine. Following individual patient review and discussion with the practice team, changes were implemented and following a re-audit in 2016 no patients were prescribed 300mg aspirin medicine. In addition the practice had just completed a re-audit on the prescribing of Warfarin medicine (warfarin is a blood thinning medicine.)

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The agency practice nurse provided evidence to the practice that they were up to date with role specific training which included immunisations and vaccinations and cytology. We discussed with the practice nurse how they maintained themselves up to date and where they attended training.
- Since the previous inspection all staff had had appraisal and they confirmed that they had attended a range of training courses including on line learning.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. However we noted a some areas requiring action to ensure patient care needs were met in a timely and appropriate manner. For example:

- We observed 119 patient pathology laboratory reports dating back to 15 March 2017 with no evidence of action on the patient record system. Further checks on patient records did show that some of the pathology reports had been discussed with patients, however we found evidence that results for one patient had not been discussed even though the patient had attended a GP appointment. The week following the inspection the practice confirmed to us in writing that all the pathology reports had been reviewed and actioned as required and a protocol had been implemented to ensure pathology laboratory results were reviewed promptly.
- We were unable to view a sample of patient care plans and following discussion with GPs it was identified that care plan templates were not available. Where records showed that a patient had a care plan in place we heard that this was following a discussion with the patient and this was not a written care plan.
- Collective monitoring of patients referred on the two week referral pathway to secondary care was reactive, in that a note was made when the practice was notified by secondary care that an appointment had been made. This meant that the practice would not be aware if a patients did not receive an appointment within the required timescale.

The practice ensured that they participated at monthly multi-disciplinary team meetings, known locally as the patient integrated care team (PICT). We heard that this had been beneficial to the practice patients with complex care needs in that additional community resources were targeted to support these patients. The practice monitored its performance and provided data which showed that the practice was slowly reducing the number of patients attending the local emergency department.

Meetings took place with other health care professionals on a monthly basis to ensure 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. However policies for Consent and the Mental Capacity Act were not available.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff spoken with demonstrated an understanding about patients' capacity to consent to treatment and provided examples where they had a assessed patients' understanding of the treatment offered.

Supporting patients to live healthier lives

Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking were supported by the practice. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 71%, which was lower than the CCG average of 78% and the national average of 82%. However the practice's clinical exception reporting rate was also lower at 6% compared to the CCG average of 13%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. 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.

The practice also referred its patients to attend national screening programmes for bowel and breast cancer screening. The practice patient uptake of these tests was similar or slightly below the CCG average which was below the national average. For example data from 2015/16 showed that 60% of females aged between 50 and 70 years of age were screened for breast cancer within six months of invitation compared the the CCG average of 59% and the England average of 74%. Data also showed screening for bowel cancer was lower at the practice with a rate of 39% for people screened within the last 30 months compared to 42% for the CCG and 58% for the England averages.

Data available for childhood immunisation rates for the vaccinations given in 2015/16 indicated that the practice was achieving above 90% or more in the three out of the four indicators.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to the CCG and national averages. For example, rates for the MMR1 (measles, mumps and rubella) vaccines given to five year olds was 96% compared to the CCG and England average of 94%

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.

Requires improvement

Are services caring?

Our findings

At our previous inspection on 14 April 2016, we rated the practice as good for providing caring services as data showed patients were generally satisfied with the service they received.

Evidence reviewed at the follow up comprehensive inspection on 25 April 2017 confirmed no change in rating for this key questions.

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.
- The practice had a plan in place to move the practice telephones to a back office to provide patients with privacy when contacting the surgery.

A total of 38 out of 40 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were described repeatedly as helpful, caring and treated them with dignity and respect.

We spoke with two patients including one member of the patient forum or patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice scored similarly to or just below the local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and national average average of 89%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% to the national average of 85%.
- 88% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 91%.
- 90% of patients said the nurse gave them enough time compared with the CCG average of 90% and the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 88% and the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% 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 decisions. Patient feedback from the comment cards we received was also positive and aligned with these views. However written care plans demonstrating the agreed treatment and support strategies for patients' individual needs were not available.

We heard that children and young people were treated in an age-appropriate way and recognised as individuals.

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 similar to local and national averages. For example:

Requires improvement

Are services caring?

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 80% and the national average of 82%.
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 83% and the national average of 85%.

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

- The staff employed by the practice were able to speak a range of different languages, which enabled staff to give individual support to patients who did not have English as a first language. Interpretation services were also available for patients who required or requested this.
- 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.

Staff spoken with including one GP said there was not aware of a list of patients who were also carer's. The practice was therefore unable to demonstrate they offered an avenue of support in a consistent and regular way to these patients.

Staff told us that if families had experienced bereavement, their usual GP sent them a sympathy card. Patients were offered a 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing responsive services. Feedback from patients reported that access to a named GP and continuity of care was not always available. The complaints procedure did not reflect recognised guidance and there was no evidence that learning from complaints had been shared with staff.

Improvements had been made at the follow up inspection on 25 April 2017. The practice is now rated as good for providing responsive services.

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 extended hours on Tuesday and Thursday evenings between 6.30pm until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability or complex health care need.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- The main surgery at Wilmslow Road provided accessible facilities, including ramped access and an adapted toilet. The branch surgery at Sale did not offer adapted facilities. However at the time of the inspection a period of patient consultation about the future of this branch surgery had commenced.
- Several staff employed by the practice were able to speak a range of different languages and so able to offer support as required to patients who did not have English as a first language.

Access to the service

Following the previous inspection the practice had reviewed how to improve patient access to appointments. As a result the practice had changed the appointment systems so that open access or walk in surgeries were available four morning each week. Patients spoken with and feedback from patient comment cards indicated that they preferred this and they could see a GP on the day they needed to. Patients acknowledged though that on occasion they had lengthy waits at the surgery to see the GP especially if patient demand was high at the open access surgery.

The Wilmslow Road practice was open between 8.00am to 6.30pm on Mondays, Tuesdays, Thursdays and Fridays. Open access or walk in surgeries were offered in the morning on these days. Patients arriving between 9am and 11am were seen on that day. Routine bookable appointments were offered at the afternoon /evening surgeries and on Wednesdays until 2pm. Extended hours were offered on Tuesday and Thursday evenings between 6.30pm until 8pm.

The Sale branch surgery was open between 9am and 10am and 5pm to 6pm on Mondays, Tuesdays, Wednesdays and Fridays. Patients can walk in during these times with no pre-booked appointments.

Telephone consultations and home visits were also provided daily as required.

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

- 82% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 81% of patients said they could get through easily to the practice by phone compared compared with the CCG average of 74% and the national average of 73%.
- 84% 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 80% and the national average of 85%.
- 93% of patients said their last appointment was convenient compared with the CCG average of 89% and the national average of 92%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 76% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 32% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 48% and the national average of 58%.

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

The practice had a system to assess whether a home visit was clinically necessary; and the urgency of the need for medical attention.

Patients who requested a home visit were telephoned by the GP to discuss the issues affecting them. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. The practice manager was the designated responsible person who handled complaints for the practice. Since the last inspection the complaint policy had been updated so that it reflected recognised guidance and contractual obligations for GPs in England. However the complaints procedure was only accessible to patients upon request from the practice manager and was not in a user friendly format.

The practice had received two written complaints in 2016/17, one of which was withdrawn by the complainant. The records available indicated the practice responded to these appropriately. Since the last inspection the practice had implemented a system of recording patient's verbal complaints. These were investigated and where improvement and learning identified this was shared with the staff. Patients were also kept informed and received a verbal apology when things had gone wrong.

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 14 April 2016, we rated the practice as requires improvement for providing well led services. The governance arrangements were not fully embedded and this had led to gaps in the safe management of the service. For example, staff did not have access to job descriptions and the policies and procedures were not always reviewed on time. There were gaps in recruitment checks, infection control audits, clinical auditing and building checks.

Although some of these arrangements had improved when we undertook a follow up inspection on 25 April 2017, we found other areas of significant concern

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

Vision and strategy

The practice did not have a clear vision and strategy recorded. GP partners confirmed the practice did not have a mission statement. The aims and objectives listed within the statement of purpose related to specific activities and did not refer to any aspirational achievement or refer to the quality of service provided to patients. The practice website included a patient charter but this referred to specific policies such as the chaperone procedure and did not refer to the practice's commitment to patient care. However the staff we spoke with were all committed to providing a high standard of care and service to patients.

Following the last inspection the GP partners brought in a consultancy agency to support the practice. However evidence suggested that the guidance and advice from the consulting agency had not always been followed. For example the practice did not have a business plan that detailed the long and term short term development objectives that the practice wanted achieve.

Governance arrangements

The practice had not improved its governance framework to support the delivery of the strategy and good quality care. Some actions had been undertaken since our last inspection in April 2016. However, this inspection identified other gaps in monitoring the service which collectively indicated an inadequate monitoring framework.

For example:

- Key policies such as the Duty of Candour , Mental Capacity Act and Consent were not available.
- Governance arrangements to monitor the provision of safe services to patients were not in place. Gaps in monitoring included:
  - The lack of oversight of patients with a safeguarding plan in place or a designation of 'at risk'.
  - Lack of systems to ensure patient pathology results were reviewed and actioned within a reasonable time frame.
  - The lack of recorded care plans for patients.
  - The lack of systems to undertake checks, such as blood test on patients receiving high risk medicines prescribed by secondary care services.
  - The lack of system to proactively monitor patients referred on the two week pathway to ensure they receive a timely response.
  - The lack of oversight, planning and action to mitigate risks identified in the fire and Legionella risk assessments.
  - The lack of evidence that the practice had taken action in response to changes in NICE guidance and alerts issued by the Medicines & Healthcare products Regulatory Agency (MHRA).
  - The lack of staff access to practice team meetings minutes and other key information when the practice manager was absent from the practice.
  - The lack of up to date information on the practice website.
  - Staff recruitment records had improved; however one staff member did not have a record of their employment status or a professional and character reference available.

However the small staff team had a clear staffing structure and staff were trained and aware of their own roles and responsibilities.

Leadership and culture

Staff told us the partners were approachable and took the time to listen to all members of staff.

A policy on the duty of candour was not available and we were unable to fully assess whether the GP partners were aware of 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). We saw only two examples of written complaints. These provided limited evidence of

Are services well-led?

Inadequate

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

interaction with the complainants. However records of verbal complaints did demonstrate that patients were contacted and informed what had been taken in response to their concern to ensure the situation was not repeated.

Since the last inspection:

- The practice held weekly full team meetings. Staff spoken with found these beneficial and stated they had a better understanding of the running of the practice and the issues that affected performance.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues on a day to day basis and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported at the practice.
- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients.

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

The practice encouraged and valued feedback from patients, the public and staff.

- The practice had a patient forum (patient participation group) and minutes were available from a meeting undertaken in August 2016. A member of the patient forum stated that a further meeting had been undertaken 'three to four months ago', however minutes were not available from this meeting. The patient confirmed the many issues were discussed at these meetings, however the meeting minutes did not record the practice response to the issues discussed.
- An action plan was available detailing briefly the practice's response to to three areas identified in the independent national GP patient survey. However this was not dated and the staff at the practice, in the absence of the practice manager, were unable to clarify when the action plan had been recorded.
- The practice had gathered feedback from staff 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. Staff told us they felt involved and engaged to improve how the practice was managed. Staff were aware of the Whistleblowing policy and who to contact should they have a concern.

Continuous improvement

- The practice recognised the challenges it faced in securing funding to improve the building at Wilmslow Road Surgery.
- The practice was proactive in working collaboratively with multi-disciplinary teams to improve patients' experiences and to deliver a more effective and compassionate standard of care.
- The practice demonstrated how it monitored its performance and benchmarked itself with other practices.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had failed to identify the risks associated with the lack of timely response to patients pathology laboratory results, the lack of some emergency medicines; the lack of recorded care plans and the lack of proactive checks to monitor patients referred on the two week pathway They had failed to identify the risks associated with the lack of action to responds to the identified risks in the fire and Legionella risk assessments. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered provider could not demonstrate they implemented a systematic approach to maintaining and improving the quality of patient care and service delivery. There was a lack of systems and processes in place to assess monitor and improve the quality and safety of services provided at the practice.

This section is primarily information for the provider

Enforcement actions

There was no clear plan of action to review and respond to gaps in service achievements.

Regulation 17(1)