Drs P Keating & H Appleton

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
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

This comprehensive inspection was undertaken on 31st August 2017 following a period of special measures, the practice is now rated as requires improvement.

We previously carried out an announced comprehensive inspection at Drs P Keating and H Appleton on 10 January 2017. Breaches of legal requirements were found in relation to services being safe and effective in the practice. We issued the practice with a requirement notice for regulation 17 good governance and warning notices for regulation 12 safe care and treatment and for regulation 18 staffing, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The warning notices required the practice to achieve compliance with the regulations by 28 April 2017. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. The full comprehensive report on the January 2017 inspection can be found by selecting the 'all reports' link for Drs P Keating and H Appleton on our website at www.cqc.org.uk.

We then conducted a focused inspection on 31 May 2017 to identify whether the practice had addressed the issues in the warning notices and now met the legal requirements. At the focused inspection on 31 May 2017 we found that the requirements of the warning notice had been met. The full report on the May 2017 inspection can be found by selecting the 'all reports' link for Drs P Keating and H Appleton on our website at www.cqc.org.uk.

This report relates to the follow up comprehensive inspection carried out on 31 August 2017

Our key findings were as follows:

- There was a policy for the management of high risk medicines however for one particular high risk medicine we found that one prescriber at the practice was unable to provide evidence through consultation notes that blood tests were reviewed prior to issuing a new dose of the high risk medicine. Some medicines are considered 'high risk' because the potential side effects mean appropriate blood monitoring and careful dose adjustment is required.

Summary of findings

- There was a system in place for managing patient safey alerts however we identified that not all staff at the practice were clear on the process and the system had not yet been fully embedded.
- The practice had introduced a programme of clinical audits to drive improvement in patient care.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- 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.

However, there were also areas of practice where the provider must make improvements.

- Ensure care and treatment is provided in a safe way to patients in relation to high risk medicines.

In addition the provider should:

- Review the process in place for managing patient safety alerts and ensure the system captures all alerts relevant to the practice.
- Review the programme of clinical audits to ensure it demonstrates lessons learned, evidence of improvement to patient care and/or identifies areas where improvement is required.
- Develop a strategy and supporting business plan that reflects the vision and the values of the practice.

I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- There was a policy for the management of high risk medicines however for one particular high risk medicine we found that one prescriber at the practice was unable to provide evidence through consultation notes that blood tests were reviewed prior to issuing a new dose of the high risk medicine. Some medicines are considered 'high risk' because the potential side effects mean appropriate blood monitoring and careful dose adjustment is required.
- There was a system in place for managing patient safety alerts however we identified that not all staff at the practice were clear on the process and the system had not yet been fully embedded.
- From the sample of five documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice was rated good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were comparable to the national average. For example, the percentage of patients with hypertension in whom the last blood pressure reading (measured in the last 12 months) was 150/90 mmHg or less was 78% compared to the CCG average of 81% and the national average of 83%. Performance had improved to 84% for 2016/17.
- Staff were aware of current evidence based guidance and had access to the latest guidance on the shared drive.

Summary of findings

- The practice had introduced a programme of clinical audits to drive quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment, all staff at the practice were up to date with mandatory training requirements.
- There was evidence of appraisals and personal development plans for all staff.
- 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.

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 several 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.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- More than one percent of patients had been identified as carers and there was support in place for these patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, there was in-house phlebotomist available as well as an in-house counsellor.
- 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.
- Information about how to complain was available and evidence from four examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Requires improvement

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

- There was a documented leadership structure and most staff felt supported by management but staff we interviewed on the day of inspection commented that the current leadership structure sometimes resulted in a lack of clarity.
- The practice had a number of policies and procedures to govern activity, but some of these were not fully embedded such as the systems for managing patient safety alerts and high risk medicines.
- An overarching governance framework was implemented and supported the delivery of the strategy and good quality care.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The partners encouraged a culture of openness and honesty.

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 provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- 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; patients over the age of 65 were given same day appointments.
- The practice was responsive to the needs of older patients, and offered home visits 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.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- The practice nurse had a lead role in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 73% compared to the Clinical Commissioning Group average of 73% and the national average of 78%.
- 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.

Summary of findings

- 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 provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- 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, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- Children under the age of five and children with acute complaints were given same day appointments.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- 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, for example, extended opening hours and appointments.

Summary of findings

- 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.
- Telephone consultations were available with the nurse and GPs.
- Access to on site phlebotomy services was available.
- Access to on site counselling services was available.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for being safe and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group. However, we did find examples of good practice.

- The practice carried out advance care planning for patients living with dementia.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.

Summary of findings

- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Performance against mental health indicators improved in 2016/17. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 80% in 2015/16 compared to the CCG average of 92% and the national average of 89%. Performance improved to 95% for 2016/17.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing above the local and national averages. A total of 261 survey forms were distributed and 102 were returned. This represented 2% of the practice's patient list.

- 90% of patients found it easy to get through to this practice by phone compared to the CCG average of 64% and the national average of 71%.
- 98% 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 84%.
- 89% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and the national average of 85%.
- 83% 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 71% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Patients expressed that they felt listened to and cared for by all staff at the practice.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, helpful and caring.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients in relation to high risk medicines.

Action the service SHOULD take to improve

- Review the process in place for managing patient safety alerts and ensure the system captures all alerts relevant to the practice.
- Review the programme of clinical audits to ensure it demonstrates lessons learned, evidence of improvement to patient care and/or identifies areas where improvement is required.
- Develop a strategy and supporting business plan that reflects the vision and the values of the practice.

Drs P Keating & H Appleton

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 and a Practice Manager specialist advisor.

Background to Drs P Keating & H Appleton

The Drs P Keating and H Appleton practice is located in Enfield, North London within the NHS Enfield Clinical Commissioning Group. The practice holds a Personal Medical Services contract (an agreement between NHS England and general practices for delivering primary care services to local communities). The practice provides a full range of enhanced services including:

- diagnosis and support for people with dementia
- supporting patients with learning disabilities
- influenza and pneumococcal vaccines
- minor surgery
- rotavirus and shingles immunisation
- unplanned admissions

The practice is registered with the Care Quality Commission to carry on the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, maternity and midwifery services and family planning.

The practice had a patient list size of approximately 4,750 at the time of our inspection. The practice had a higher level of people with a long standing health conditions (58% compared to the CCG average of 52% and the national average of 54%). The practice serves a predominantly

White British population (80%). Other prevalent population groups include Polish, Turkish, African, and Black British. At 80 years, male life expectancy is in line with the CCG average of 80 years and the England average of 79 years. At 85 years, female life expectancy is above the CCG average of 84 years and the England average of 83 years. The practice has fewer patients aged 60 years of age and older compared to an average GP practice in England. The surgery is based in an area with a deprivation score of six out of ten (one being the most deprived). Children and

older people registered with the practice have a lower level of income deprivation compared to the local average. Compared to the average GP practice in England, patients at this practice have a lower rate of unemployment.

The staff team at the practice included two GP partners (one male, one female), one female practice nurse, one female healthcare assistant, one female phlebotomist (a health care professional that collects blood samples from patients) and one female counsellor. At the time of our inspection the practice manager role was vacant. There was an interim solution in place consisting of a team of three practice managers working together to fill the role of a full time practice manager. The practice had eight administrative staff. There were 16 GP sessions and four nurse sessions available per week.

The practice is open between 8.00am and 6.30pm Monday to Friday. GP appointments are available between 8.00am and 12.30pm and between 3.00pm and 6.00pm Monday to

Friday. Extended hours appointments are available on Monday from 6.30pm to 7.00pm and Tuesday from 6.30pm

to 8.00pm. The surgery is closed on Saturdays, Sundays and bank holidays. Urgent appointments are available each day and GPs also provide telephone consultations for patients. An out of hour's service is provided for patients when the practice is closed. Patients can access the out of hour's service by contacting 111. Information on the out of hour's service is provided to patients on the practices answerphone message, through posters in the waiting area and the practice leaflet.

Why we carried out this inspection

We undertook a comprehensive inspection of Drs P Keating and H Appleton on 10 January 2017 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 and effective services and was placed into special measures for a period of six months.

We also issued warning notices to the provider in respect of safe care and treatment and staff; we informed the practice that they must become compliant with the law by 28 April 2017. We undertook a follow up inspection on 31 May 2017 to check that action had been taken to comply with legal requirements. The full comprehensive report on the May 2017 inspection can be found by selecting the 'all reports' link for Drs P Keating and H Appleton on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of Drs P Keating and H Appleton on 31 August 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice was now meeting legal requirements.

How we carried out this inspection

We carried out an announced visit on 31 August 2017. During our visit we:

- Spoke with a range of clinical and non-clinical staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed an anonymised 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.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

At our previous comprehensive inspection on 10 January 2017 the practice had been rated as Inadequate for providing safe services. Specifically, at that time we found that:

- Patients were at risk of harm, for example, the practice did not have a supply of oxygen for dealing with emergency situations.
- The practice had not undertaken an infection control audit in 2016 and could not demonstrate whether action points from previous audits had been acted upon.
- There was insufficient attention to safeguarding children and vulnerable adults. There was no evidence to demonstrate that staff had received recent safeguarding training and vulnerable patients were not flagged on the clinical system.
- There was no evidence to show that arrangements for acting on patient safety alerts enabled safety concerns to be actioned in a timely manner.
- Although we found the practice had a system for managing repeat prescriptions, there was limited guidance or protocols for the prescribing of high risk medicines.
- Although the practice carried out investigations when there were unintended or unexpected safety incidents, there was limited evidence to show that lessons learned were communicated and that safety was improved.

We issued a warning notice in respect of these issues and found arrangements had improved and the practice were meeting legal requirements when we undertook a follow up inspection of the service on 31 May 2017.

At our comprehensive inspection on 31 August 2017 we found that a number of improvements had been made. We did identify some areas for further improvement, however there was a significant amount of improvement made overall which resulted in practice being rated as requires improvement for providing safe services.

Safe track record and learning

At the previous comprehensive inspection on 10 January 2017 we found that the practice did not have an effective system for managing patient safety alerts. For example,

At the inspection on 31 August 2017 we found that there was a system in place for managing safety alerts including those from the Medicines and Healthcare Products Regulatory Agency (MHRA). We reviewed three alerts that were logged by the practice within the last six months and found that action was taken in line with practice policy. We saw evidence that safety alerts were now discussed at clinical meetings and two members of staff confirmed this. However, the system was not yet fully embedded. For example, we spoke with clinical and non-clinical members of staff about their understanding of how safety alerts were managed. Two of the four members of staff we spoke with were unaware of the process in place for managing safety alerts. When we reviewed the log of alerts we found that a MHRA alert issued on 24 August 2017 was not captured in the practice safety alert log or in the e-mail alerts coming into the practice. We asked the practice leads about this and they were unable to confirm why the alert had not been captured.

At the previous comprehensive inspection on 10 January 2017 we also found that the system in place for managing incidents and significant events was ineffective. For example, the practice were unable to provide evidence that significant events were investigated, action was taken and learning outcomes were identified and shared with staff.

At the inspection on 31 August 2017 we found evidence that there was now an effective 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 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).
- From the sample of five documented examples 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 incident reports and minutes of meetings where significant events were discussed. We found that the practice carried out a thorough analysis of the significant events at clinical meetings; we reviewed three examples of minutes from clinical meetings where significant events were discussed. The minutes were available to all staff on the shared drive.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient requested test results over the telephone. A non-clinical member of staff took the call and incorrectly interpreted information on the clinical system which caused concern for the patient. The patients GP was informed and the GP phoned the patient the same day to explain the situation and apologise. The non-clinical member of staff was given additional training in what information to give to patients when relaying tests results to prevent a similar occurrence.

Overview of safety systems and process

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were recently updated and 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. From the sample of three documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. Of the examples we reviewed we found that action was taken in a timely manner and there were fail safes in place to ensure that outside agencies were notified when required.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child protection or child safeguarding level 3. All other members of staff at the practice were trained to child protection level 1.
- Notices in the waiting room and clinical consultation rooms 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. There were comprehensive 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 and all staff had received up to date training. An annual IPC audit was completed within the last 12 months. The practice brought in a specialist company to complete the IPC audit. We saw evidence that the practice took action following the IPC audit. For example, the practice nurse and the healthcare assistant were given additional IPC training and the cleaning schedule was updated. The practice met regularly with the cleaning company to review and implement the new cleaning plan.

There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). However, we found that record keeping protocols for managing high risk medicines were not always followed. Medicines are considered 'high risk' if the potential side effects mean regular blood monitoring and careful dose adjustment is required.

- We reviewed three types of high risk medicine, warfarin, lithium and methotrexate and found that these were being managed in line with clinical guidelines. However, when we reviewed records to assess the management of warfarin and we found that record keeping protocols were not being followed by one of the prescribers at the

practice. We spoke with the prescriber and were assured that high risk medicines were only prescribed after reviewing recent blood results in line with national guidance. However, as these results were not always noted on the patients record another clinician would be unable to access information demonstrating that it remained safe for the patient to receive the medicine. The practice took immediate action and put a system in place to ensure the date and theraputic range of the most recent blood test results were recorded in the consulation notes.

- There were processes for handling repeat prescriptions. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. We saw evidence that the practice recently ordered digital locks for all staff areas where blank prescription pads were kept to maintain security.
- Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation. PGDs allow some registered health professionals to administer specified medicines to a pre-defined group of patients. The health care assistant was trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately. PSDs are the traditional written instruction, signed by a GP for medicines to be administered to a named patient after the GP has assessed the patient on an individual basis.

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

Monitoring risks to patients

At the previous inspection on 10 January 2017 we found that there gaps in the monitoring and managing of risks to patient safety. At that time the practice were unable to provide evidence of a completed fire risk assessment, fire drills were not conducted, not all staff had completed fire safety training, the practice did not have a completed infection and prevention control audit and legionella testing had not been completed. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

When we inspected the practice on 31 August 2017 we found that the arrangements for assessing, monitoring and managing risks to patient and staff safety had improved. For example:

- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All staff were up to date with fire safety training and the practice completed regular fire drills.
- 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 to monitor safety of the premises such as control of substances hazardous to health and infection and prevention control and legionella.
- There was a health and safety policy available.
- 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

When we previously inspected the practice on 10 January 2017 we found that the practice did not have appropriate arrangements in place for responding to medical emergencies. For example the practice did not have a supply of oxygen on the premises and not all staff had completed basic life support training. At the inspection on 31 August 2017 we found that the practice had improved there arrangements for responding to medical emergencies:

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Requires improvement

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 January 2017 the practice had been rated as Inadequate for providing effective services. Specifically, we found that:

- Data showed patient outcomes were largely below and in some cases significantly below local and national averages for most indicators.
- Clinical staff had received professional development appropriate for their roles however, we found there was no clear training programme in place and there were gaps in mandatory training provided. For example, not all staff were up to date with training for safeguarding adults and children, infection control and basic life support.
- Patient outcomes were hard to identify as no reference was made to audits in the last two years or quality improvement, including no evidence that completed two cycle audits were being used to drive improvements.
- Arrangements to appraise staff had not been followed for the previous two years and the learning needs of staff were not always being identified.
- Childhood immunisation rates for the vaccinations given were lower than the CCG average.

We issued a warning notice in respect of these issues and found arrangements had improved and the practice were meeting legal requirements when we undertook a focussed follow up inspection of the service on 31 May 2017.

These arrangements had further significantly improved when we undertook this follow a comprehensive inspection on 31 August 2017. The provider is now rated as good for providing effective services.

Effective needs assessment

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

- 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.

Management, monitoring and improving outcomes for people

When we previously inspected the practice on 10 January 2017 we found that the practice was an outlier for Quality and Outcomes Framework (QOF) and clinical targets. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results were from 2015/16 and showed that the practice achieved 76% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. At that inspection we spoke with the lead GP about the QOF performance for 2015/16 and in particular about the high exception reporting rate. The GP told us they were aware of this and explained that the practice had switched to a new clinical system in 2015 and this had led to coding errors in certain areas, this also coincided with a long period of absence by one of the GP partners. We reviewed QOF performance for the previous three years and noted that exception reporting rates had been in line with local and national averages.

At the inspection in January 2017 exception reporting for many of the clinical domains was significantly higher than the national average; including diabetes and mental health. 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

At the inspection on 31 August 2017, we reviewed QOF performance for the year ending 2016/17 and the current position for 2017/18 data and found that the practice had shown improvement across all domains; also, exception reporting across all domains had decreased. The year-end data for 2016/17 and the current position for 2017/18 had not yet been verified at national level and published at the time of our inspection.

The practice achieved 94% of the total number of points available in 2016/17 an improvement from the achievement of 76% in 2015/16. We spoke to the GPs at the practice and were told that following our inspection in January 2017 the senior GP partner at the practice took the lead for QOF and held weekly QOF review meetings to monitor progress of improvement. We were assured that QOF review meetings were effective as the practice had improved performance for 2016/17 indicators within less

than three months. Our findings show that this change had been sustainable as the current position for 2017/18 was on track for a higher achievement than 2015/16 data. For example:

- Performance for (COPD) related indicators in 2015/16 was below the CCG and national average. For example, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the medical research council dyspnoea scale in the preceding 12 months was 32% compared to the CCG and national average of 90% (exception reporting was 6%). Performance improved to 97% for 2016/17 (exception reporting rate 8%) and current performance for 2017/18 was 100% at the time of inspection (nil exception reporting).
- Performance for cancer related indicators in 2015/16 was below the CCG and national average. For example, the percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within six months of the date of diagnosis was 33% compared to the CCG average of 93% and the national average of 94% (exception reporting was 40%). Performance improved to 95% for 2016/17 (exception reporting rate 17%) and current performance for 2017/18 was 78% at the time of inspection (nil exception reporting).
- Performance for asthma related indicators in 2015/16 was below the CCG and national average. The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that includes an assessment of asthma control using the three Royal College of Physicians questions was 44%, significantly lower than the local and national average of 76% (exception reporting was 3%). Performance improved to 76% for 2016/17 (exception reporting rate 0.34%) and current performance for 2017/18 was 77% at the time of inspection (nil exception reporting).
- Performance for mental health related indicators in 2015/16 was below the local and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 80% compared to the CCG average of 92% and the national average of 89% (exception reporting was 57%). Performance improved to 95% for 2016/17 (exception reporting rate 14%) and current performance for 2017/18 was 87% at the time of inspection (nil exception reporting).
- Performance for hypertension related indicators in 2015/16 was in line with the local and national averages. For example, the percentage of patients with hypertension in whom the last blood pressure reading (measured in the last 12 months) was 150/90 mmHg or less was 78% compared to the CCG average of 81% and the national average of 83% (exception reporting was 3.2%). Performance improved to 84% for 2016/17 (exception reporting rate 3%) and current performance for 2017/18 was 80% at the time of inspection (nil exception reporting).
- Performance for dementia related indicators in 2015/16 was below the local and national averages. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 73% compared to the CCG average of 85% and the national average of 84% (exception reporting was 58%). Performance improved to 89% for 2016/17 (exception reporting rate 9%) and current performance for 2017/18 was 88% at the time of inspection (nil exception reporting).
- The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding four months was 33% in 2015/16 compared to the CCG average of 77% and the national average of 89% (exception reporting was 0%). Performance improved to 100% for 2016/17 (nil exception reporting) and current performance for 2017/18 was 67% at the time of inspection (nil exception reporting).

At the previous inspection on 10 January 2017 we found that there was no evidence of quality improvement for the last two years, including clinical audit. We asked the practice to provide us with details of any clinical audits they had undertaken. We were provided with documentation of two full cycle clinical audits completed in 2014 around repeat medication and prescribing. The practice did not have an ongoing audit programme or strategy where they had made continuous quality improvements to patient care in a range of clinical areas.

At the inspection on 31 August 2017 there was evidence of the practice introducing a programme of clinical audits.

Good

Are services effective?

(for example, treatment is effective)

The audits we reviewed showed that the practice was beginning to use clinical audit with the aim of improving patient care. However, the audit templates used by the practice did not provide evidence of improved patient care. When compared to the clinical audit guidelines from the Royal College of General Practioners the audits currently used by the practice did not clearly state the reason for the audit, the criteria to be measured, the standard set, description of change implemented and lessons learned.

- There had been three clinical audits conducted within the last 12 months, all of these of these were completed two-cycle audits.
- Findings were used by the practice to identify improvements in clinical care for patients. For example, recent action taken as a result included an audit to identify patients with a vitamin D deficiency to ensure they have been offered treatment. The first audit was conducted in May 2017 and identified a total of 73 patients with vitamin D deficiency. A total of 46 patients were already on treatment, the remaining 27 patients were not on treatment for vitamin D deficiency and would be recalled for treatment. A second audit was carried out in August 2017 and found that the remaining 27 patients had been offered treatment for vitamin D deficiency.The audit did not specify whether the 27 patients were treated for vitamin D deficiency or lessons learned.

Effective staffing

At the previous inspection on 10 January 2017 reviewed evidence to assess whether staff had the skills and knowledge to deliver effective care and treatment. We found that there was limited evidence to demonstrate that staff had undertaken mandatory training including basic life support and safeguarding training. We found evidence that showed the learning needs of staff were not consistently identified through a system of appraisals.

At the inspection on 31 August 2017 we found that arrangements for staff training and appraisal had significantly improved. The practice subscribed to an online training provider which allowed staff access to training. We saw evidence that staff were sent on external training where required for their role. For example, the practice nurse and health care assistant completed online infection and prevention control training and were also sent on external training as a recommendation of the infection and prevention control audit.

Evidence reviewed around effective staffing showed that:

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. We saw evidence that the practice nurse completed chronic obstructive pulmonary disease training.
- 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. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for nurse revalidation. All staff had received an appraisal within the last 12 months.
- 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 were given access to external training when required.

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.

Good

Are services effective?

(for example, treatment is effective)

- From the sample of three 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. For example, we saw evidence that the practice shares information with school nurses, health visitors and social services when appropriate.

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 (MCA) 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. We saw evidence that all clinical staff were up to date with MCA training.

Supporting patients to live healthier lives

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

- Patients 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.
- A counsellor was available on the premises for patients with mental health needs.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 80% 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. For example, rates for the vaccines given to under two year olds ranged from 90% to 94% and five year olds from 90% to 93%.

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 encouraged its patients to attend national screening programmes for bowel and breast cancer.

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

At our previous inspection on 10 January 2017, we rated the practice as requires improvement for providing caring services as there was no carer's register.

We found that the carer's register had been introduced when we undertook a comprehensive inspection on 31 August 2017. The practice is now rated as good for providing caring services.

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.

All of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients including one member of the 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 was comparable to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 85%.
- 81% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 85%
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% national average of 86%.
- 94% of patients said the nurse was good at listening to them compared with the CCG average of 85% and the national average of 91%.
- 95% of patients said the nurse gave them enough time compared with the CCG average of 86% 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 95% and the national average of 97%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% 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 all 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, there were same day appointments for children and patients over the age of 65.

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 the local and national averages. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 70% national average of 82%.
- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 90%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The practice also made use of a translation leaflet that provided medical complaints and symptoms in 15 languages.
- 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; this information was available in two languages. Information about support groups was also available on the practice website and in the patient waiting area. There was a carer's newsletter available in the patient waiting area which provided information on social, support and legal services for carers. 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 53 patients as carers (more than one percent of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. For example, same day appointments and longer routine appointments.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 10 January 2017, we rated the practice as good for providing responsive services. At the inspection on 31 August 2017 we reviewed evidence that showed the practice continued to provide a responsive service whilst making improvements to the overall service to patients. The practice is 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. For example, the practice have a higher than average number of patients with mental health issues. To meet the needs of these patients the practice employed an in-house counsellor and also refer patients to an online counselling service that has been recognised by the Health Service Journal as being innovative. In addition we found that the practice offered patients the following:

- The practice offered extended hours on a Monday evening from 6.30pm to 7.00pm and Tuesday evening from 6.30pm to 8.00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disabilities, complex health issues and carers.
- 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 children, patients over the age of 65 and those patients with medical problems that require 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 and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate. For example, fact sheets available on the practice website in 21 languages.
- A patient registration form was available for download on the practice website which meant that patients could complete this form at their convenience.
- Staff at the practice told us that GPs did not turn away patients asking for emergency same day appointments. Patients we spoke to on the day of inspection shared their experiences of not being turned away in an emergency.
- Vulnerable patients had access to the service. For example, homeless patients could be registered at the practice.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.00am to 12.30pm every morning and 3.00pm to 6.00pm daily. Extended hours appointments were offered at the following times two evenings per week. In addition to pre-bookable appointments that could be booked up to 12 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 the local and national averages.

- 81% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average and national average of 76%.
- 90% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 71%.
- 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 80% and the national average of 84%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 95% of patients said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 91% of patients described their experience of making an appointment as good compared with the CCG average of 66% and the national average of 73%.
- 53% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 49% 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.

Reception staff were trained 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, posters displayed in the patient waiting are, information in the practice leaflet and complaint leaflets available at reception.

We looked at four complaints received in the last 12 months and found that complaints were dealt with in a timely way and in line with practice policy. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we reviewed a complaint from a patient that was unhappy with the communication during a GP consultation. The practice acknowledged the GP was rushed that day and apologised to the patient in writing.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 10 January 2017, we rated the practice as requires improvement for providing well-led services as a lack of leadership led to below average performance against national clinical targets and there were large gaps in governance systems, staff training and appraisal.

We issued a requirement notice in respect of these issues and found arrangements had improved and the practice were meeting legal requirements when we undertook a follow up inspection of the service on 31 May 2017.

At the comprehensive inspection on 31 August 2017 we found that although improvements had been made to the service there was still improvement to be made to leadership arrangements. For example, the practice employed a team of three practice managers as an interim solution for the practice manager vacancy. The team worked together and provided two full days of cover per week at the practice. On the day of inspection staff told us that the current leadership arrangements sometimes resulted in a lack of clarity of practice protocols such as the system for managing patients safety alerts. During the inspection we found that some systems had not yet been fully embedded and that not all staff were clear on the arrangements. For example, the system for managing high risk medicines.

Vision and strategy

The practice's current focus was on improving the overall service, with the help of three part-time practice managers. For example, the practice had largely improved governance systems although not all the systems were fully embedded.

The practice's aims and objectives included:

- To provide patients with safe, high quality healthcare in a clean and well equipped environment.
- To offer a flexible service to meet patient choice.
- Working in partnership with other professionals in the care of patients.
- The practice had a mission statement, although this was not on display; staff knew and understood the values.

The practice did not have a strategy and supporting business plans which reflected the vision and values. Staff at the practice were open and honest with us about this on the day of inspection. The GP partners at the practice identified areas for improvement and staff at the practice demonstrated knowledge of the improvements underway. For example, when we inspected on 10 January 2017 we were told that one of the partners was identified as the QOF lead and would hold weekly meetings focusing on improving performance. At the inspection on 31 August 2017 staff confirmed these meetings took place and the practice was able to demonstrate improvement in QOF achievements.

Governance arrangements

The practice had implemented an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- The practice had implemented a programme of continuous clinical audit to drive improvement, there were three clinical audits completed at the time of our inspection. The quality of the audits could be improved. For example, based on guidelines from the Royal College of General Practitioners the audits currently used by the practice do not clearly state the reason for the audit, the criteria to be measured, the standard set, description of change implemented and lessons learned.
- There were systems in place for identifying, recording and managing risks, issues and implementing mitigating actions however these were not always effective. For example, the system for managing high risk medicines was not followed by all prescribers at the practice.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- An understanding of the performance of the practice was maintained.

Leadership and culture

Are services well-led?

Requires improvement

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

The GP partners were visible in the practice and staff told us they enjoyed working in the practice and felt supported. However, GPs recognised that there had been a period when practice management systems had become less effective and this impacted on governance systems. The partners put an interim solution in place with the employment of a team of three practice managers working together to fill the role of one full time practice manager. They told us they prioritised safe, high quality and compassionate care. Staff told us that as a team they were committed to driving improvement.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of five documented examples 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.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a 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 and school nurses to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings, although not all staff were able to demonstrate knowledge of the topics discussed at these meetings. For example, a member of staff we spoke with told us that patient safety alerts were not discussed at practice meetings. We saw minutes of practice meetings where patient safety alerts were discussed.
- 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.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by 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. For example, the PPG suggested that the practice put up a calendar in the reception area for patients to see when booking appointments.
- the NHS Friends and Family test, complaints and compliments received.
- 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 run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment must be provided in a safe way for service users. The registered persons had not done all that was reasonably practicable to ensure that service users received safe care and treatment. In particular: • We found that blood results for patients on high risk medicines were not always noted on patients records showing it remains safe for the patient to receive the medicine This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.