Healthwatch Limited

Oxford Private Medical Practice

Inspection report

Mayfield House
3rd Floor
256 Banbury Road
Oxford
OX2 7DE
Tel: 01865 423425
Website: oxfordprivategp.com

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Overall summary

We carried out an announced comprehensive inspection on 15 December 2015 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

Our key findings were:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named healthcare professional and that 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- There was an effective system in place for reporting and recording significant events.

However,

Summary of findings

- Risks to patients were not always assessed and well managed, including those relating to recruitment checks.
- The practice had a number of policies and procedures to govern activity, but some were missing or overdue a review.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Patient Group Directions which were used to administer medicines had not been correctly authorised in line with legislation.
- Not all staff had the skills, knowledge and experience to deliver effective care and treatment.

We identified regulations that were not being met and the provider **must:**

- Implement formal governance arrangements, local policies and systems for assessing and monitoring risks to comply with the requirements for the control of substances hazardous to health, health and safety and Mental Capacity Act and best interest decisions.
- Implement and embed in practice a medical emergency policy, including a protocol for staff roles.
- Ensure assessment, monitoring and improvement in quality of service is evidenced through of a programme of completed clinical audit cycles.
- The provider must ensure they are complying with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Carry out Disclosure and Barring Service checks or detailed risk assessments for non-clinical staff undertaking chaperone duties.
- Ensure all staff have evidence of an appropriate level of training suitable for their role, including; Mental Capacity Act 2005, Safeguarding and Health & Safety at work. Implement a programme of yearly appraisals and monitor ongoing training requirements and updates for all staff.
- Ensure that Patient Group Directions comply with current legislation and meet legal requirements.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider **should** make improvements:

- Review and update procedures and guidance.
- Liaise with the landlord to ensure cleaning schedules for shared facilities are reviewed and monitored.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- Patients were at risk of harm because systems and processes were not in place or had weaknesses. For example, there were no health and safety protocols or guidance available, including control of substances hazardous to health risk assessments. There was no policy outlining arrangements for dealing with a clinical or medical emergency.
- Patient group directions for medicines were not legal documents and prescribing was not audited to ensure safety.
- Recruitment and background checks were incomplete for some members of staff. In particular, with regard to references and disclosure and barring services checks.
- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- When there were safety incidents, people receive reasonable support, truthful information, a verbal or written apology and are told about any actions to improve processes to prevent the same thing happening again.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- Patient outcomes were not reviewed as part of audits or quality improvement.
- There was evidence of engagement with independent stakeholders. Out of the private arena, engagement was limited to mental health stakeholders only.
- There was limited recognition of the benefit of an appraisal process for clinical staff.
- There were identified gaps in training for essential skills such as the Mental Capacity Act (2005) and health and safety, including moving and handling.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- 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 service was easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- Patients said they found it easy to make an appointment with a named GP and that 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 easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The practice had a number of policies and procedures to govern activity. However, there were no policies that addressed health and safety at work or Mental Capacity Act and best interest decisions.
- Staff told us they had received inductions but the practice was unable to demonstrate this in personnel files. No member of staff was offered a performance review or yearly appraisal.
- It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management.
- The practice held weekly staff meetings and twice daily “huddles” to ensure issues and ideas were communicated to everyone.

Oxford Private Medical Practice

Detailed findings

Background to this inspection

The inspection was carried out on 15 December 2015. Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a CQC inspection manager and a CQC pharmacist specialist.

Prior to the inspection we had asked for information from the provider regarding the service they provide. We asked other organisations, such as the local Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 15 December 2015 as part of a pilot programme of inspections of independent healthcare services. The comprehensive inspection key lines of enquiry were tailored to this service utilising aspects of the CQC model of inspection for NHS GPs. During our visit we:

- Spoke with a range of staff including, GPs, administration and reception staff and spoke with patients who used the service.
- Reviewed 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.'

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Background to Oxford Private Medical Practice

Oxford Private Medical Practice is an independent provider of GP services owned by Healthwatch Limited. The lead GP is the registered manager (a registered manager is someone who has been selected by a provider to be legally responsible for managing regulated activity from a provider location) and responsible individual on behalf of the company.

Based in Oxford the practice have patients listed from Oxfordshire and the surrounding counties. There are over 7,000 registered patients of whom up to 2,000 are still currently active on their list. The practice also registers patients from foreign countries who require medical assistance whilst visiting the UK from abroad. These are mostly one-off consultations.

The practice is run from two clinics in the Oxford area: Mayfield House and Stratum Clinic. We inspected the Mayfield House location during this inspection. Mayfield House has two consulting rooms and one treatment room. There is an open plan office with reception area and seating.

There are three GPs (including the lead GP) who cover ten GP sessions per week. All the GPs also undertake NHS work with other providers. Two practice nurses work a total of two variable sessions per week of three to four hours. The nurses offer vaccinations, phlebotomy (blood taking) and a variety of health tests including Electrocardiogram (ECG) recording and spirometry. The practice has arrangements in place with external healthcare professionals who provide

Detailed findings

services. These include a clinical psychologist, a psychiatrist, two psychotherapists, a consultant paediatrician (specialising in children from birth to two years of age), a dietician and a social worker. In addition to the clinical staff, the provider employs two administration support staff and a financial/business manager.

Oxford Private Medical Practice is open Monday to Friday from 8.30am to 6pm. The practice is not required to offer an out of hours service. Patients who need medical assistance out of corporate operating hours are requested to seek assistance from alternative services such as the NHS 111 telephone service or accident and emergency. This is detailed on the practice website.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards which were all positive about the standard of care received. Patients reported that they had received an excellent service and the doctors were caring and helpful. Many comments expressed satisfaction at being listened to and found the reception staff friendly, efficient and helpful. We spoke with two people on the day of inspection who also provided positive feedback about the service.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

There was an effective system in place for reporting and recording significant events:

- Staff told us they would inform the practice manager of any incidents and there was also a recording form available.
- The practice carried out a thorough analysis of significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an incident involving a child needing restraint for a vaccination resulted in child restraint training for all staff and a change in policy to reflect the responsibilities of the parent in providing restraint to their child.

When there are safety incidents, people receive reasonable support, truthful information, a verbal or written apology and were told about any actions to improve processes and prevent the same thing happening again.

We looked at 14 safety incidents over the preceding 12 months. All had been investigated, discussed at meetings and shared with staff. Clinical incidents were raised with the GP, nurse or other health care professional (HCP), action identified and implemented. For example, a GP gave the wrong dose of a vaccine to a patient. As soon as the error was identified the GP recalled the patient and arranged for them to be seen by a specialist to ensure the overdose was not detrimental to the patients' health. The GP immediately stopped offering injections and was supported to undertake additional training with the practice nurse in injection technique and safety.

The staff told us that the relevant safety alerts were forwarded to the office administrator for filing. Prior to July 2015 the office administrator was receiving the safety alerts directly and we saw a spreadsheet that contained date received the alert summary and action taken. Since July 2015 the lead GP had received safety alerts via the Independent Doctor's Federation distribution. The practice stated that these were forwarded to the office administrator however they were unable to evidence any action taken in response to these alerts since July 2015.

The practice told us that they did not have any substances related to the control of substances hazardous to health (COSHH) regulations. However, staff told us that there were antibacterial wipes for cleaning equipment and surfaces and bleach products in the kitchen and treatment and consultation rooms. In addition, the practice held oxygen in store for emergency use, but had not identified that this also required a COSHH risk assessment.

Reliable safety systems and processes (including safeguarding)

The practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The lead GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. The lead GP was trained to Safeguarding children level three. Staff we spoke to on the day were able to demonstrate they understood their responsibilities but not all staff could evidence they had received training relevant to their role. For example, one GP stated they had undertaken adult safeguarding training but were unable to evidence this with a certificate, two healthcare professionals had "N/A" detailed in the training log and two non-clinical members of staff had only received safeguarding children training.
- There was no Mental Capacity Act (MCA) 2005 training offered to staff by the provider as the practice told us it was unnecessary for their service provision. The practice were unable to demonstrate they had considered or assessed this as a risk. However, GPs we spoke to on the day were able to demonstrate a good understating of MCA and best interest decisions.
- We reviewed five personnel files and found that most recruitment checks had been undertaken prior to employment. The provider's recruitment policy clearly stated that checks required included: proof of identification, two references, proof of qualifications, registration with the appropriate professional body and

the appropriate checks through the Disclosure and Barring Service (DBS). We found two personnel files with only one reference check, (one of which had been requested for a post which had commenced eight months prior to the inspection date). We also found one file with no qualification certificate. The practice informed us, two days after the inspection, they had checked the member of staff entry to the register with their governing body and felt this was acceptable as a demonstration of qualification. There was another file without a DBS check (deemed relevant to the role). The practice told us they were following up on the outstanding reference and chasing the DBS check as it had been sent to the wrong home address.

Medical emergencies

There were arrangements in place to deal with a clinical or medical emergency, but no formal policy. For example, if a patient collapsed a member of staff would call 999 to request an emergency ambulance, however, it was not clear who would initiate this contact and who would let the building security know (for access).

Emergency medicines (including oxygen) were 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 fit for use. All staff had received basic life support training. The practice had a defibrillator available on the premises.

There was no system for alerting other healthcare staff to an emergency (e.g. emergency alarm or panic button) although it was noted that the consultation and treatment rooms were in close proximity to one another and the waiting room. Therefore, if an emergency arose, a call for help could be heard.

Staffing

There was adequate staffing to meet the demands of the service, with an integrated multi-disciplinary team focus on holistic care. The lead GP provided cover in the event of illness or absence and they had access to locums and agency staff if required.

Notices in the consulting rooms advised patients that nurses or other staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and all but one member of staff had received a disclosure and barring (DBS) check. The practice had not risk assessed this decision and advised us they would stop the member of staff from acting as a chaperone until the relevant DBS check came through. (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)

Monitoring health & safety and responding to risks

There were some procedures in place for monitoring and managing risks to patient and staff safety. However, there was no record of any health and safety training or awareness and a poster was not on display as required by law. The lead GP explained that there was no requirement for manual handling or health and safety training as the service they provided did not call for it. However, we noted that one of the consultation rooms had multiple uses and required the bed to be moved regularly to accommodate patient and clinician need. In addition, all staff used computers and monitors as a regular part of their work. We were told that a health and safety poster had been ordered.

The practice had been informed of an up to date fire risk assessment by the landlord. The practice had carried out a fire drill in June 2015 and there was a plan for another drill within a week of the inspection visit.

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

Infection control

The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff told us they had received up to date training. We saw evidence that an infection control audit was undertaken within the last 12 months. There was alcohol gel and liquid soap available for hand hygiene.

The practice had undertaken legionella testing and had not been required to carry out any actions related to this.

Premises and equipment

The practice maintained appropriate standards of cleanliness and hygiene within their offices. We observed the premises to be clean and tidy. We were told the lead GP ensured the standard of cleanliness was being monitored through random checks. The staff and patients shared

Are services safe?

toilet facilities with the landlord and other building users. The toilet facilities cleaning regime was strictly under the landlord control and we noted high surface cleaning was poor with door frames thick with accumulated dust.

There were no spill kits available in the event of a body fluid spillage, instead, the practice had equipped each treatment and consultation room with gloves, aprons, bleach, paper towels and antibacterial wipes available to deal with any spillages. However, there had been no risk assessments of the equipment used, or if bleach and antibacterial wipes were suitable or appropriate for use. In addition, the staff had not received any training on how to deal with body fluid spillages.

Safe and effective use of medicines

During our inspection we looked at the systems in place for managing medicines. We spoke to the lead GP and administrative staff involved in the governance, administration and supply of medicines.

Medicines were stored appropriately in the practice and there was a clear audit trail for the ordering, receipt and disposal of medicines. There were processes in place to ensure that the medicines were safe to administer and supply to patients.

The GPs and other clinicians rely on the information provided by the patient to make safe prescribing decisions. The GPs and other clinicians did not access other patient records (for example, from NHS hospital services or NHS GPs, where there was one). We were told that the practice rarely passed on patient medical information to NHS healthcare organisations. That was sometimes because the patient did not want their information shared and often because access to NHS patient records was restricted with no information sharing offered to or from NHS organisations. Risk assessments were not in place to ensure the safety of prescribing with the potential for multiple medicines from different sources. The practice followed local guidance for prescribing.

Prescription pads were stored securely in the practice to ensure that only authorised prescriber's could use them. However, there were no formal systems in place to monitor their use.

The practice did not carry out regular medicines audits and were therefore unable to ensure prescribing was in line with best practice guidelines for safe prescribing. The lead GP informed us they would review prescribing only in response to an event or complaint.

Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). The PGDs had been written and authorised by the lead GP, however this process was not sufficient to comply with current legislation, whereby a pharmacist must also sign them, and therefore the PGDs were not legal documents.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence best practice guidelines. The practice were not monitoring that these guidelines were followed through risk assessments, audits or random sample checks of patient records.

Clinical staff were expected to keep up to date through their NHS work and there was no formal process for determining training needs with the provider.

Patient records were viewed and found to contain a full explanation of the presenting complaint or purpose of the appointment. Details pertaining to the examination, diagnosis and referral (if required) were also seen. Follow up management was not routinely reviewed as it was dependant on patient request. For example, there was no formal process for following up on medicines compliance other than an alert if a repeat prescription was requested too soon. The reason given was the potential for financial impact on the patient and the low number of patients registered for repeat prescriptions. Due to restricted links with NHS organisations, details informing NHS services of any follow up reviews that were required were offered only if there was a patient request for the information to be provided.

Clinical audits

The practice told us there had been a number of clinical audits over the last two years. They showed us three examples. An audit on obesity had identified actions around coding issues and the provision of healthy living information given to patients. This audit had only recently been undertaken and no review date had been set, therefore, the practice were unable to demonstrate how this had impacted on patient outcomes.

The practice had also run an audit of smear results. The cytology sample results were checked against the patient record to identify who had been recalled. This was similar to the abnormal blood test results audit where the results were checked to ensure they had been acted upon. There were no collective recording processes or any action planning and a review date had not been set. In addition, the practice were unable to evidence a plan of future audits or monitoring of patient outcomes.

Staff training and experience

The practice had recently introduced an induction programme for newly appointed members of staff that covered topics such as fire procedures, significant events and complaints. There had been an inconsistent approach to inductions for staff offering healthcare services from the practice prior to this. It was noted the induction did not cover safeguarding, Mental Capacity Act, confidentiality or health and safety at work training.

Staff had recently been offered access to online training to assist with their learning needs and to cover the scope of their work. However, the practice could not demonstrate how they ensured role-specific training and updating for relevant staff as there was no formal system in place to document and monitor staff training. Two days after the inspection the practice sent the inspector a training matrix where the identified gaps had been been clearly identified. There was also no formal system of appraisals for clinical staff. The lead GP informed us that this process had been undertaken as part of the practitioner's routine NHS work and there was no requirement for it in the independent environment. We were told that both members of the non-clinical team had been offered an annual appraisal since December 2014.

Working with other services

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 assessments, medical records, investigation and test results.

The practice shared relevant information with other independent services when necessary. For example when referring people to other private services. There were established communication links between the private mental health services provided and NHS mental health stakeholders.

There was no routine sharing of information with NHS GP services or general NHS hospital services. This was due to restrictions in communication links between NHS and independent stakeholders. Consequently, the provider did

Are services effective?

(for example, treatment is effective)

not have access to a full medical history from medical or hospital records and relied solely on the patient offering their history freely during a consultation. If an NHS service required any information, the practice would print a list of medicines and diseases/disorders for the patient to take with them.

Staff worked together as a multidisciplinary team to meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. The practice made referrals to other independent or private sector services and could not refer to NHS services. Information sharing was restricted between out of hours (OOH) services and the provider due to the NHS inability to record an independent healthcare provider as a patients primary GP service. The provider told us if a patient attended an OOH service or Accident &Emergency, the patient was responsible for advising them a consultation had occurred and for providing documentation relating to the consultation. The provider had no jurisdiction in how NHS services shared their information.

Consent to care and treatment

Staff sought patients' consent to care and treatment. However, this was not always in line with legislation and guidance.

- The practice were unable to demonstrate that all staff understood the relevant consent and decision-making requirements of legislation and guidance, as no-one had been offered Mental Capacity Act 2005 (MCA) training through the provider. Any MCA training received through the NHS was not evidenced with a certificate or accreditation. However, GPs we interviewed on the day of the inspection were able to describe their role and responsibilities in relation to MCA.
- The process for seeking consent was not monitored through records audits. The practice could not ensure it met the responsibilities within legislation and followed relevant national guidance.
- We were shown patient consent forms where consent for minor surgery was documented in patient records. The details were clear, concise and appropriate for the consultation.

The provider offered full, clear and detailed information about the cost of consultations and treatments, including tests and further appointments.

The information had not always explicitly outlined the treatment costs of medicines and had been reviewed following a complaint. For example, a patient required an injectable medicine. The medicine became contaminated during the consultation and a second was used. Both sets of medicine were charged to the patient. The patient complained and as a result the provider had reworded their written information to reiterate that all medicines opened or used during consultation would be charged for.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

We observed that members of staff were courteous and very helpful to patients and treated people dignity and respect.

- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Curtains were not provided in one of the consultation rooms or the treatment room to maintain patients' privacy and dignity during examinations, investigations and treatments. If a patient needed to get undressed, the GP or nurse would pull down the blinds at the windows and leave the room. We were told that curtains had been ordered for one of the consultation rooms as the other one had a separate examination area. The practice advised that curtains were unsuitable for the treatment room due to its multiple uses, resulting in some of the examination furniture being moved to accommodate different patient needs.

All of the 39 patient CQC 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. Comments included how professional the doctors were, patients felt listened to and supported. There were positive comments about individual doctors and therapists with many patients expressing how they would recommend the service to others.

We spoke with two patients on the day. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice facilities were on the third floor of an office building, accessed by a lift or stairs. There were security doors with keypad access. The main reception was decorated in neutral colours and had seating appropriate for patients whilst they waited for their appointment. GP appointments were for half an hour and could be extended if required. Reasonable adjustments could be made to patients requesting to see a GP of their choice, although two of the doctors worked part time and were not available every day. The lead GP aimed always to accommodate patients' needs to be seen as far as possible. Initial appointments for the clinical psychologist, psychotherapist and counsellor could take up to two weeks from time of request, and could be expedited sooner according to need.

Tackling inequity and promoting equality

The practice offered appointments to anyone who requested one (and had viable finance available) and did not discriminate against any client group. Home visits were available for patients who were unable to access the service. There were disabled facilities and translation services available.

Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were available daily and up to two months in advance. We were told that most patients contacted the practice on the day or within two to three days of requiring an appointment. There were limited extended hours surgeries offered on a Saturday by pre-bookable appointment only.

The practice had recently audited the waiting times for GP appointments. Of 47 appointments, six were found to have been ten minutes or over from the allocated appointment time. The GPs identified were offered support to improve their consultation times.

There was no out of hours service provision. Patients were advised to contact the NHS 111 service or the emergency services, if required, out of office hours.

Concerns & complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- A complaints form was available to help patients understand the complaints system. There was information on how to complain on the practice website.

We looked at nine complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. The practice demonstrated an open and transparent approach in dealing with complaints. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, four complaints related to a misunderstanding of fees. This had resulted in a review of the website to ensure a complete transparency of fees, an online booking system that took a payment at the same time and a review of an agreement with an insurance company relating to the fee structure in place.

All complaints were discussed at weekly meetings and actions agreed and corroborated.

Are services well-led?

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

Our findings

Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place, but had obvious gaps:

- Practice specific policies were in place and were available to all staff, although some were missing. For example, there was no policy which set out the actions to take in a medical emergency, such as, examples of medical emergencies that may arise, how to raise the alarm and who is responsible for initiating contact with emergency services and building security.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, health and safety risks were overlooked and no health and safety at work policy was in place. In addition, there was no policy which reflected Mental Capacity Act and best interest decisions guidance.
- A programme of internal business and management audits which were used to monitor quality and to make improvements. However, the programme of clinical audit was limited and did not relate to improving outcomes for the practice patients. For example, both the smear and abnormal test results audits focussed on the results and who had been recalled. The audits did not reflect on poor sampling or inaccurate techniques to determine if clinical staff required support or training.

Leadership, openness and transparency

The lead GP had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised high quality and compassionate care. The lead GP was visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

When there were safety incidents the practice gave affected people reasonable support, truthful information and a verbal or written apology.

There was a clear leadership structure in place and staff felt supported by the management team.

- Staff told us that the practice held weekly team meetings and twice daily "huddles" to discuss issues arising. Most team meetings were attended by administration staff and the lead GP. Due to the part time hours of the other clinicians, not everyone attended these meetings routinely.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, felt confident in doing so and supported if they did.
- Staff said they felt respected, valued and supported, particularly by the provider 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
- The culture of the service encouraged candour, openness and honesty.

Learning and improvement

The practice values demonstrated the practice aim to be the primary GP provider for their regular patients, providing doctor led care and easy access during office hours. This was backed up by a close-knit multidisciplinary team approach to care. The practice were open to feedback and offered patients the opportunity to reflect on their experiences. The practice encouraged and shared learning from complaints and significant events to improve services.

Identification of learning needs and training was not routinely discussed, as there was an inconsistent approach to the appraisal processes for all staff working from the practice. All of the clinical staff worked in NHS services as well as the independent sector and the inference from management was they would receive an appraisal through their NHS employment. However, this was not followed up by the practice to ensure appraisal had been undertaken. In addition, there was a missed opportunity to ensure staff had received appropriate supervision and support for their independent work.

Provider seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

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

The practice had gathered feedback from patients through surveys and complaints received. For example, there was a keypad in reception for patients to offer their feedback for that particular visit.

The practice also engaged patients with the friends and family test and discussed the results at regular meetings. We looked at 49 survey responses from November 2015. The majority were complimentary towards the service experienced and were confident in the practitioner seen.

The practice had also gathered feedback from staff through staff meetings 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. For example, the reception and administration staff have been involved in the plans for the new reception area layout.

This section is primarily information for the provider

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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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Regulation 19(2)(a)(b) Not all information specified under Schedule 3 was available. This included an incidence of a lack of a criminal background check and references.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Regulation 18(2)(a) We found the registered provider did not operate effective systems to ensure staff received appropriate training, professional development and appraisal. The provider must ensure that staff are supported to undertake training, learning and development to enable them to fulfil the requirements of their role.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Regulation 17(1) and 17(2)(a)(b)(d)(f) The registered provider did not have systems and processes that enabled them to identify and assess risks to the health, safety and/or welfare of people who use the service (including risks to others, such as staff,

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visitors or tradespeople). This included a lack of recognition of the requirements of the Control of Substances Hazardous to Health (COSHH) and undertaking relevant COSHH risk assessments.

The registered provider was not ensuring they were assessing, monitoring or improving quality of service through of a programme of completed clinical audit cycles.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Regulation 12(2)(a) The provider was not ensuring risk assessments relating to the health, safety and welfare of people using services were completed and reviewed. Regulation 12(2)(b) The provider could not evidence they were complying with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Central Alerting System and the Medicines and Healthcare products Regulatory Agency. The provider did not have a policy describing arrangements in the event of a clinical or medical emergency. Regulation 12(2)(g) We found that the registered provider did not comply with current legislation and guidance with regard to the use of Patient Group Directions.