Newcastle Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced inspection of this practice on 8 December 2016. The practice was rated as inadequate for providing effective and well-led services, requires improvement for providing safe, caring and responsive services and inadequate overall. The practice was placed in special measures on 28 September 2017.

The full comprehensive report on the December 2016 inspection can be found at: http://www.cqc.org.uk/location/1-3017488527

This comprehensive inspection was undertaken on 6 July 2017. Overall, the practice is rated as inadequate.

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

- The delivery of the high-quality care was not assured by the leadership and governance of the practice. The provider had taken steps to make improvements following the last inspection in December 2016. An action plan was developed by the practice in March 2017 in response to areas of concern highlighted by the inspection. They had developed a clearer vision, strategy and plan to deliver high quality safe care, however, these did not focus on the atypical nature of the practice population. Many of the new arrangements were at an early stage and work was still in progress in many areas.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, minutes of meetings and records of significant events did not consistently detail discussion, actions taken and learning to lead improvements.
- The practice's system for identifying, capturing and managing issues and risks was not effective.
- Staff were aware of current evidence based guidance. Most staff had received training to provide them with the skills and knowledge required to deliver effective care and treatment.
- Data that showed the practice's Quality and Outcomes Framework (QOF) achievement for 2016/2017 was 68%. This was 8% lower than their achievement for 2015/2016. The practices clinical exception rate for 2016/2017 was 17%. This was 10% improvement on

Summary of findings

clinical exception rate for 2015/2016. This data has not yet been verified or published. Action has been initiated by the practice to improve patient outcomes although this was still at an early stage. It is of note that the practice serves a predominantly student population and that practice has a low number of patients with long-term conditions.

- The practice told us that given the atypical nature of the practice's patient population QOF was not effective as a measure of the practice's performance despite this, the practice had not monitored their outcomes compared to other similar services.
- From the sample of 13 clinical records we reviewed, we saw that the information recorded in clinical records was not thorough.
- The practice had improved their approach to quality improvement work and clinical audit. We saw that seven single-cycle reviews had been completed or were on-going and that audit meetings had been introduced.
- The practice participated in the CCG practice engagement programme. This included work to improve their prescribing performance and engagement with the CCG. They had performed well, for example, they had low levels of antibiotic prescribing.
- Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with or above average for its satisfaction scores on consultations with GPs. Satisfaction scores for consultations nurses were generally comparable to local and national averages.
- The practice had developed a small range of information about services that was available to meet the needs of the practices population. For example, as the practice had a high number of patients who spoke Chinese they had recently ensured their patient leaflet was available in Chinese. We saw that the practice planned to introduce a wider range of information for patients in Chinese.
- Most patients we spoke with said they had to use the walk-in surgery to see a GP promptly and that it was difficult to book an appointment to see a named GP if you wanted to be seen in a timely manner. Some patients said there had been an improvement in the last six months. Urgent appointments were available the same day at the walk-in surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clearer leadership structure and staff felt more supported by clinical leadership of the practice than they had when we last inspected this practice. Staff development was a priority and staff felt supported in this area.
- The practice had gathered the views of patients by issuing their own surveys the results of which they acted on. They did not have an active patient participation group (PPG). Members had recently been recruited, however, no meetings had been held at the time of this inspection.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. Specifically, to embed and sustain the systems and processes in place to assess monitor and improve the quality and safety of the service provided which includes addressing the learning and actions from clinical audit improvement work, significant events and complaints to show improvements in patient care. The practice also must ensure that accurate, complete and contemporaneous notes are maintained in respect to each patient.

The areas where the provider should make improvement are:

- Enable the persons employed in the provision of the regulated activity to receive the appropriate support, training, professional development, supervision and appraisal that is necessary to enable them to carry out their duties. Specifically, training in child safeguarding and the use of the clinical system (EMIS).
- Continue to take steps to improve their identification of carers registered at the practice.
- Continue to improve arrangements for the provision of a patient participation group (PPG) to ensure the views of patients are sought and considered by the practice.
- Review how they routinely collect and monitor information about the outcomes of patients care and treatment.

Summary of findings

The practice has made some improvements since our last inspection in December 2016. This is reflected in our report that shows the practice is rated as good for providing a safe and caring service. There remain significant shortfalls with regard to effectiveness and leadership. As a result, this practice is rated as being inadequate overall and is in special measures. In line with our enforcement procedures, we have issued a requirement notice. The practice is expected to devise an action plan that addresses the shortcomings identified in the report. The service will be kept under review and if needed we may escalate our enforcement action and this may lead to the cancellation of the practice's registration as a general practice. Another inspection will be conducted within six months.

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?

Good

The practice is rated as good for providing safe services.

The practice had taken action to address the concerns raised during our previous inspection in December 2016. They had implemented systems that would support them to demonstrate that they provided safe services. We found that:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, minutes of meetings and records of significant events did not consistently detail discussion, actions taken and learning to lead improvements.
- The system for monitoring the use of blank prescriptions had been reviewed and was now in line with national guidance.
- The arrangements for the management of Patient Group Directions (PGDs) and Patient Specific Directions (PSD's) were now in line with national guidance.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Although staff demonstrated that they understood their responsibilities and all had received training on vulnerable adults not all staff had received training on safeguarding children relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

The practice was in the process of addressing the concerns raised during our previous inspection in December 2016. They had started to implement systems that would support them to demonstrate that they provided effective services. We found that:

- The practice now ensured that all clinical staff were aware of new National Institute for Health and Clinical Excellence (NICE) guidelines.
- There was an increased focus on improved outcomes for patients. The practice kept a log of work completed to improve QOF achievement.
- The practice had recently developed a palliative care register.
- Data showed that outcomes for patients were low and had declined in the last year. The practice enabled CQC to have access to recently submitted data that showed the practice's

Summary of findings

Quality and Outcomes Framework (QOF) achievement for 2016/2017 was 68%; this was 8% lower than their achievement for 2015/2016. The practices clinical exception rate for 2016/2017 was 16.7%; this was 10% improvement on clinical exception rate for 2015/2016. This data has not yet been verified or published. Action has been initiated by the practice to improve patient outcomes; however, this was still at an early stage.

- The practice told us that given the atypical nature of the practice's patient population QOF was not effective as a measure of the practice's performance despite this, the practice had not monitored their outcomes compared to other similar services.
- The practice had improved their approach to quality improvement work and clinical audit. We saw that seven single-cycle reviews had been completed or were on-going and that audit meetings had been introduced.
- From the sample of 13 clinical records we reviewed, we saw that the information recorded in clinical records was not thorough.
- Staff had the skills and knowledge to deliver effective care and treatment.
- 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.

Are services caring?

Good

The practice is rated as good for providing caring services.

The practice had taken action to address the concerns raised during our previous inspection in December 2016. They had started to implement systems that would support them to demonstrate that they provided caring services. We found that:

- National GP patient 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.
- In May 2017, the practice undertook its own patient satisfaction survey. Of those who responded 80% said the GP spent the right amount of time with them. However, only 21% of patients said it was easy or very easy to schedule an urgent appointment with a GP when they were ill.
- The practice had increased the number of carers identified from 0.04% to 0.07% of the practice population. They had invited all carers for a health check with the nurse and so far one carer had attended the practice for a health check.

Summary of findings

- The practice had developed a small range of information about services that was available to meet the needs of the practice's population. For example, as the practice had a high number of patients who spoke Chinese they had produced a patient leaflet in Chinese. We saw that the practice planned to introduce a wider range of information for patients in Chinese.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

The practice had taken some action to address the concerns raised during our previous inspection in December 2016. They had started to implement systems that would support them to demonstrate that they provided responsive services. We found that:

- Data from the national GP survey, published in July 2017 showed that patients continued to rate the practice lower than average for access to care and treatment.
- The practice had had developed a small range of information that was available to meet the needs of the practice's population. This included information in Chinese and Spanish on the complaint process at the practice.
- The practice reviewed the uptake of appointments at the walk-in surgery from January to April 2017 and responded to the outcome of the reviews by providing additional appointments at busy times. However, they had not carried out a follow up review to determine whether the action taken had been effective.
- Most patients could get information about how to complain in a format they could understand. However, minutes of the meetings we reviewed showed no evidence that learning from complaints had been shared with staff.
- The practice told us they had an atypical patient population due to the high number of students registered at the practice, the high number of patients whose first language was not English and the fact that the vast majority of their patients were in the 20-29 year age group. Although the practice had reviewed the needs of its patient population, it did not have a plan to secure improvements for all of the areas identified.
- The practice had recently initiated work to take account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and

Summary of findings

patients living with dementia. For example, the practice had recently introduced a palliative care register and it was agreed that this register would include a wide range of life-limiting conditions.

- Most patients we spoke with said they had to use the walk-in surgery to see a GP promptly and that it was difficult to book an appointment to see a named GP if you wanted to be seen in a timely manner. Some patients said there had been an improvement in the last six months. Urgent appointments available the same day at the walk-in surgery.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Inadequate

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

The practice had taken some action to address the concerns raised during our previous inspection in December 2016. They had started to implement systems that would support them to demonstrate that they provided well-led services. We found that:

- The practice had no realistic plans in place to achieve their vision and strategy. Although the practice had a plan to deliver high quality care and promote good outcomes for patients these plans were not focused on the atypical nature of the practice. The practice told us they had an atypical patient population due to the high number of students registered at the practice, the high number of patients whose first language was not English and the fact that the vast majority of their patients were in the 20-29 year age group.
- The delivery of the high-quality care was not assured by the leadership and governance of the practice. Although the practice's governance framework more effectively supported the delivery of their strategy and good quality care, it is not yet possible to determine if the changes made were effective, sustainable or embedded into practice. For example, although lead members of staff had been allocated in some clinical areas, however, one of the allocated GP's had been assigned a lead role without being clear of the remit of the role. In addition, the governance of significant events and complaints required review.
- We saw that scheduled meetings were held and that minutes of these meetings were produced.

Summary of findings

- Staff had been made aware of the need to record both verbal and written complaints and we saw evidence that confirmed this. However, minutes of the meetings we reviewed showed no evidence that the learning from complaints had been shared with staff.
- The practice had an ineffective system for identifying, capturing and managing issues and risks.
- There was limited engagement with the people who use the service. The practice had gathered the views of patients by issuing their own surveys. They had recently recruited members for their patient participation group (PPG), but this had yet to meet at the time of the inspection. Six patients had agreed to join the PPG and attend meetings and a further three patients had agreed to join a virtual PPG.
- Staff had received inductions when they were appointed, annual performance reviews and would attend staff meetings. Staff took up training opportunities when available.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- There was a clearer leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. However, some of these policies required review.
- There was an increased focus on learning and improvement at all levels. Staff development was a priority and staff felt supported in this area. Staff told us the clinical leadership at the practice had improved.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate 

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of older patients. For example, there was no quality improvement work targeted at older people, the practice did not maintain a palliative care register and there was no lead GP for older people.
- When we inspected the practice in July 2017, we saw that that practice was in the process of addressing the concerns raised during the previous inspection. In April 2017, a lead GP was allocated for older people and an action plan was developed to improve outcomes for older people that focused on dementia and osteoporosis although this work was at an early stage. The osteoporosis action plan resulted in the identification of two patients who required referral to secondary care. A palliative care register had recently been developed and a single-cycle review had been completed that was relevant to the care of older people.
- The practice had a register of patients with dementia. The practice had a very low number of patients on this register.
- The practice enabled CQC to review unverified and unpublished QOF data for 2016/2017 that showed that for outcomes for conditions commonly found in older people performance varied. For example, in 2016/2017 the practice's performance for atrial fibrillation and stroke had declined (by 10% and 19% respectively) when compared to the previous year. Performance for heart failure and peripheral arterial disease had stayed the same.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice followed up on older patients discharged from hospital.
- The practice offered immunisations for shingles and pneumonia to older people.
- The practice had a very low number of older people registered.

Summary of findings

People with long term conditions

Inadequate

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of people with long-term conditions.
- When we inspected the practice in July 2017, we saw that that practice was in the process of addressing the concerns raised during the previous inspection. In April 2017, they had allocated a GP to lead on long-term conditions and an action plan had been developed to improve outcomes for long-term conditions such as chronic obstructive pulmonary disease (COPD) and atrial fibrillation. This work was at an early stage.
- The practice enabled CQC to review data that showed that for outcomes for long-term conditions varied. For example, in 2016/2017 the practice's performance for the management of patients with diabetes and hypertension had declined (by 62% and 48% respectively) when compared to the previous year. Performance for rheumatoid arthritis had improved by 67%. This data has not yet been verified or published.
- GP's and nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- A member of the administration team had been appointed to support the work to improve QOF and update the recall process.
- All patients with a long-term condition had a named GP and there was an improved system to recall patients for a structured annual health and medication review. 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.
- The practice had a lower than average number of people with long-term conditions registered.

Families, children and young people

Inadequate

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of families, children and young people. Childhood immunisation and cervical screening update rates were low. We also saw that the arrangements adopted by the practice to administer vaccines were not in line with national guidance.

Summary of findings

- When we inspected the practice in July 2017 more recent published screening and immunisation data was not yet available so we were unable to determine whether there had been any improvement. However, we saw that that practice was in the process of addressing the concerns raised during the previous inspection. For example, an action plan had recently been developed to improve the uptake of childhood immunisations and we saw that more information was provided to support patients. We saw that the arrangements adopted by the practice to administer vaccines were in line with national guidance.
- 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.
- Not all staff had undertaken child safeguarding training to the expected level.
- 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.
- The practice had a lower than average number of children registered at the practice.

Working age people (including those recently retired and students)

Inadequate

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of working age people (including those recently retired and students). For example, there was limited quality improvement work targeted at working age people and cervical screening uptake was lower than average. We also saw that while the practice had a higher than average number of working age people registered they had not ensured that these services were accessible, flexible or offered continuity of care.
- When we inspected the practice in July 2017, we saw that the practice was in the process of responding to the concerns raised during the previous inspection. For example, a cervical

screening action plan had recently been developed and we saw that cervical screening information was now available in Chinese and this was placed in the registration packs for new patients. More recent published cervical screening data was not yet available so we were unable to determine whether there had been any improvement.

- The practice had completed two single-cycle reviews that were relevant to the care of working age people (including those recently retired and students).
- The age profile of patients registered with the practice mainly consisted of working age, student and recently retired patients but the services the practice provided had not been adapted to fully reflect the needs of this group.
- The practice offered extended opening hours for appointments on Saturdays with a nurse or a healthcare assistant. No extended hours appointments were available with a GP.
- Patients could book appointments or order repeat prescriptions online.
- Some of the patients we spoke with told us that health promotion advice had not been offered and we saw that there was limited accessible health promotion material available in the waiting area. Following the inspection the practice told us they now have a wide range of health promotion material available. The practice website provided a good range of health advice.

People whose circumstances may make them vulnerable

Inadequate

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of people whose circumstances make them vulnerable. For example, not all staff knew who the practices safeguarding lead was, low numbers of carers had been identified and carers had not been offered carers health checks. The practice did not maintain a palliative care register.
- In July 2017, all the staff we spoke to where aware of who the practice's safeguarding lead was. We saw that the practice had recently developed a palliative care register. The practice had worked to improve the number of carers identified and now offered carers health checks. The number of carers identified was still low at 0.07% of the practice population. It is expected that most practices would have 2-5% of their practice population being identified as carers depending on the characteristics of the patient population.

Summary of findings

- The practice had completed one single-cycle review that was relevant to care of people whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including patients with a learning disability; patients with learning disabilities had been invited to the practice for an annual health check. All of the patients on this register had received an annual review in the last 12 months.
- 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)

Inadequate

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

- When we inspected the practice in December 2016, we saw little evidence that the practice worked to improve the care of people experiencing poor mental health. Nationally reported data showed that outcomes for patients with mental health conditions were below average.
- When we inspected the practice in July 2017 we saw that two single-cycle reviews had been completed that were relevant to people experiencing poor mental health (including dementia). No two-cycle clinical audits had been completed. The practice care of the elderly action plan included work to improve outcomes for patients with dementia, this work was ongoing.
- The practice carried out advance care planning for patients living with dementia. The practice had a very low number of patients living with dementia.
- The practice enabled CQC to review data that showed that for outcomes for mental health indicators was low. The practice had achieved 68% of the QOF points available for mental health

related indicators. This was 9% lower than their achievement for 2015/2016. The clinical exception rate was 8%; this was a decrease of 17%. This data has not yet been verified or published.

- The practice advised us that due to their close proximity to a number of local universities they had a high turnover of student patients with approximately 1500 – 2000 students registering at the start of each autumn term. The practice also reported that they had a high proportion of student patients who presented with mental health related issues. However, from the QOF data we reviewed, the practice had achieved 0% of the points available for the depression related indicator for the last three years. Preliminary data for 2017/2018 indicated that the practice had achieved 57% of the QOF points available for this indicator as at 4 July 2017. This data is not yet verified or published. This data covered the last 12 months and is not directly comparable to other data used in this report.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had introduced a dementia protocol to ensure 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.

Summary of findings

What people who use the service say

What people who use the practice say

The most recent national GP patient survey results were published on 7 July 2017. The results showed that patient satisfaction scores were lower than average when compared to local and national averages. There were 388 forms sent out and 31 were returned. This is a response rate of 8% and represented 0.2% of the practice's patient list. Of those who responded:

- 69% found it easy to get through to this surgery by telephone (CCG average 77%, national average of 71%).
- 78% were able to get an appointment to see or speak to someone the last time they tried (CCG average 84%, national average 84%).
- 60% described the overall experience of their GP surgery as good (CCG average 87%, national average 85%).
- 53% said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 80%, national average 77%).
- 70% found the receptionists at this surgery helpful (CCG average 88%, national average of 87%).
- 71% said the last appointment they got was very convenient (CCG average 81%, national average 81%).
- 34% described their experience of making an appointment as good (CCG average 74%, national average of 73%).
- 48% usually waited 15 minutes or less after their appointment time to be seen (CCG average 67%, national average 64%).

The July 2017 survey results showed that how the patients rated the practice had improved in some areas. Between January and March 2017, patients at the practice were asked to respond to 23 questions. The results showed an improvement for 16 questions, a decline for six questions and for one question, the result stayed the same.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We provided these comments cards in a variety of languages to ensure as many patients as possible could comment on the service they received if they wished to. We received one comment card. The patient was newly registered with the practice and they commented that the registration process had been easy.

The practice had gathered the views of patients by completing two surveys in the last year. In March 2017, patients were surveyed on the appointment system and responses varied. For example, of those who responded:

- 74% responded positively when asked how they would describe their experience of making an appointment.
- 30% were able to see or speak to their preferred GP.
- 71% were positive when asked to describe their experience of the GP surgery.

In May 2017, patients were surveyed on satisfaction with the practice and the care provided by the GP's. Of those who responded 80% said the GP spent the right amount of time with them. However, only 21% of patients said it was easy or very easy to schedule an urgent appointment with a GP when they were ill. Neither of these surveys asked patients about their experience of the walk-in surgery.

We spoke with 12 patients during or shortly after the inspection, including one member of the recently developed patient participation group. Most patients we spoke with said they had to use the walk-in surgery to see a GP promptly and that it was difficult to book an appointment to see a named GP if you wanted to be seen in a timely manner. Some patients said there had been an improvement in the last six months. Urgent appointments were available the same day at the walk-in surgery. They told us they were satisfied with the care provided by the practice during consultations and said their dignity and privacy was respected and that the practice appeared clean and hygiene. However, a small number of patients commented negatively on the persistent unpleasant smell that was evident when we inspected the practice. The practice told us they had reported this issue to their landlord to action.

The practice gathered patients' views on the service through the national Friends and Family test (FFT). (The FFT is a tool that supports the fundamental principle that people who use NHS services should have the

Summary of findings

opportunity to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices). The practice told us they had received some recent responses to this test, however, when we reviewed the published data during the inspection planning process we could find no responses during the period October 2016 to March 2017 (the most recently published data available when we inspected the practice). Following the inspection, the practice supplied details of the completed responses. Between October 2016 and March 2017, 190 responses had been received. Of those that responded, 67% said they would recommend the practice and 9% said they would not recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. Specifically, to embed and sustain the systems and processes in place to assess monitor and improve the quality and safety of the service provided which includes addressing the learning and actions from clinical audit improvement work, significant events and complaints to show improvements in patient care. The practice also must ensure that accurate, complete and contemporaneous notes are maintained in respect to each patient.

Action the service SHOULD take to improve

- Enable the persons employed in the provision of the regulated activity to receive the appropriate support, training, professional development, supervision and appraisal that is necessary to enable them to carry out their duties. Specifically, training in child safeguarding and the use of the clinical system (EMIS).
- Continue to take steps to improve their identification of carers registered at the practice.
- Continue to improve arrangements for the provision of a patient participation group (PPG) to ensure the views of patients are sought and considered by the practice.
- Review how they routinely collect and monitor information about the outcomes of patients care and treatment.

Newcastle Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector and an Expert by Experience.

Background to Newcastle Medical Centre

Newcastle Medical Centre is registered with the Care Quality Commission to provide primary care services. The practice provides services to around 14,600 patients from one location. The practice has a high proportion of patients who are students. We visited this address as part of the inspection:

- Boots the Chemist, Hotspur Way, Intu Eldon Square, Newcastle upon Tyne, Tyne and Wear, NE1 7XR.

Newcastle Medical Centre is located in the centre of Newcastle upon Tyne within Boots the Chemist in the Eldon Square shopping centre. The practice serves the centre of Newcastle upon Tyne and some of the surrounding areas. All patient services are provided at lower ground floor level. The practice can be accessed by the stairs, an in store escalator or by a passenger lift. On-site parking is not available due to the practice's city centre location. The practice is located in central Newcastle, close to two universities and student accommodation.

The practice population is made up of a higher than average proportion of patients who are students or of working age. Information from Public Health England showed that:

- 67% of patients are between the ages of 20-29 (CCG average 19%, national average 14%).
- 13% of patients are between the ages of 30-39 (CCG average 14%, national average 14%).
- 5% of patients are between the ages of 40-49 (CCG average 13%, national average 14%).

The practice has a lead GP (male) and five contracted GP's (two male, three female) who are contracted to provide GP services for the practice. The practice employs two practice managers, two nurse practitioners, two practice nurses, a healthcare assistant and eleven staff who undertake reception and administrative duties (one of which also works as a phlebotomist). The practice provides services based on a General Medical Services (GMS) contract agreement for general practice.

Newcastle Medical Centre is open at the following times:

- Monday 8am to 12pm and 1pm to 6:30pm
- Tuesday to Friday 8am to 6:30pm
- Saturday 8:30am to 5:30pm

The telephones are answered by the practice during their opening hours apart from on Saturdays when there is no telephone availability. This information is also available on the practice's website and in the practice leaflet. The service for patients requiring urgent medical care out of hours is provided by the NHS 111 service and Vocare, which is locally known as Northern Doctors Urgent Care Limited.

The practice runs a walk-in clinic Monday to Friday. Every patient who presents at the surgery between 8am and 9am are guaranteed to see a GP that day. In addition to this pre-bookable appointments are available at the following times:

- Monday 8am to 12pm then 1pm to 5:30pm
- Tuesday and Wednesday 8am to 5:30pm
- Thursday and Friday 8am to 6:30pm

- Extended hours appointments with a nurse or healthcare assistant are available from 8:30am to 5pm on Saturday's.

The practice is part of NHS Newcastle Gateshead Clinical Commission Group (CCG). Information from Public Health England placed the area in which the practice is located in the fifth most deprived decile. In general, people living in more deprived areas tend to have greater need for health.

The proportion of patients with a long-standing health condition is below average (29% compared to the national average of 53%). The proportion of patients who are in paid work or full-time employment or education is above average (85% compared to the national average of 62%).

The proportion of patients who are unemployed is above average (12% compared to the national average of 4%).

The practice has a high proportion of patients who are from ethnic minorities. In February 2017, the practice reported that of the patients they recorded the ethnicity for 37% were white British, British, mixed British or Irish and 35% were recorded as Chinese. Seventy-one ethnic categories were recorded by the practice.

The practice had a high number of patients whose preferred language was not English. This information was collected when patients registered at the practice. The practice provided data that showed that, on the day of the inspection, 9622 (66%) out of 14,600 patients had noted a language preference. Of these who had recorded a language preference 53% recorded English, 28% recorded Chinese (including Cantonese and Mandarin) and 4% recorded Arabic.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. A previous comprehensive inspection had taken place on 8 December 2016 after which the practice was rated as inadequate and placed into special measures. We rated the practice as inadequate for providing effective and well-led services; requires improvement for providing safe, caring and responsive services, and inadequate overall. The purpose of this inspection was to check that action had been taken to address the areas of concern that had been identified.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the local clinical commissioning group to share what they knew. We carried out an announced visit on 6 July 2017.

During our visit we:

- Spoke to staff and patients. This included the lead GP, three contracted GPs, two practice managers, a nurse practitioner, a practice nurse, the healthcare assistant and two members of the reception team. We spoke with 12 patients who used the service. We spoke with two members of the extended community healthcare team who were not employed by, but worked with the practice.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed one comment card where a patient had 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?

Detailed findings

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

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

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

On the day of the inspection, the practice completed the data submission that allowed QOF performance to be calculated. They enabled CQC to have access to data that showed the practice's QOF achievement for 2016/2017. This data has not been verified or published and cannot be compared to local and national averages at this stage. CQC also reviewed reports on the practice's QOF data that were produced shortly before the practice was inspected. These reports cannot be directly compared to the practice's performance for 2015/2016 or 2016/2017, as the report was produced part way through the reporting year.

Good

Are services safe?

Our findings

Safe track record and learning

When we inspected the practice in December 2016, we found that the practice was not able to demonstrate a safe track record over time or demonstrate that learning from significant events was effective. We found:

- The practice had not always effectively recognised when a significant event had occurred and when some events occurred the practice had not reviewed the actions taken by the practice to prevent recurrence. As reviews had not been carried out we were unable to determine the impact of the care provided by the practice.

During the inspection in July 2017, we found:

- 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 10 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 when appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses and staff told us the practice was more aware of significant events.
- However, minutes of meetings and records of significant events was not consistent in detailing discussion, actions taken and learning to lead improvements. We also found that not all significant events that had been discussed by the practice were recorded on the significant events log.

Overview of safety systems and processes

When we inspected the practice in December 2016, we found they had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, however, some of these required improvement. We found:

- Not all staff were aware of who was the safeguarding lead at the practice and we were not able to see how child safeguarding issues were fed back to the practice following meetings with the health visitor.
- Most patients we spoke with were not aware of the chaperone system, however there were notices in the waiting area.

During the inspection in July 2017, we found:

- All staff were aware of who the practice's safeguarding lead was and more effective arrangements were in place to ensure that safeguarding issues were discussed and documented at the practice.
- Notices in the waiting room advised patients that chaperones were available if required and patients we spoke with were now aware of the chaperone system. 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).
- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. Information on who to contact externally for guidance was displayed in each of the clinical and treatment rooms.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and most had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- A nurse practitioner 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 staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

When we inspected the practice in December 2016, we found they had some systems, processes and practices in place that kept patients safe and safeguarded from abuse, however, some of these required improvement. We found:

- The management of blank computer prescriptions, Patient Group Directions (PGD's) and Patient Specific Directions (PSD's) was not in line with national guidance.

During the inspection in July 2017, we found:

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

- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) Patient Specific Directions (PSD) had been adopted by the practice to allow the healthcare assistant (HCA) to administer medicines in line with legislation. (A PSD is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis). The practice now managed PGDs and PSDs in line with national guidance.
- The provider updated their prescription storage policy in March 2017; this included a more effective system for recording and monitoring blank computer prescriptions. Administrative staff completed training on this policy in April and May 2017. In March 2017, the practice introduced regular audits of prescriptions that had not been collected by patients and ensured these prescriptions were destroyed.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

We reviewed four 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 Disclosure and Barring Service (DBS). (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 risks to patients

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

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster, which identified local health and safety representatives. The practice had an up to date fire risk assessment, this was last completed in October 2016 and no follow up actions were required. The practice took part in regular fire drills carried out by Boots the Chemist that involved the whole building.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- 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 control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Panic alarms were fitted in the clinical rooms.

Good

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a disaster handling and recovery plan. It included details of actions to be taken in the event of possible disruptions to service, for example, loss of power. The staff listed in the plan has been updated since we last inspected the practice.
- The practice also had an operating manual that included the emergency procedures of Boots the Chemist that ensured they were aware of the actions required if an emergency affected the building they were situated within.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

When we inspected the practice in December 2016, we found that the practice was not able to demonstrate how it ensured effective needs assessments. We found:

- The process to ensure all clinical staff were aware of new National Institute for Health and Clinical Excellence (NICE) guidelines was not effective, scheduled meetings where clinical guidelines could be discussed were not always held and the lead GP did not attend these meetings.

During the inspection in July 2017, we found:

- The practice now ensured that all clinical staff were aware of new National Institute for Health and Clinical Excellence (NICE) guidelines. The practice had updated their NICE guideline policy in March 2017 to reflect that new NICE guidance was to be discussed at a clinical meetings with regular attendance by the lead GP. No new NICE guidelines relevant to GP's have required implementation yet.

Management, monitoring and improving outcomes for people

When we inspected the practice in December 2016, we found that the practice was not able to demonstrate the effective management, monitoring and improvement of outcomes. We found:

- For 2015/2016 the practice had achieved 76% of the total number of QOF points available compared to the local clinical commission group (CCG) average of 97% and the national average of 95%. At 26%, their clinical exception-reporting rate was 16% above the local CCG average and 9% above the national average. (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).

During the inspection in July 2017, we found:

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

On the day of the inspection, the practice completed the data submission that allowed QOF performance to be calculated. They enabled the QCQ to have access to data that showed the practice's QOF achievement for 2016/2017 was 68%; this was 8% lower than their achievement for 2015/2016. The practices clinical exception rate for 2016/2017 was 17%; this was 10% improvement on clinical exception rate for 2015/2016. This data has not been verified or published and cannot be compared to local and national averages as this data is not yet available.

The practice told us that given the atypical nature of the practice's patient population QOF was not effective as a measure of the practice's performance despite this, the practice had not monitored their outcomes compared to other similar services.

Data from 2016/2017, that had not yet been verified or published, showed:

- Outcomes for conditions commonly found in older people performance varied. For example, the practice had achieved 90% of the QOF points available for atrial fibrillation related indicators. This was 10% lower than their achievement for 2015/2016. The clinical exception rate was 31%; this was an increase of 9%. We also saw that the practice had achieved 81% of the QOF points available for stroke related indicators. This was 19% lower than their achievement for 2015/2016. The clinical exception rate was 26%; this was a decrease of 3%. Their performance for heart failure and peripheral arterial disease indicators had stayed the same at 100%.
- Outcomes for long-term conditions varied. For example, the practice had achieved 33% of the QOF points available for diabetes related indicators. This was 62% lower than their achievement for 2015/2016. The clinical exception rate was 15%; this was a decrease of 24%. We also saw that the practice had achieved 52% of the QOF points available for hypertension related indicators. This was 48% lower than their achievement for 2015/2016. The clinical exception rate was 14%; this was a decrease of 10%. The practice told us that they had been using an incorrect diabetic referral form that would have affected their performance in this area. The practice are now using the correct form. We also saw that the practice had achieved 83% of the QOF points available for rheumatoid arthritis related indicators. This was 67%

higher than their achievement for 2015/2016. The clinical exception rate was 17%; this was a decrease of 58%. Their performance for heart failure related indicators had remained the same at 100%.

- Outcomes for mental health indicators were low. The practice had achieved 68% of the QOF points available for mental health related indicators. This was 9% lower than their achievement for 2015/2016. The clinical exception rate was 8%; this was a decrease of 9%.
- The practice advised us that due to their close proximity to a number of local universities they had a high turnover of student patients with approximately 1500 – 2000 students registering at the start of each autumn term. The practice also reported that they had a high proportion of student patients who presented with mental health related issues. However, from the QOF data we reviewed, the practice had achieved 0% of the points available for the depression related indicator for the last three years (patients aged 18 or over with a new diagnosis of depression in the proceeding 1 April to 31 March who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis). Preliminary data for 2017/2018 indicated that the practice had achieved 57% of the QOF points available for this indicator as at 4 July 2017. This data is not yet published or verified.
- Performance for asthma related indicators was 100%; this was 37% higher than their achievement for 2015/2016. The clinical exception rate was 18%; this was an increase of 11%.
- When we inspected the practice in July 2017, more recent published childhood immunisation or cervical screening data was not yet available. Action plans had been developed and work was on going but we were unable to determine if the actions taken had been effective.

When we inspected the practice, we saw in increased focus on improved outcomes for patients. Areas of lead responsibility had been allocated to the contracted GP's for referrals, long-term conditions, QOF, atrial fibrillation and care of the elderly. Action plans had recently been developed. However, as these action plans were still ongoing it was not possible to identify how effective they would be in the long-term. Preliminary data indicated that the practice had improved their QOF performance for 2017/2018; however, this data is not yet verified or published, as this data was produced part way through the reporting year. The data provided by the practice showed that they may have improved in many areas. The practice told us that they expected to have improved their performance in the several QOF indicators, including atrial fibrillation, stroke, diabetes, hypertension, rheumatoid arthritis and mental health.

An action plan was developed by the practice in March 2017. It included work to improve QOF achievement and we saw that QOF was now a regular agenda item in a range of meetings that included clinical and non-clinical staff, including the lead GP. The practice kept a log of work completed to improve QOF achievement and we saw that the contracted GPs met regularly to review the work completed. A member of the administration team had been appointed to support the work to improve QOF and update the recall process and we saw that they were very committed to this new role. However, it was not always clear why the areas identified for improvement had been chosen. For example, work had been completed to improve outcomes for patients with dementia yet the practice had a very low number of patients with dementia registered at the practice. An action plan had also been developed to improve outcomes for patients with atrial fibrillation, however, the practice had achieved 100% of the points available for atrial fibrillation in 2015/2016. We also saw that performance for 2016/2017 had declined by 10%. The osteoporosis action plan resulted in the identification of two patients who required referral to secondary care and a further three patients had the correct clinical codes added to the medical records. The practice had low numbers of patients with long-term conditions.

When we inspected the practice in December 2016 we saw that limited quality improvement work was taking place and there was little evidence that clinical audit was driving improvements in performance to improve patient outcomes. We found:

- Evidence of three single-cycle reviews, but no two-cycle clinical audits had been completed.

During the inspection in July 2017, we found:

- There had been seven single-cycle reviews in the last year. For example, the practice had undertaken a review of all patients prescribed an opioid medication for pain management. Patients were offered an appointment with a GP to determine whether the prescribing of an opioid was appropriate and, if so, if the dosage was

correct. Six patients were reviewed, the prescribing of the opioid and dosage was found to be appropriate for three patients (50%). The dosage was reduced for two of the other patients (one of whom had been referred to specialist pain management services to assist with this). The final patient had been regularly reviewed by GPs at the practice and was in the process of moving and transferring to another GP practice. We also saw that the practice had undertaken a review of patients over the age of twenty who had completed an alcohol screening tool and scored more than 5 (193 patients). If the patient had not responded when they were contacted by letter, a receptionist contacted each patient by telephone to determine the number of alcohol units consumed each week. Of the 103 patients who responded 88 (85%) required no further action, 15 (14.5%) consumed over five units of alcohol per week and were to be invited for an appointment with the nurse or HCA.

- Work was ongoing in most of these reviews, for example, we saw that patients who had not responded to a request to attend a review appointment were still being contacted by the practice.
- Clinical audit meetings had been introduced; we saw that these had taken place in April, May and June 2017. These meetings monitored the progress of on-going audit work and determined if any changes were required to the agreed process.
- The practice had introduced a referral review process where non-urgent referrals were reviewed to confirm they were appropriate.
- The clinical commissioning group (CCG) pharmacist completed CCG led prescribing audits at the practice.
- The practice had participated in the CCG practice engagement programme. This included work to improve their prescribing performance and engagement with the CCG. They had performed well in many areas, for example, they had low levels of antibiotic prescribing. We also saw that they had a projected budget underspend of 72% for 2016/2017. They had actively worked to achieve their targets and were engaged in the work that was required. The practice CCG pharmacist supported the work required.

Effective staffing

When we inspected the practice in December 2016, we found that the practice was not always able to demonstrate effective staffing arrangements. We found:

- Nursing staff did not have regular clinical supervision.

During the inspection in July 2017, we found:

- New clinical supervision arrangements for the nursing staff had been put in place. Staff told us that the new arrangements were excellent and that they welcomed the support this provided. Some staff told us it would be useful to have a copy of their supervision record to support their personal development.
- The lead GP and a contracted GP had undertaken a peer review of each other's practice in November 2016 which had led to training and support being identified for the contracted GP. The peer review process extended in March 2017 when the peer review policy was updated. The practice planned to complete GP peer reviews each quarter and we saw evidence that this work had been completed so far. However, it was not clear from the records we reviewed what actions were carried out when a peer reviewer did not agree with the action taken. Following the inspection the practice told us that if a clinician did not agree with the actions taken they would note this on the conclusion section of the form for the practice manager to review and action.
- 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.
- Staff administering 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, mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

Inadequate

Are services effective?

(for example, treatment is effective)

- The healthcare assistant who worked at the practice had originally been employed as a receptionist but had been supported by the practice to progress to a clinical role. They had completed the Care Certificate qualification for healthcare assistants and had recently commenced more advanced training. Staff told us that the practice supported training and professional development, some staff roles had been developed in response to the concerns raised in the previous CQC report.
- Staff received training that included: fire safety awareness, basic life support, information governance and equality and diversity. Staff had access to and made use of e-learning training modules, in-house training and external training. We saw that the healthcare assistant was only trained to level one in child safeguarding. Not all of the administrative staff had completed the online child safeguarding training that was included in the practices list of mandatory training.
- During the inspection, it was sometimes difficult to access the information we required as some staff were not aware of how to provide or access this information.

Coordinating patient care and information sharing

When we inspected the practice in December 2016, we found that the practice did not maintain a palliative care register.

During the inspection in July 2017, we found:

- A palliative care register was now in place at the practice. The lead GP had held a series of meetings to ensure the new register was up to date and effective. The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of 13 clinical records we reviewed, we saw that the information recorded in clinical records was not thorough. It was not clearly documented in seven of these that repeat prescriptions had been reviewed when altering or adding medications. We also saw that for six records the notes did not clearly show evidence of follow-up arrangements felt to be clinically appropriate.

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. The practice had introduced an Extended Health Care Meeting where a range of staff were able to discuss concerns about vulnerable patients. The district nurses and health visitors that worked with the practice were invited to attend part of the meetings to discuss any areas of concern and vulnerable patients.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

When we inspected the practice in December 2016, we found that the practice did not always provide information that supported patients to live healthier lives. We found:

- Although the practice recognised that their practice population contained a high proportion of patients who did not have English as their first language they had not taken steps to ensure they communicated effectively with these patients.

During the inspection in July 2017, we found:

The practice had reviewed the information they provided for patients whose first language was not English. We saw that the practice leaflet and cervical screening information was now available in Chinese and that the practice had recruited a member of staff to translate a range of practice and clinical information into Chinese. The practice carried out this work as CQC had raised concerns about this.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice had worked to improve how they identified patients who may be in need of extra support and signposted them to relevant services. This included 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.

When we inspected the practice in December 2016, we found that the practice's uptake of cervical screening and childhood immunisation was not in line with local and national averages. We found:

- Plans to improve he practice's uptake of cervical screening and childhood immunisation were not well developed and had not been effective.

During the inspection in July 2017, we found:

- When we inspected the practice in July 2017 more recent published screening data was not yet available.
- There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice also encouraged their patients to attend national screening programmes for bowel and breast cancer screening. The practice told us that they encouraged patients who were eligible for screening to attend for testing and they ensured a female sample taker was available. We saw that the practice had an action plan, which included an increased focus on meeting the needs of the practice's population. For example, information had been made available in Spanish and Chinese. We were told that all eligible patients who registered during the local universities 'fresher's week' in September 2017 would be sent information on cervical screening. Although it is not yet possible to determine if these actions have had any impact on uptake or have become embedded into practice the practice told us the nursing staff thought that uptake had recently improved.
- 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.

Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice told us that as many of their patients were students they were not always at the practice for the time required to complete the immunisation programme. Childhood

immunisation rates for some of the vaccinations given were lower than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two years old ranged from 64.3% to 92.9% (CCG average 64.7% to 97.1%). For five year olds rates ranged from 68.2% to 90.9% (CCG average 90.1% to 97.4%). National data that covered 2015/2017 was due to be published in June 2017 but had been delayed. We saw evidence that work had been initiated by the practice to improve the uptake of childhood immunisations. For example, information displayed in the waiting area advising patients to have their children vaccinated. Clinical staff checked children's immunisation records when they attended for other appointments and administrative staff had been advised of the procedures that ensured the practice held the correct childhood immunisation records. It is not yet possible to determine if these actions have had any impact or have become embedded into practice.

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

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. We found that some conversations could be overheard in the waiting area.
- Patients could be treated by a clinician of the same sex if this was their choice.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We provided these comments cards in a variety of languages to ensure as many patients as possible could comment on the service they received if they wished to. We received one comment card. The patient was newly registered with the practice and they commented that the registration process had been easy.

Results from the national GP patient survey, published in July 2017, showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs, satisfaction scores for consultations nurses were generally comparable to local and national averages. For example:

- 97% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG average 91%, national average 89%).
- 90% of patients said the GP gave them enough time (CCG average 90%, national average 86%).
- 97% of patients said they had confidence and trust in the last GP they saw (CCG average 97%, national average 95%).
- 93% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 89%, national average 86%).
- 93% of patients said the nurse was good at listening to them (CCG average 94%, national average 91%).
- 93% of patients said the nurse gave them enough time (CCG average 95%, national average 92%).
- 91% of patients said they had confidence and trust in the last nurse they saw (CCG average 98%, national average 97%).
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 93%, national average 91%).
- 70% of patients said they found the receptionists at the practice helpful (CCG average 89%, national average 87%).

In May 2017, the practice completed its own survey on satisfaction with the practice and the care provided by the GP's. Of those who responded 80% said the GP spent the right amount of time with them. However, only 21% of patients said it was easy or very easy to schedule an urgent appointment with a GP when they were ill. The practice told us they planned to survey patients on care provided by nurses when they next surveyed patients.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey, published in July 2017, showed patients generally responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages and there was some improvement compared to the previous survey, published in July 2016. For example:

- 93% of patients said the last GP they saw was good at explaining tests and treatments (CCG average 89%, national average of 86%).
- 87% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 86%, national average of 82%).
- 90% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 92%, national average of 90%).

- 79% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 89%, national average of 85%).

The practice told us that due to the low response rate (8% of the practice patient population) they had not reviewed the results published in July 2016 as they felt that it would not be representative sample of patient's views. However, it is of note that the published results are weighted. Weighing is a process that adjusts the data to take into account potential age and gender differences. The July 2017 survey results were published one day after the practice was inspected.

An additional patient survey on satisfaction with the appointment system was completed in March 2017 and the practice published this information on their website. It plans to repeat this survey in September 2017. Results showed that most patients were generally satisfied.

The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments at busy times. We were also told that the practice had introduced an open surgery for nurse appointments; they hoped this would reduce waiting times.

When we inspected the practice in December 2016, we found that the practice's facilities to help patients be involved in decisions about their care required review to fully meet the needs of patients. We found:

- Information available in the waiting area, and the patient leaflet, was only available in English.

During the inspection in July 2017, we found:

- Since we inspected the practice in December 2016, the practice had reviewed the information they provided and now some information was available in Spanish and Cantonese. For example, we saw that the practice leaflet and a sample of cervical information was available in Chinese, the practice planned to provide more information for patients in these languages. This included the carers identification form, the complaints procedure and the patients online access form.
- Translation services were available for patients who did not have English as a first language. The practice told us that this service was well utilised by patients at the practice and that when patients who required an interpreter attended the walk-in surgery, or attended for an urgent appointment a telephone interpretation service was used.
- 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.
- A hearing loop was available for patients who were hard of hearing.

Patient and carer support to cope emotionally with care and treatment

When we inspected the practice in December 2016, we found that the support for patients and carers to cope emotionally with care and treatment required review to meet the needs of these patients. We found:

- Very low number of carers had been identified by the practice and health checks for carers were not being provided.

During the inspection in July 2017, we found:

- The practice had developed an action plan in March 2017 to improve the identification of carers. The practice had introduced a carers six-monthly review with the practice nurse to ensure appropriate care and support is provided for carers. All carers have been offered this review, so far one patient has attended for a review.

Patient information leaflets and notices were available in the patient waiting area that told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated patients or patients who had

clinical needs that resulted in difficulty attending the practice patients included signposting to relevant support and volunteer services. The practice had very low numbers of isolated patients and patients who had clinical needs that resulted in difficulty attending the practice.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 10 patients as carers (0.07% of the practice list). The practice told us that due to the high number of young patients that they had registered lower numbers of carers would be expected at the practice than at other practices, however, this does not recognise that many younger people have caring

Good

Are services caring?

responsibilities. Written information was available to direct carers to the various avenues of support available to them and we saw information for carers was displayed in the waiting area.

Staff told us that if families had experienced bereavement, their usual GP contacted them by telephone if appropriate.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they had an atypical patient population due to the high number of students registered at the practice, the high number of patients whose first language was not English and the fact that the vast majority of their patients were in the 20-29 year age group. The practice requested information on ethnicity and preferred language when patients registered at the practice.

Information from Public Health England showed that:

- 67% of patients are between the ages of 20-29 (CCG average 19%, national average 14%).
- 13% of patients are between the ages of 30-39 (CCG average 14%, national average 14%).
- 5% of patients are between the ages of 40-49 (CCG average 13%, national average 14%).

We saw that:

- The practice had a high number of patients whose preferred language was not English. This information was collected when patients registered at the practice. The practice provided data that showed that, on the day of the inspection, 9622 (66%) out of 14,600 patients had noted a language preference. Of these who had recorded a language preference 53% recorded English, 28% recorded Chinese (including Cantonese and Mandarin) and 4% recorded Arabic. The practice had introduced a range of information to support patients whose first language was not English and planned to introduce more.
- The practice has a high proportion of patients who are from ethnic minorities. In February 2017, the practice reported that of the patients they recorded the ethnicity for 37% were white British, British, mixed British or Irish and 35% were recorded as Chinese. Seventy-one ethnic categories were recorded by the practice.
- The practice told us that they had higher than normal number of patients who contracted malaria each year and a high number of patients who had an eating disorder. On the day of the inspection, we saw no evidence that the practice had responded to these issues by either providing targeted services or educational programmes to reduce the risks to patients.

We also found:

- There were longer appointments available for patients with a learning disability, patients with long terms conditions and those requiring the use of an interpreter.
- Home visits were available for older patients and patients who had clinical needs that resulted in difficulty attending the practice.
- When a patient had more than one health condition that required regular reviews, they were able to have all the healthcare checks they needed completed at one appointment if they wanted to.
- The practice had recently introduced a palliative care register and it was agreed that this register would include a wide range of life-limiting conditions.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had a walk-in surgery Monday to Friday. Every patient who presented at the practice between 8am and 9am was guaranteed to see a GP the same day.
- Patients were able to receive a wide range of travel vaccinations. The practice was a designated yellow fever vaccination centre.
- Patients could call the practice each day and receive test results from the healthcare assistant.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice provided contraceptive and sexual health advice to patients but this did not include the fitting of coils or implants.
- Extended hours pre-bookable appointments with a nurse or a healthcare assistant were available each Saturday. The lead GP was on call and available for any clinical queries, however, they were not at the practice when these appointments were carried out. No extended hours appointments were available with a GP.
- A practice newsletter had been introduced mid-2017 that provided information on the services available and any changes at the practice.

Access to the service

The practice runs a walk-in clinic Monday to Friday. Every patient who presents at the surgery between 8am and 9am are guaranteed to see a GP that day. In addition to this pre-bookable appointments are available at the following times:

- Monday 8am to 12pm then 1pm to 5:30pm

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Tuesday and Wednesday 8am to 5:30pm
- Thursday and Friday 8am to 6:30pm
- Extended hours appointments with a nurse or healthcare assistant are available from 8:30am to 5pm on Saturday's.

Results from the national GP patient survey, published in July 2017, showed that patient's satisfaction with how they could access care and treatment was below local and national averages.

- 71% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG average 81%, national average of 76%).
- 69% of patients said they could get through easily to the practice by phone (CCG average 77%, national average of 71%).
- 78% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment (CCG average 84%, national average of 84%).
- 71% of patients said their last appointment was convenient (CCG average 81%, national average of 81%).
- 34% of patients described their experience of making an appointment as good (CCG average 74%, national average of 73%).
- 40% of patients said they don't normally have to wait too long to be seen (CCG average 60%, national average of 58%).

In March 2017, patients were surveyed on the appointment system and responses varied. For example, of those who responded 74% responded positively when asked how they would describe their experience of making an appointment and 30% were able to see or speak to their preferred GP. Of those who responded 71% were positive when asked to describe their experience of the GP surgery.

Most patients we spoke with said they had to use the walk-in surgery to see a GP promptly and that it was difficult to book an appointment to see a named GP if you wanted to be seen in a timely manner Some patients said there had been an improvement in the last six months. Urgent appointments were available the same day at the walk-in surgery.

On the day of the inspection, there was a routine appointment with a nurse available same next day. A routine GP appointment was available in three working days. The inspection was completed during the universities summer break when fewer students would require appointments.

The practice had a system to assess:

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

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

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

When we inspected the practice in December 2016, we found that the practice did not always record verbal complaints. At this inspection, we saw that staff had been made aware of the need to record verbal complaints and staff confirmed that they now recorded verbal complaints. We reviewed six records that showed verbal complaints were now being recorded by the practice and that action was taken, when required, to address the concerns raised.

We looked at nine of the complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way and with openness and transparency when with dealing with the complaint. The practice told us that lessons were learned from individual

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

concerns and complaints. We reviewed copies of the minutes of over 30 meetings held at the practice in 2017 involving a wide range of staff. None of the meetings recorded details of any complaints being discussed. It was therefore not clear how the practice ensured the whole team learned from complaints received. The practice's complaints policy stated that they would ensure the whole practice was aware of learning and that they would discuss issues and trends at practice meetings.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

When we inspected the practice in December 2016, we found that the practice was not able to demonstrate how it planned to achieve the vison and strategy of the practice. We found:

- The business plan in place did not reflect the management of the practice and it did not contain current goals and objectives. We also found that they had no plans to address the frequent concerns raised by patients about the wait to see a GP at the walk in surgery.

During the inspection in July 2017, we found:

- The practice had no realistic plans in place to achieve their vision and strategy. Although the practice had a plan to deliver high quality care and promote good outcomes for patients these plans were not focused on the atypical nature of the practice. The practice told us they had an atypical patient population due to the high number of students registered at the practice, the high number of patients whose first language was not English and the fact that the vast majority of their patients were in the 20-29 year age group.
- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The mission statement was displayed in Chinese and Spanish as well as English.
- An action plan was developed by the practice in March 2017; it is not yet possible to determine if this action plan has been fully effective. It included work to address many of the areas of concern identified at the previous inspection. We saw evidence that the plan was regularly monitored and that staff were engaged with the work that had been initiated.
- The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments. However, no work had been completed to assess whether the changes they had made had been effective. Following the inspection the practice told us they planned to review the uptake of appointments every three months.

Governance arrangements

When we inspected the practice in December 2016, we found that the practice's governance framework did not effectively support the delivery of their strategy and good quality care. We found:

- Not all staff were aware of who the practice's safeguarding lead was, the practice did not always understand their responsibility to review significant events and that limited quality improvement work was taking place.

During the inspection in July 2017, we found:

- Despite some improvements to the practices governance arrangements, the delivery of high-quality care was not assured by the leadership and governance arrangements of the practice.
- There was a clearer staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. In April 2017 the contracted GP's had been allocated lead roles in long-term conditions, QOF, care of the elderly, atrial fibrillation and referrals. However, one of the allocated GP's had been assigned a lead role without being clear of the remit of the role
- Practice specific policies were implemented and were available to all staff. Three of the six polices we reviewed required some review. For example, the recruitment policy did not guide staff on the requirement for DBS checks or risk assessments to be completed when staff were recruited, or on the need for proof of identity to be obtained prior to appointment. The practice manager told us that they would update the policy to include these.
- A more effective understanding of the performance of the practice was maintained. Minutes of meetings we reviewed showed that regular meetings were now held which provided an opportunity for staff to learn about the performance of the practice. However, the practice was not yet able to demonstrate that the new governance arrangements had led to improved patient outcomes. On the day of the inspection, the practice completed the data submission that allowed QOF performance to be calculated. They enabled CQC to have access to data that showed the practice's QOF achievement for 2016/2017 was 68%; this was 8% lower than their achievement for 2015/2016. This data has not yet been verified or published.

Are services well-led?

Inadequate

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

- Preliminary data indicated that the practice had improved their QOF performance for 2017/2018; however, this data is not yet verified or published, as this data was produced part way through the reporting year. The data provided by the practice showed that they may have improved in many areas. The practice told us that they expected to have improved their performance in the several QOF indicators, including atrial fibrillation, stroke, diabetes, hypertension, rheumatoid arthritis and mental health.
- The practice had improved their approach to quality improvement work and clinical audit. We saw that seven single-cycle reviews had been completed or were on-going and that audit meetings had been introduced.
- The practice's system for identifying, capturing and managing issues and risks was not effective.
- We saw evidence from minutes that a meetings structure had been developed and that most staff now attended regular meetings. However, minutes of meetings and records of significant events did not consistently detail discussion, actions taken and learning to lead improvements. The minutes of the meetings we reviewed also showed no evidence that learning from complaints had been shared with staff.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses and staff told us the practice was more aware of significant events.
- In advance of the inspection, we asked the practice to provide us with a summary of any significant events in since 01 January 2016, the actions they had taken in response and how learning was implemented. Details of 29 significant events were provided. Following this inspection the practice confirmed no additional significant events had occurred since the last event noted on their log in May 2017. When we reviewed the minutes of the meetings where significant events had been discussed five events had occurred that had been discussed but were not recorded on the log. For some of the events we reviewed on the day of the inspection the log did not record the correct date the event had occurred. The governance system in place had not identified these issues.
- The practice administration team completed some quality assurance work. For example, letters had been sent to patients who attended A & E between September 2016 and March 2017 during practice opening hours to determine if the visit had been justified. They had also started to monitor the post they received that was not related to current patients.

Leadership and culture

On the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The practice told us that given the atypical nature of the practice's patient population QOF was not effective as a measure of the practice's performance despite this, the practice had not monitored their outcomes compared to other similar services.

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 supporting 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 seven 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 now kept written records of verbal interactions as well as written correspondence.

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

- The practice held and minuted, a range of multi-disciplinary meetings. One of the GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings and we saw minutes that confirmed this.
- 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. However, minutes of the meetings we reviewed showed no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

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

- Staff said they felt respected, valued and supported by the practice. All staff had been involved in discussions about how to improve the practice.

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

When we inspected the practice in December 2016, we found that the practice had taken some steps to gather feedback from patients, however, these required review. We found:

- The practice did not have a patient participation group, the practice had not responded to the concerns raised by patients that related to the walk-in surgery and that the practice were not recording or managing verbal complaints effectively.

During the inspection in July 2017, we found:

- There was limited engagement with the people who use the service. They did not have an active patient participation group (PPG). Members had recently been recruited, however, no meetings have been held to date.
- The practice reviewed the uptake of appointments at the walk-in surgery over January and April 2017 and responded to the outcome of the reviews by providing additional appointments.
- The practice had gathered the views of patients by completing their own surveys.
- The practice gathered some feedback from patients through the complaints they received. Following the inspection in December, the practice took action to improve how they recorded and responded to verbal complaints. However, minutes of the meetings we reviewed showed no evidence that learning from complaints had been shared with staff.
- The practice gathered patients' views on the service through the national Friends and Family test (FFT). The practice told us they had received some recent responses to this test, however, when we reviewed the published data when we planned the inspection no responses had been reported between October 2016 to March 2017. Following the inspection, the practice supplied details of the completed responses. Between October 2016 and March 2017, 190 responses had been received. Of those that responded, 67% said they would recommend the practice and 9% said they would not recommend the practice.
- The practice had gathered feedback from staff through staff meetings, appraisal and discussion. Most told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Several staff told us that practice now worked better as a whole team and that they had started to work more cohesively since the last inspection.

Continuous improvement

The practices approach to continuous improvement had improved; however, with respect to identifying, analysing and learning from significant events, complaints or other issues, the practice had failed to show they had an effective system in place to capture issues and manage risks associated with providing health and medical care to patients.

There was little evidence of further innovation or service improvement. Work that had commenced remained at an early stage and was therefore unable to show sustained improved outcomes. We noted that practice planned to introduce a minor surgery service for patients.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider failed to have in place effective systems or processes in order to monitor and improve the outcomes, quality and safety of the service provided. In particular: The practice failed to ensure that their system for recording and managing significant events that occurred at the practice were effective in order to analyse and learn from such events. The practice clinical audit and governance systems were not effective. The practice failed to ensure that accurate, complete and contemporaneous notes were maintained in respect to each patient. The practice did not have an effective complaints process in place in order to ensure learning from for the practice as a whole. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.