

Wallington Medical Centre

Quality Report

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

Ratings

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

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires improvement overall. (Previous inspection – January 2015 - Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Requires improvement

Families, children and young people – Good

Working age people (including those recently retired and students – Requires improvement

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Wallington Medical Centre on 7 November 2017, as part of our scheduled inspection programme.

At this inspection we found:

- Some safety systems and processes had deteriorated since the last inspection. Some risk assessments were not being used effectively to manage risk, and there were gaps in staff training.
- There were some areas (such as cervical screening, NHS health checks, and care of patients with some long-term conditions, as measured by QOF) where the practice performance was below average.
- The practice had clear systems to manage safety incidents. When incidents did happen, the practice learned from them and improved their processes.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

The areas where the provider **must** make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. (See requirement notices section at the end of the report for more detail.)

The areas where the provider **should** make improvements are:

Summary of findings

- Assess whether the practice is compliant with the NHS Accessible Information standard, and take action on any areas identified for improvement (For example, by developing easy read materials).

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Wallington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist adviser.

Background to Wallington Medical Centre

Wallington Medical Centre is a well-established GP practice located within the London Borough of Sutton and is part of the NHS Sutton Clinical Commissioning Group (CCG) which is made up of 27 GP practices. The practice provides primary medical services to approximately 2,400 patients.

The age range of patients is predominately 15 – 49 years and the number of five – 24 year olds is greater than the England average. The practice population deprivation score is higher than the England average and there is a high incidence of unemployment.

The practice holds a Personal Medical Services (PMS) contract. (PMS is one of the three contracting routes that are available to enable commissioning of primary medical services).

There are three GP partners (two male, one female). There is one part-time female practice nurse who is supported by a part-time healthcare assistant. There is no practice manager (the previous practice manager left the practice in February 2017). One of the partners has been covering the practice management function. There is a plan to merge with another local practice. The plan has a number of phases, beginning with back office functions in 2017. Supporting the practice management function are an office manager and three receptionists (one of whom is also the health care assistant). The practice is an accredited GP training practice, but does not currently host any GPs in training.

The practice opening hours are 8am to 7.30pm Monday, 8am to 6.45pm on Tuesday, and 8.00am to 6.30pm on Wednesday, Thursday and Friday.

The practice has opted out of providing out of hours services and have arranged with an alternative provider to provide cover when the practice is closed. The details of the out-of-hours service provider are communicated on the practice website and a recorded telephone message directs patients to contact 111 NHS advice line when the practice is closed.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- Two of the three GPs at the practice completed training on how to safeguard children from abuse in January 2014, one completed online update training shortly before the inspection. National guidance recommends training for GPs at least every three years. The practice had no evidence of child safeguarding training for the third GP. The practice had no evidence of adult safeguarding training for two of the three GPs. However, the clinical and non-clinical staff we spoke to knew how to identify and report concerns.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- One of the partners was the infection control lead, although she had not any specialist training for the role. The last available infection control audit was completed in 2014. The practice had had an external infection control audit shortly before the inspection, but the report was not yet available. The partner practice manager told us that some relatively minor issues had been identified, which had been addressed, for example handwashing posters replaced. The practice was generally clean and tidy although there was a little

surface dust in one area of a patient toilet and a window sill. Not all staff had completed formal infection control training, but those we spoke to were able to give an explanation of responsibilities relevant to their role.

- Practical measures to prevent and control infection were in place, for example, personal protective equipment for staff, spillage kits and documented decontamination procedures for clinical equipment.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff told us that there were generally enough staff, but that ensuring sufficient staff for reception and administration could be a challenge with the current staffing levels.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- The practice kept prescription stationery securely, but there was no effective system to monitor its use. Serial numbers of prescription forms were not being recorded as they were received or as they were assigned to prescribers. Although few handwritten prescriptions were written, there were multiple prescription pads in use reducing the effectiveness of the monitoring system.
- In general, staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, the practice had recently recruited a locum nurse who had been in post for a little more than a week at the time of the inspection. There were no Patient Group Directions in place for this nurse, who had been administering vaccinations. Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We also found that the system to monitor prescriptions that had not been collected was not effective. Amongst the prescriptions awaiting collection there were five dated from August or earlier (with one from May and two from June).
- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Track record on safety

Management of arrangements for ensuring safety had slipped since the departure of the previous practice manager. Although we found that fire and other risks were

well assessed and mitigated when we inspected in January 2015, risk assessments for fire and legionella were not available at this inspection. The practice had arranged for new assessments for fire and legionella risk to be carried out two days after the inspection.

Practical arrangements to manage fire safety were in place, including checks on fire alarm and safety equipment and regular fire drills. Electrical equipment was checked to ensure it was safe.

The practice used a formal risk assessment tool as part of their system to learn from significant events, to help it to understand risks and plan appropriate action.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example after a staff member received a needlestick injury, the practice took appropriate immediate action, then reviewed the incident and took action including training for the staff member.

There was a system for receiving and acting on safety alerts, such as medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as requires improvement for providing effective services for people with long-term conditions and for working age people. It is therefore rated as requires improvement for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice did not provide general health checks for patients aged over 75. The practice reviewed the health of some specific older patients as part of a scheme to avoid unplanned hospital admissions (that the practice had signed up to provide).
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- In the latest published Quality and Outcomes Framework (QOF), the practice was an outlier for several

indicators of care for patients with long-term conditions. QOF is a system intended to improve the quality of general practice and reward good practice. For example, in 2016/17:

- The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c was 64 mmol/mol or less in the preceding 12 months was 67% compared to a local average of 78% and a national average of 80%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 50%, compared to a local average of 76% and a national average of 78%.
- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who were treated with anticoagulation therapy was 74%, compared to a local average of 89% and a national average of 88%.
 - The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 71% compared to a local average of 80% and a national average of 83%.
- GPs provided the care for patients with long-term conditions with the support of a health care assistant.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 65% in 2015/16, which was below the 80% coverage target for the national screening programme.
- Out of 927 patients aged 40-74 eligible for an NHS check, only five had received a health check.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 100% of patients on the practice's register of patients with a learning disability had received an annual health check.

People experiencing poor mental health (including people with dementia):

- 80% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is in line with the national average.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is better than the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 96%; CCG 92%; national 91%).

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 86% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 96% (for 2016/17). The overall exception reporting rate was 4% compared with a national average of 6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

The overall QOF performance had improved from 2015, when the practice achieved 79%. And some specific indicators had been improved to in line with national average, for example in 2015/16, the percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 55%, compared to a local average of 89% and a national average of 90%. This improved to 82% in 2016/17.

However, the care of patients with some long-term conditions, particularly diabetes remained below average. The GPs told us that they believed that performance would be improved for the year 2017/18 by using the same strategies as had achieved the previous improvement, but could provide no evidence to demonstrate this improvement.

The practice was involved in quality improvement activity. There had been six audits in the past two years, of which two had been repeated to check for improvement. One of these was an audit of the treatment of sore throats, which showed an increase in prescribing in line with guidance. In the second audit 80% of antibiotics were prescribed in line with guidance and there were no examples where GPs had decided not to prescribe antibiotics where this decision was not in line with guidance. Most of the audits carried out were designed and encouraged by the clinical commissioning group, and there had been no clinical audit completed since October 2016 (although an audit was underway).

Effective staffing

The practice had recently employed a long-term locum nurse through an agency, and the agency had sent evidence of the nurse's specialist training. This appeared to show that the nurse had not updated their specialist skills and knowledge for the role for some time.

For example, the certificate for tissue viability was dated November 2012, childhood immunisations July 2015, travel health March 2012 and taking samples for the cervical screening programme was dated 2015. Nurses providing childhood and travel health immunisations are advised to complete update training every year. The practice said that they believed that that the nurse may have completed more recent training, but that evidence of this had not been obtained.

- There were gaps in staff training.
- Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, appraisals, clinical supervision and support for revalidation.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- All of the 27 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and fifty-six surveys were sent out and 105 were returned. This represented about 4% of the practice population. The practice was in line with average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 83% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 96%.
- 92% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 83%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 91%; national average - 91%.
- 92% of patients who responded said the nurse gave them enough time; CCG - 92%; national average - 92%.

- 95% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful; CCG - 89%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- There were no easy read materials, but the practice had arranged to receive support from a local charity group on how to improve support for patients with learning difficulties.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 27 patients as carers (1% of the practice list).

- Carers were offered flu immunisations and advice as to support available locally.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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

Are services caring?

- 84% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 82%.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 87% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 85%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, to ensure that all patients received timely support from a GP, all patients requesting an appointment by telephone initially received a return telephone call from a GP, who would offer (as appropriate) advice or a face to face consultation or take other action such making a referral or a prescription. Patients who needed an appointment generally received one within two days (and most received one the same day). There were low numbers of patients who did not attend for appointments.
- Appointments could be booked online.
- The practice had recently bought a text messaging service, which it planned to use to promote practice services, which they hoped would improve uptake.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. Patients with communication difficulties were coded on the computer system to ensure that they were booked face to face appointments rather than a telephone call back. Patients who worked or had other commitments could specify a time for their call back.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent

appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- 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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

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

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment from the practice.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Are services responsive to people's needs?

(for example, to feedback?)

- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. Three hundred and fifty-six surveys were sent out and 105 were returned. This represented about 4% of the practice population.

- 64% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 80%.
- 83% of patients who responded said they could get through easily to the practice by phone; CCG – 75%; national average – 71%.
- 75% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG – 78%; national average – 75%.
- 84% of patients who responded said their last appointment was convenient; CCG – 82%; national average – 81%.
- 72% of patients who responded described their experience of making an appointment as good; CCG – 77%; national average – 73%.
- 63% of patients who responded said they don't normally have to wait too long to be seen; CCG – 59%; national average – 58%.

Previously, the practice was closed on Thursday afternoons, but the practice had now decided to open on Thursday afternoons to help improve access. This had added three hours of extra clinical time per week (approximately 936 appointments per year).

In addition, the practice had recognised a substantial peak in demand on Monday mornings for telephone call-backs from GPs. As a result, the practice had decided to add an additional shorter GP session for telephone consultations on Monday morning over the winter period to increase capacity at this bottleneck.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. One complaint was received in the last year. We reviewed this complaint and found that they were satisfactorily handled in a timely way.
- Verbal complaints were also noted, so that the practice could analyse trends.

Are services well-led?

Requires improvement 

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

Our findings

We rated the practice as requires improvement for providing a well-led service.

Leadership capacity and capability

- Leaders were clear about the structural challenges for the practice, and were addressing them, but there were issues with day to day management and control of the quality of services during the change process.
- Leaders at all levels were visible and approachable.

Vision and strategy

- There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve their priorities.
- The practice was in the early stages of a merger with another local practice. Leaders were clear about the likely benefits of the merger for patients and the rationale for merging with the particular practice chosen.
- Considerable efforts had been made to engage patients and the wider public with the merger plans. A public meeting was advertised in the library and other public buildings, and the local MP was invited to attend. Partners and members of the patient participation group from both practices spoke about the merger plans. Forty-seven people attended. The partners asked attendees to vote on the plans, and forty-six voted in favour.
- Staff we spoke to were well informed and positive about the plans.
- It was intended that by the end of 2017 all practice management functions would be merged. Therefore when the practice manager left in February 2017, the practice did not replace her. Instead, one of the partners agreed to temporarily cover the practice management function. The partner undertaking the practice management function had no prior experience of this role. Merging the practice management had been delayed by a focus on building work at the other practice and had not yet begun.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.

- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff.

Governance arrangements

Governance systems were relatively informal and in some cases were insufficient.

- Policies, procedures and activities to ensure safety were in place but some were incomplete (for example, monitoring of prescription stationery) and for others there were weaknesses in systems to assure and assured themselves that they were operating as intended (for example the arrangements to monitor uncollected prescriptions).
- There had been efforts to address issues shortly before the inspection, but it appeared that the weaknesses had been highlighted by the approach of the inspection rather than by the practice's own governance processes.
- One of the three partners was not routinely involved in the governance of the practice. The other two partners communicated frequently to ensure good care for individual patients and issues as they arose, but there were no formal governance meetings or clinical meetings.

Managing risks, issues and performance

There were weaknesses in the processes to identify, understand, monitor and address risks including risks to patient safety.

- Risk assessments, including fire, legionella and audits of infection control were not being undertaken or reviewed regularly.

Are services well-led?

Requires improvement 

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

- There were some significant gaps in training prior to the inspection, which the practice had taken steps to address, but that demonstrated a lack of process to ensure that knowledge and skills were kept up-to-date. The practice had recently employed a long-term locum nurse through an agency, and the agency had sent evidence of the nurse's specialist training. The certificates were dated from 2012 - 2015.
- Clinical audit had been used to improve patient care, but most of the audits carried out were designed and encouraged by the clinical commissioning group, and there had been no clinical audit completed since October 2016 (although an audit was underway).
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

- The partners were aware of the practice's below average performance in caring for patients with some long-term conditions and (as measured by the Quality and Outcomes Framework) and had improved some areas, but others (particularly those that required changes in patient behaviour) remained below average, and had been for several years. These indicators were not being monitored specifically to ensure improvement.

- Cervical screening rates were low. The practice had recognised that access to nurse appointments could be an issue, but had not yet put in place a plan to address this.
- The practice submitted data or notifications to external organisations as required.
- There were appropriate arrangements to manage patient records.

Engagement with patients, the public, staff and external partners

- The practice involved patients, the public, staff and external partners in their plans for the future.
- There was an active patient participation group, who had been involved in previous improvement work, such as the changes to the appointment system.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The practice used significant events and suggestions from staff to improve.
- Larger changes, such as the appointment call back system introduced in 2014, were made based on evidence, were planned with the patient participation group and were monitored to ensure the benefits were realised.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The uptake of cervical screening was below average. The practice had recognised that access to nurse appointments could be an issue, but had not yet put in place a plan to address this. • There was no effective action to improve the low numbers of patients had received an NHS health check. • The care of patients with some long-term conditions, particularly diabetes, was below average as measured by QOF, and had been for several years. The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There was no effective system to ensure that staff training, including in child safeguarding, remained up-to-date. The records for a newly employed locum nurse had no evidence of recent training for their specialist roles. • Infection control audits had not been undertaken annually. • The system to monitor prescription stationery was ineffective as it did not involve recording the serial numbers of forms entering the practice. • Oversight of the system for monitoring uncollected prescriptions was not effective, as it had not identified that the procedures were not being followed.

This section is primarily information for the provider

Requirement notices

- Risks from legionella and fire were not being effectively assessed and managed.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.