Hurley Clinic

Quality Report

Ebenezer House
Kennington Lane, SE11 4HJ
Tel: 020 7735 7918
Website: www.hurleyclinic.co.uk

Date of inspection visit: 19 November 2014
Date of publication: 23/07/2015

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hurley Clinic on 19 November 2014. We visited the practice site at Ebenezer House, Kennington Lane, SE11 4HJ.

Overall the practice is rated as good. Specifically, we found the practice to be good at providing safe, effective, caring and well-led services. We found the practice to require improvement for providing a responsive service. We found the practice to be good for providing services to the population groups of older people, people with long term conditions, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, families, children and young people, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used proactive methods to improve patient outcomes, working in multidisciplinary teams to share best practice.
- The practice had strong governance arrangements in place.

We saw one particular area of outstanding practice. The practice were engaged with their PPG and provided them opportunities to input into decisions about the running of the practice. For example, members of the PPG had been an active part of the recruitment process of new GPs into the practice, and had been satisfied with the decisions made about the new GPs recruited.

However, there were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Summary of findings

- ensure it takes action to address the difficulties patients have with the appointments system

In addition the provider should:

- ensure mandatory staff training is up to date, particularly fire safety training.
- ensure a suitable and clear means of communication with patients to go in for their appointments is in place in the practice waiting area.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average compared to national performance for key indicators. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. The majority of patients we spoke with said they were treated with compassion, dignity and respect. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

However, not all felt cared for, supported and listened to; and data showed that patients rated the practice lower than others for some aspects of care.

Are services responsive to people's needs?

Requires improvement

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

Patients reported that they had difficulties getting appointments, and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The

Summary of findings

practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand. However, there was insufficient evidence of actions being taken in response to complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

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

Quality and outcomes framework (QOF) data showed that the practice performed well against indicators relating to the care of older people. For example, the practice maintained a register of patients in need of palliative care (there were 18 patients on the register), and had regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed. All the practice patients with rheumatoid arthritis had received an annual face to face review in the 12 months ending 31 March 2014. All their patients with rheumatoid arthritis aged 50 or over and who have not attained the age of 91 had had a fracture risk assessment in the preceding 24 months before 31 March 2014.

The practice maintained a register of older patients, and at the time of our inspection there were 529 patients on this register. All but one of the patients had a named GP.

The practice provided home visits to patients who were housebound. Annual health checks were offered to house bound patients, and at the time of our inspection 75% of these patients has received their annual health check.

Double appointments were available for patients who had that need.

People with long term conditions

Good

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

Registers were maintained of patients with different long term conditions and they received specific interventions in line with the Quality and Outcomes Framework (QOF), such as periodic reviews and assessments and referrals to other services that may be of benefit to their health and wellbeing. Some allied health professionals were based on the practice site, and their input was sought into the management of these cases.

At the time of our inspection in November 2014, there were 283 patients on the avoiding unplanned admissions for vulnerable people scheme. Most of these patients were older people. These patients had plans of care in place for them and these plans were

Summary of findings

subject to three monthly reviews. The practice had also started chronic disease management clinics for at risk groups. Patients were provided 30 minute appointments at these clinics which provided time for care planning and any required reviews and assessments.

Families, children and young people

Good

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

Appointments were available outside of school hours. Extended hours appointments were available, if they were pre-booked, between 7.00am-8.00am and 6.30pm-7.30pm on Tuesdays and Thursdays.

The premises were suitable for children and babies.

The practice offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, sending secure messages to the practice, viewing medical record and updating patient details.

There were systems in place 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 hospital emergency department attendances.

The practice's performance for childhood immunisations for 2013/14 was relatively high compared to other practices in the local area for all immunisations recommended at 12 months, 24 months and five years of age.

Working age people (including those recently retired and students)

Good

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

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Appointments were available outside of normal working hours. Extended hours appointments were available, if they were pre-booked, between 7.00am-8.00am and 6.30pm-7.30pm on Tuesdays and Thursdays.

The practice offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, sending secure messages to the practice, viewing medical record and updating patient details.

Summary of findings

The practice nurse had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions. The healthcare assistant in the practice led the smoking cessation clinic.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including people of no fixed abode and those with a learning disability.

The practice was signed up for the learning disability direct enhanced service (DES). The service involved the practice identifying patients aged 14 and over with the most complex needs and offering them an annual health check as well as a health action plan.

As part of the learning disability DES, the practice maintained a register of patients with learning disabilities. At the time of our inspection in November 2014, five of the 76 patients on the learning disabilities register for the 2014 / 15 year had received an annual health check. The practice manager told us that there was an action plan in place to ensure there checks were completed for all patients on the register which included offering these patients appointments at specialist chronic disease clinics they had scheduled for 12 and 19 December. They also planned to arrange for the healthcare assistant to carry out some of the health checks.

Patients whose circumstances may make them vulnerable were discussed at clinical meetings. These included patients with new cancer diagnosis, and patients about whom there was a safeguarding concern. Together the clinical team discussed these patients and decided on the best course of action to support them. Some allied health professionals, such as health visitors and midwives, were based on the practice site, and their input was sought into the management of these cases.

The practice included equality training in its programme of mandatory staff training.

A side room was available adjacent to the reception area, which staff were able to use to hold private conversations with patients.

A separate telephone line was available for vulnerable patients to use, which allowed them quicker access to the GP practice.

The practice provides Violent Patient Scheme (VPS) DES. The VPS DES aims to provide a secure environment in which patients who have been violent or aggressive in their GP practice can receive

Summary of findings

general medical services. At the time of our inspection, the practice had 10 to 15 patients receiving care and treatment under the scheme. They had protocols and facilities in place to protect the patients and their staff. Vulnerable patients were coded on the electronic record system and had a named GP.

People experiencing poor mental health (including people with dementia)

Good

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

The practice provided more specialised care to meet the needs of patients with dementia. These patients were discussed at the practice clinical team meetings, and plans of care were put in place for them.

At the time of our inspection, there were 39 patients requiring additional care for dementia. Records showed that 66% of these patients had had care plans prepared for them.

The practice maintained a register of patients with mental health needs, and there were 193 patients on this register at the time of our inspection. As part of the care provision to this group of patients, care plans were prepared with them. Records showed that 106 patients (55%) had a care plan in place for them.

Summary of findings

What people who use the service say

We spoke with three members of the practice's patient participation group (PPG), who also had involvement with the local area (Lambeth) Healthwatch. The PPG members we spoke with told us they were well supported by the practice, particularly by the local medical director, in organising and delivering their PPG programmes. They told us they received administrative support as well as a meeting space for their two monthly PPG meetings. The practice involved the PPG in important decisions, such as their recent recruitment of two salaried GPs, where the PPG members formed part of the recruitment panel. The PPG members were aware of the problems with the issues with the practice appointment's systems, and told us they had experienced these problems themselves. They were however encouraged that the practice management team were taking action to rectify the situation and felt the management team were committed to make improvements.

The results of the latest national GP patient survey at the time of our inspection (published July 2014) showed that patients felt the practice was performing well in certain aspects of the service. For example, 73% of respondents described their overall experiences of the surgery as fairly good or better and 85% of respondents said that the reception staff were helpful. Sixty three percent would probably or definitely recommend the surgery. However 40% said they could be overheard in the reception area and they weren't happy about it.

We received 35 completed comments cards from patients using the practice, of which 24 (or 69%) were positive. Patients told us they had been treated with care, had received a good service, that the staff team were polite, caring and helpful. Patients gave examples of particular care and attention they had received such as prompt referrals and particular considerations been given to their needs. Eleven of the completed comments cards (or 31%) were less positive or entirely negative. The key complaints patients raised related to the difficulties they experienced with getting appointments, and the lack of continuity of care they experienced due to the difficulties with getting appointments with the same doctor.

We spoke with four patients during our inspection, and their feedback about their experiences was mainly negative. Whilst the patients we spoke with felt they received reasonable care and one patient in particular was complimentary about being able to get a same day appointment using the GP triage system, patients raised concerns about having a lack of continuity of care, difficulty getting appointments, and sometimes finding the reception staff unhelpful.

The practice carried out their own patient survey during 2013. The practice survey found that 83% of respondents found their treatment had been acceptable or better. Around 59% of respondents had experienced difficulties in getting through on the telephone and 29.9% had had difficulty in speaking to a doctor. Around 51% of respondents said that they did not have a regular doctor and would like one. Lack of continuity of care was also one of the main complaints listed in the freehand comments provided by patients. These results aligned with the feedback we received from our CQC completed comments cards, but were less in line with the feedback from the national GP patient survey which were more positive.

Areas for improvement

Action the service MUST take to improve

The provider must ensure it takes action to address the difficulties patients have with the appointments system

Action the service SHOULD take to improve

The provider should ensure mandatory staff training is up to date, particularly fire safety training.

The provider should ensure a suitable and clear means of communication with patients to go in for their appointments is in place in the practice waiting area.

Summary of findings

Outstanding practice

We saw one particular area of outstanding practice. The practice were engaged with their PPG and provided them opportunities to input into decisions about the running of the practice. For example, members of the PPG had been an active part of the recruitment process of new GPs into the practice, and had been satisfied with the decisions made about the new GPs recruited.

Hurley Clinic

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The other team member at this inspection was a GP specialist advisor. Experts and advisors that we use on inspections are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Hurley Clinic

Hurley Clinic is a GP practice in Kennington in the London borough of Lambeth. The practice operates from purpose built premises with the ground floor comprising the reception and waiting area, treatment and consultation rooms, staff offices and meeting rooms. The upper floor of the premises is designated for staff offices and meeting spaces.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, family planning services, maternity and midwifery services, surgical procedures, treatment of disease, disorder or injury. The practice is able to provide these services to all groups in the population.

The practice staff team comprised two GP partners, nine GPs, two female practice nurses, one female healthcare assistant, a practice manager, and a team of 15 administrative and receptionist staff.

At the time of our inspection the practice had 13394 registered patients.

The practice has a Personal medical Services (PMS) contract for the provision of its GP services to the local population.

Hurley clinic is a GP training practice. At the time of our inspection they had one GP registrar in training in the practice.

The practice had opted out of providing out-of-hours services to their own patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This 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.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

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?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 November 2014. During our visit we spoke with a range of staff (GPs, nurses, healthcare assistant, practice manager, and administrative staff) and spoke with patients who used the service.

We observed how people were being cared for and talked with carers and/or family members and reviewed patient treatment records. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example there was a recent incident which had been reported where changes to a patient's medication had been made by their secondary care mental health team but the change had not updated in their dosset box.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

National patient safety alerts were managed by the practice's medicines management team. Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were received by the practice manager, who shared this with the clinical and reception teams.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. Staff at the practice could report significant events and accidents (SEAs) through the organisation's SEAs management system, and any manager could then review them. There were policies and procedures in place to support the management of SEAs, including an accidents, incidents and near misses policy. This set out the process for reporting, investigating and taking action in response to SEAs. All staff were responsible for reporting SEAs.

SEAs were managed by the organisation's clinical governance group. The group has oversight of SEAs across all the organisation's GP practices and shared learning from these with staff at all sites.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including the health care assistant, and key members of reception staff had been trained to be able to act as chaperones. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

For families, children and young people, there was identification and follow up of children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers). On the day of our inspection, the practice clinical team held their weekly meeting to discuss children and families in vulnerable circumstances and reviewed the care arrangements they had in place for this group of people. The practice clinical team submitted information for child protection case conferences and reviews and serious case reviews where appropriate. Reports were sent if staff were unable to attend.

Good

Are services safe?

There was a system in place for identifying patients, including children and young people, with a high number of hospital emergency department attendances. The system also identified vulnerable patients, such as those who were house bound or had complex health needs. Patients with co-morbidities and those prescribed multiple medicines were reviewed at regular intervals.

There was systematic follow up of children who persistently failed to attend appointments, for example for childhood immunisations.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and their records but recognised there was a need for better liaison with partner agencies such as the police and social services in the delivery of care of particular vulnerable children and adults.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. Patient group directions (PGDs) and patient specific directions (PSDs) were authorised by the local medical director.

Patients prescribed medicines for long periods were subject to periodic review of these medicines. When the patient was close to receiving the maximum authorised number of repeat medicines, a letter was attached to their prescription inviting them to make an appointment for a review.

The practice manager told us the practice team worked closely with the local pharmacist situated on the opposite side of the road to the practice, and that they invited them to clinical meetings to discuss the care of patients.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control, who was one of the practice nurses, who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during our interview with the healthcare assistant, she described the precautions she took to minimise the risk of infections when she took bloods from patients. This included wearing suitable PPE in the form of gloves and an apron. She also showed us how she wiped down equipment such as the treatment couch, between patients.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments.

They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. It was the practice policy that all staff, clinical and non-clinical, received DBS checks prior to their employment in the practice.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The organisation had some guidelines that were used to decide staffing levels and skills mix, and there was also human resources (HR) department input into deciding local practice needs. The practice manager told us they took account of the patient population in local practices in deciding the staffing needs. Local management teams were able to present a business case for additional staffing needs as they arose.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice carried out maintenance checks on different aspects of the premises. For example their annual gas safety checks were last completed in July 2014, and they completed twice yearly fire safety maintenance checks. The practice manager told us that four members of staff were identified as fire marshals. However we only saw evidence that one of them had had additional training to carry out this role, having completed a course in March 2014.

Fire safety training was included in the practice's list of mandatory training for its staff team. However we found that some staff had not attended the course.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Medicines used to treat patients in medical emergencies (anaphylactic medicines) were available in each treatment and consultation room in the practice and all staff we asked about this knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services safe?

The practice manager had carried out a workplace risk assessment that included actions required to maintain fire safety. The assessment did not highlight any outstanding actions. However records showed that staff were not up to date with fire training and that there were no records that they practised regular fire drills.

The practice had an Ebola action plan in place in response to the current Ebola pandemic.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients had their needs assessed and their care planned and delivered in line with published guidance, standards and best practice such as those published by the National Institute for Health and Care Excellence (NICE) and those from their local commissioners.

The clinicians we spoke with told us, and we saw meeting minutes that confirmed, that patients with new cancer diagnosis were discussed at clinical meetings to ensure the appropriate care and referral pathways were followed so that there was no delays to their care and treatment.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included a Chlamydia screening audit. The aim of the audit was to assess the number of females under the age of 25 who were offered chlamydia screening when they were prescribed contraception. The audit was prompted by the national chlamydia screening programme which sought early detection and treatment of asymptomatic infection to reduce onward transmission, prevent the consequences of untreated infection and raise awareness and skills among health professionals. The first cycle of the audit was completed between November and December 2012, and found that 39.7% of eligible patients seen in consultation had been offered or screened for chlamydia in preceding year. The national target was 70%. The audit found that nursing staff offered the greatest proportion (50%) of the screening, followed by the reception team (23.5%). The doctors offered the least proportion (22.9%) of the screening that took place in the preceding year. An action plan was put in place to update all the contraception consultations templates on the electronic patients records system to prompt clinicians to offer Chlamydia screening. A second cycle of the audit was then carried out during February and March 2013, which found of 56.9% of eligible patients seen in consultation, had been offered or screened for chlamydia in preceding year. The auditor concluded that although the practice had not yet met the national target their performance had improved, and there were some way to meeting the targets. The clinical teams were encouraged by the auditor to continue using the consultation templates to ensure further improvements.

The first cycle of an audit of new cancer diagnoses was carried out on 10 November 2014. A search was carried out of the electronic patient records system for patients with new cancer diagnoses according to the Royal College of GPs (RCGP) toolkit. Fourteen new cases were identified, 11 of whom were female. A review of the cases concluded that 10 were referred from the practice, and the remaining were identified via other routes – breast screening, COPD clinical trial, dental appointment and emergency department. Six of the 10 cases referred by the practice were for two week wait appointments. The auditors assessed how many GP attendances the patient made with complaints relating to the diagnosis before they were referred. In the majority of cases they were referred after one attendance. However they found one case, which was complex, that was seen multiple times and they discussed this case. They also discussed the other cases and those that were delayed in being treated. They concluded that some delays were due to patients not attending appointments after their initial suspected case. They prepared an administrative process to follow up patients not attending their two week wait appointment. They also found that there was a need to prepare a letter to provide to patients giving them guidance on what to do if they had problems with their faecal occult blood (FOB) test kit (home test kit used for bowel cancer screening). The clinical team also planned to start coding death notifications at their multidisciplinary team meetings, so that they could pick up, discuss and learn from cases that were entirely managed by the hospital. They planned to carry out a second cycle of audit in February 2015.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff attended mandatory courses such as annual basic life support and safeguarding children and adults from abuse.

We noted a good skill mix among the doctors with four having additional diplomas in obstetrics and gynaecology, one in sexual and reproductive medicine, and one with a diploma in tropical medicine and hygiene. All GPs were up to date with their yearly continuing professional

Good

Are services effective?

(for example, treatment is effective)

development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

The practice nurse had lead roles for example, in the administration of vaccines, and in cervical cytology. The nurse also had lead roles in seeing patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes and coronary heart disease. They had support from the GPs to manage or to discuss any complex cases.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required.

The practice was commissioned to provide the direct enhanced service (DES) for unplanned admissions. The service was intended to proactively case manage at-risk patients, and required at least 2% of the practice population over 18 years of age to be included in this group. Patients in this group also received annual reviews and we saw records indicating that they had care plans prepared for them. As part of this service, the practice had a process in place to follow up patients discharged from hospital. The practice undertook periodic audits of clinical correspondence. The most recent audit had been completed in September 2014, which identified the proportion of unprocessed documentation and where duplicated actions had occurred in response to correspondence. In response to the audit findings, the local medical director had arranged some specialist paperwork sessions for the clinical team. A floating management session was also put in place to allow for additional administration time. The administrative team were also tasked with tracking and updating workflowed processes. The practice manager explained to us that if a workflow was not processed within three days, the matter was escalated to the practice manager to institute a management session, so that time was made to process the work.

The practice held two weekly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Members of the practice management team attended regular practice meetings with other GP practices in their organisation.

The medical director in the practice attended locality meetings with other practices in their clinical commissioning group (CCG).

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (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).

For emergency patients, the practice was signed up to and using the electronic Summary Care Record system. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in

Good

Are services effective?

(for example, treatment is effective)

an emergency or out of normal hours). Patients were provided with information on the practice website about how to opt out of the system if they had any concerns or simply did not want their information used in this way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention of ill health

All new patients were offered a consultation with the healthcare assistant, which included history taking and the carrying out of some basic health checks.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice performance for the 2013 / 14 year for all immunisations was above the average national performance. There was a clear policy for following up non-attenders by a named practice nurse.

Bowel cancer screening was available for men and women aged 60 to 69. Patients in this age group were automatically recalled every two years for screening. Patients aged 70 and over, and therefore not part of the automatic recall system who wished to continue to be screened, could also request a test kit.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (published July 2014), and a survey of 400 patients undertaken by the practice. The evidence from these sources showed patients were not entirely satisfied with the care and treatment they received. According to the GP national patient survey, the practice was also slightly below the national average for its satisfaction scores on consultations with doctors and nurses. Of those responding, 82% of practice respondents saying the GP was good at listening to them (national average was 88%) and 77% saying the GP gave them enough time (national average was 86%). In response to their nurse consultations, 69% of practice respondents saying the nurse was good at listening to them (national average was 80%) and 71% saying the nurse gave them enough time (national average was 81%).

Results from the GP national patient survey found that 75% of patients felt their GP treated them with care and concern (national average was 83%). In addition, 47% felt they had definite confidence and trust in their GP, whilst 46% had some degree of confidence and trust in their GP. The national averages for these responses were 64% and 28% respectively.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed comments cards, of which 24 were positive. Patients told us they had been treated with care, had received a good service, that the staff team were polite, caring and helpful. Patients gave examples of particular care and attention they had received such as prompt referrals and particular considerations been given to their needs. Eleven of the completed comments cards were less positive or entirely negative. The key issues patients raised related to the difficulties they experienced with getting appointments, and the lack of continuity of care they experienced due to the difficulties with getting appointments with the same doctor.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responses to questions about their involvement in planning and making decisions about their care and treatment was less favourable than national averages. For example, data from the national patient survey showed 63% of practice respondents said the GP involved them in care decisions (national average was 75%); and 76% felt the GP was good at explaining treatment and results (national average was 82%).

Patient feedback on the comment cards we received was varied, with some patients commenting that they had felt well cared for, whilst others raised concerns that there was a lack of continuity of care and that they felt consultations were rushed and not thorough.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

For specific groups of people and individuals with complex needs, such as older people and people with long-term condition, there was evidence of care plans prepared with them.

Patient/carer support to cope emotionally with care and treatment

There were notices in the patient waiting area and the practice website also told people how to access a number of support groups and organisations. Patients were able to

Good

Are services caring?

be referred to Lambeth Primary Care Psychological Therapies Service for common psychological problems including depression, stress and anxiety. A counsellor from the psychological therapies service held a weekly session within the practice.

The practice's computer system alerted GPs if a patient was also a carer, and they were referred to organisations that could provide support to them.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an active patient participation group (PPG). We spoke with three members of the PPG during our inspection, who told us that the practice were engaged with them and provided them opportunities to input into decisions about the running of the practice. For example, members of the PPG had been an active part of the recruitment process of new GPs into the practice, and had been satisfied with the decisions made about which GPs were recruited.

The PPG organised a number of health promotion events in the practice targeted as specific groups of people. During the 2013 / 14 year they had arranged two healthy eating mornings in the practice waiting area, where patients were able to get information and advice. They had also arranged two Keeping Warm and Well in Winter events at the local library during February and March 2014, which had attracted approximately 80 patients; they planned to repeat the event during February and March 2015. The PPG also arranged an event for diabetic patients in June 2014, where a diabetes specialist and one of the practice nurses gave presentations.

The practice management team worked to implement changes in response to feedback from patient surveys, particularly responding to issues raised about the need for more appointments, more continuity of care, improved telephone access and improving wait times for appointments. The practice team had worked the reception team to look at ways of reducing the wait for bookable appointments. For example they had reviewed frequent attenders and were minimising missed appointments. Greater publicity is also being given to online booking for appointments.

The practice prepared a quarterly newsletter which was made available to patients in the practice and through their website. The newsletter gave information about staff news, and aspects of the available services, such as changes and updates to the appointments system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, including people living in vulnerable circumstances, asylum seekers, and people who had been removed from other practice lists because of a history of violence.

The practice had access to online and telephone translation services. Languages spoken among the staff team included French, Spanish and a native Ghanaian language. The practice had a large population of non - English speaking patients, many who were of West African origin. They were able to cater for other different languages through translation services.

The practice provided equality and diversity training through e-learning, as part of their set of mandatory staff training courses. However records showed that most staff had not completed the course at the time of our inspection.

The premises and services had been adapted to meet the needs of patient with disabilities. There was ramp access and automatic doors to allow patients in wheelchairs easier entry and exit from the premises.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. All consultation and treatment rooms in the practice were on one floor level, the ground floor.

For people whose circumstances may make them vulnerable, the practice maintained a register of people who may be living in vulnerable circumstances. There was a system for flagging vulnerability in individual records. The practice allowed patients to register with them who had been removed from other practice lists due to their history of violence in those practices. They had developed protocols and risk management procedures for caring for and treating these patients to ensure they and their staff team were kept safe at all times.

People were easily able to register with the practice, including those with "no fixed abode" care of the practice's address. There was a system to communicate with people of "no fixed abode".

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Workplace assessments were completed for staff to ensure they had safe and suitable working environment and equipment.

Access to the service

Appointments were available from 08:00 am to 6:30 pm on weekdays. Extended hours appointments were available, if they were pre-booked, between 7.00am-8.00am and 6.30pm-7.30pm on Tuesdays and Thursdays. The practice was closed at the weekends. The practice phone lines were open from 8am-6:30pm on weekdays. Information was available on the practice website about how to access medical care when they were closed. These included local urgent care and walk in centres, out of hours services and NHS Direct.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

According to the national GP patient survey, people reported that they normally booked appointments by phone (76%) and in person (47%). Very few patients (3%) reported booking app0ointments online. However 40% reported that they would prefer to book their appointments online. Overall the phone remained the most popular method people preferred to use to make their appointments, with 65% saying they preferred to make their appointments this way, and 33% saying they preferred to make appointments in person.

The practice had received feedback from different sources, including the national GP patient survey, its own survey and complaints, indicating that the appointments system was not meeting people's needs. Patient feedback indicated they were dissatisfied with the appointments system. Common issues raised were with getting through to the practice on the phone to make appointments, and there being a shortage of available appointments.

Eighty three percent reported that at their last appointment they wanted to see a GP at the surgery, 7% wanted to see a nurse. The remaining 10% wanted to speak with a doctor or nurse. Most people wanted their appointment on the same day (62%), 20% wanted an appointment a few days later. Just over half of respondents, 54%, were able to get an appointment to see or speak to someone, 19% said they could get an appointment but had to call back closer to or on the day they wanted the appointment, 23% said they weren't able to get an appointment to see or speak with someone.

The most common reasons people said they weren't able to get an appointment was that there weren't any available on the day they wanted (54%) and 15% said there weren't any available for the time they wanted. Twelve percent said they didn't get an appointment as none were available with their preferred GP. Half of respondents reported having a good experience of making appointments, whilst 30% reported having a poor appointments booking experience.

Many respondents to the national GP patient survey said they had long waits at the practice for their appointments, with 48% waiting more than 15 minutes to be seen.

The practice had trialled a number of changes to address the issues they had with the appointments system, including a nurse-led and more recently a doctor-led triage system, which has been in use in the practice since August 2013. The system required any patient with an urgent need needing attention the same day to call the practice and one of the duty GPs would return their call within two hours. The duty GP would then assess the patient and either advise them over the phone, or book an appointment the same day to see them.

The practice also reduced the waiting times for pre-bookable appointments. Patients were able to book an appointment up to a month ahead to see a GP with a non-urgent need.

Longer appointments and home visits were available for patients who needed them, such as older people and those with long-term conditions.

The practice used a public address (PA) system in the waiting area to indicate to patients where they needed to go for their appointment. Patient and PPG members' feedback was that the system was not audibly clear. We observed during our inspection that patients did not always hear what the PA announcement was saying, and they had to go and double check their appointment details with the reception staff.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

For families, children and young people, and working age people, appointments were available outside of school hours. The practice premises were suitable for children and young people. The practice offered online services for appointments booking and management, and ordering repeat prescriptions. Telephone and online consultations were also available for less urgent needs.

There was multidisciplinary working to understand the needs of the most vulnerable in the practice population. They were provided with longer appointments if needed.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We saw that a complaints leaflet was available in the practice waiting area to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the summary of the 53 complaints received in the 12 months beginning 01 November 2013. Sixteen of the complaints related to the appointments system and 17 complaints related to consultations and treatment provided. Other complaints related to system failures such as problems with the issue of repeat prescriptions. We found the complaints were responded to, investigated and actions taken deal with them individually. However there was insufficient evidence of actions being taken to address the strong emerging themes in complaints.

The practice manager also responded to comments made, mostly complaints, about the practice on NHS choices website. Reviewers were invited to contact the practice manager to discuss confidential matters and only general feedback based on the practice's policies was shared through the website.

The regional manager received and reviewed complaints from each of the practice sites on a monthly basis. They then compiled an annual report which was presented at Board level summarising all complaints received. The regional manager delivered a number of training topics to local practices based on highlighted needs, such as complaints handling and customer service.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The members of staff we spoke with shared this vision and knew what their responsibilities were in relation to this.

The practice maintained ongoing communications with its patient population through its quarterly newsletter. This gave details of operational changes or updates, such as staff news, health promotion campaigns and key information about the appointments system.

Governance arrangements

There were four GP partners in the Hurley Group, the organisation that operates the Hurley Clinic. Two of the GP partners had sessions at the practice, so the leadership was worked closely with the rest of the staff team and were visible and accessible to them.

The organisation had a number of policies and procedures in place to govern activity across all its practice sites, and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures, including the recruitment policy, and saw that they were reviewed periodically and kept up to date.

There was a clear leadership structure at the practice with named members of staff in lead roles. For example, there was a lead nurse for infection control and a senior partner was the lead for safeguarding children and adults. There was a local medical director in the practice, who took the lead practice management and clinical role. The local medical directors across the organisations held regular meetings where they shared learning, policies and practices.

The staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. They had a dedicated member of the administrative team who had key responsibilities in the monitoring and reporting on QOF performance to their colleagues. The staff member was able to show us some of the ways they supported the clinical team to meet QOF targets. For example, they sent the clinical team reminders about key care activities that were required for different patients or groups of patients, and also attached prompts to scheduled appointments, reminding clinicians to offer and provide relevant care opportunistically.

The QOF data for this practice showed it was performing in line with national standards. The QOF administrator prepared monthly reports for the staff team to support them in monitoring their performance and progress in different aspects of their service. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

There were corporate level arrangements in place to support the organisation and local practice governance. There were monthly operations meetings attended by the practice manager, the lead GPs, lead nurse and regional manager. Matters discussed at the meetings included the practice performance and key performance indicators (KPIs), recruitment, as well as delivery of enhanced services. Action plans were put in place to address any shortfalls in performance.

The organisation held quarterly clinical governance meetings since the launch of the Hurley Clinical Governance Group (HCGG) in September 2012. The group included managers and clinical directors and had overall responsibility for clinical governance and the quality of patient care throughout the organisation. Matters considered at the HCGG meetings were primarily patient complaints (reported by the Practice Managers), 1% Audit – a random case-note analysis of 1% of all GP Walk In Centre (GPWIC) consultations and Significant Event Reports.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Recent audits undertaken included a chlamydia audit and a new cancer diagnosis audit.

The practice also undertook some quality improvement projects. Two examples they provided us with was of recoding exercise they completed of children on their child protection registers, and actions they had taken to deliver an improved service for patients with learning disabilities.

Leadership, openness and transparency

Are services well-led?

Good

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

We saw from minutes that team meetings were held regularly in the practice. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

There was a corporate level overview and responsibilities for human resource policies and procedures. We reviewed a sample of policies and the staff handbook which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had functionality on its website for patients to give instant feedback, indicating whether they had had a great or poor experience when they recently visited the practice. This feedback was monitored monthly and discussed at staff meetings.

The practice also monitored response from other sources such as NHS choices, and the results of national GP patient surveys. The practice also conducted their own annuals surveys to get further feedback on patient experiences. We found complaints were responded to, investigated and actions taken deal with them individually. However there was insufficient evidence of actions being taken to address the strong emerging themes in complaints.

There were various meetings in the practice among the staff team, including daily 'call over meetings' between the clinical team to discuss specific patient cases, referrals and other actions arising from the day's appointments, weekly clinical meetings, two weekly multidisciplinary meetings and two weekly reception and administrative team meetings.

The practice had a patient participation group that met every two months. A meeting space was provided for the group to meet in the practice but the group remained autonomous and able to direct their agenda and priorities.

Management lead through learning and improvement

Hurley Clinic is a training practice. At the time of our inspection they had one GP registrar in training in the practice.

Mandatory training courses were in place for the staff team, according to their roles and responsibilities, and were made available through online and classroom sessions depending on the topics. However we found some gaps in the training sessions that had been completed by the staff team.

Staff received annual appraisals with progress reviews held midway through the year.

The provider offered a talent management programme to staff identified to have practice management potential. These included senior administrators and reception staff within the organisation. They were provided a four hour learning session every six weeks on key topics such as leadership and motivation, and finance for non-finance personnel. At the end of the programme, the staff were required to complete a project taking up to six months in their practice. This showed the organisation was committed to recruiting internally into leadership roles.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. How the regulation was not being met: The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to have regard to information received in relation to the quality of services including complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf. This was in breach of Regulation 10 (1)(2)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not take sufficient action to address the difficulties patients have with the appointments system.