Knightsbridge Doctors

Inspection report

15 Basil Mansions
Basil Street
London
SW3 1AP
Tel:

Date of inspection visit: 13 July 2022
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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 location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

We carried out an announced inspection at Knightsbridge Doctors on 13 July 2022. This is the first inspection under this provider registration and it is a rated inspection.

This practice is rated as **Requires improvement** overall.

The full reports for previous inspections can be found by selecting the 'all reports' link for Knightsbridge Doctors-Basil Mansions, the previous registered provider, on our website at www.cqc.org.uk

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Knightsbridge Doctors as part of our inspection programme. The practice is an independent GP practice located at 15 Basil Mansions, Basil Street, London, SW3 1AP.

Knightsbridge Doctors is an independent provider of medical services and offers a full range of private GP services.

Nine people provided feedback via online reviews about the practice. All the feedback we received was positive, with an average of 4/5 stars, about the staff and services provided by the practice.

Dr Eoin James Waters, 'the provider' is registered with CQC as an individually-registered person. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run. They are registered with the CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

This practice is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Knightsbridge Doctors provides a range of student and occupational health services and third party visa medicals for immigration purposes. For example, for clients wishing to emigrate to Australia, Canada and New Zealand, which do not come within CQC scope of registration. Therefore, we did not inspect or report on these services.

Our key findings were:

- The safety systems and processes in place required regular monitoring to ensure they remained effective.
- There were gaps in relation to medicines prescribing.

Overall summary

- Learning from significant events was not always clear.
- The provider had safeguarding systems and processes in place.
- Staff did not always have the information they needed to deliver safe care and treatment to patients.
- There were gaps in some staff training.
- The practice did not have a consistent system in place to monitor and manage patient complaints.
- Clinical care was not consistently delivered in line with national guidance.
- The practice respected patients' privacy and dignity.
- Staff helped patients to be involved in decisions about care and treatment.
- Staff worked together and worked well with other organisations, to deliver care and treatment.
- Patients were able to access care and treatment from the practice within an appropriate timescale for their needs.
- We saw no evidence of discrimination when making care and treatment decisions.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way for patients.
- Establish effective systems to and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report).

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

- Monitor that carpets in clinical areas are cleaned every six months.
- Take action to streamline medical emergency policies into one document.
- Continue to embed the business contingency plan with practice staff.
- Carry out two-cycle audits as part of improvement activity.
- Take action to embed the DNACPR processes already in place within an appropriate policy.
- Take action to record learning from complaints.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector and included a CQC GP Specialist Adviser.

Background to Knightsbridge Doctors

Knightsbridge Doctors is a private GP practice, registered at 15 Basil Mansions, Basil Street, London, SW3 1AP. The practice premises is situated on the ground floor of 14-25 Basil Mansions, Basil Street, SW3 1AP and is a listed building.

The practice staff consist of one full-time lead GP who is the registered manager. They are supported by five full and part-time GPs, both male and female and a full-time practice manager, who is the practice nurse, a remote immigration administrator, a secretary, a radiographer; an x-ray manager and several reception/administration staff.

The practice provides general radiographic services to patients within the practice, as well as receiving referrals from nearby practices. Services provided include travel advice and vaccinations and are a designated Yellow Fever centre. In addition to this, blood tests, long-term condition management, cervical screening, cryotherapy and health screening services are provided to adults and children.

The practice opening hours are between Monday to Friday between 9am and 5pm. The lead GP is also available out of hours and operates an on-call service. The practice website can be found at: www.knightsbridgedoctors.com

How we inspected this practice

Before the inspection we reviewed a range of information submitted by the practice in response to our provider information request. During our visit we interviewed staff, observed practice and reviewed documents.

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

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

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

Requires Improvement

Are services safe?

The provider is rated as requires improvement for providing safe services because:

- There were gaps in mandatory training such as fire and health and safety and sepsis training.
- Some legionella risk assessment action points had not been completed, including where water temperatures were out of range.
- Some of the sinks did not comply with infection prevention and control recommended guidelines.
- The clinicians had not recorded contemporaneous notes in four of the records we reviewed.
- There were gaps in relation to medicines prescribing.

Safety systems and processes

Safeguarding systems and processes were developed and implemented in a way that kept people safe; however, they required monitoring to ensure they remained effective.

- The practice had systems and processes to keep patients safe. There were safeguarding registers in place for children and vulnerable adults. These patients had alert flags in their medical records, including electronic labels which enabled them to generate reports as required.
- There were appropriate safeguarding policies in place for both adults and children. Staff knew how to recognise and act on suspected abuse and would refer any concerns to the practice safeguarding lead.
- We saw evidence that the provider worked with other agencies to support patients. For example, they shared information with us regarding safeguarding referrals they had made to the relevant local authorities.
- All clinicians were trained to the appropriate level of safeguarding children level three, except for one clinician who had received safeguarding children level two.
- We reviewed recruitment records which had been safely and effectively managed, including Disclosure and Barring Service (DBS) checks which had been undertaken where required.
- We saw that staff who acted as chaperones were trained for the role and had completed a DBS check in line with practice policy.
- The practice had a system in place to ensure that adults, who may accompany a child to appointments at the practice, had parental consent and authority. A policy was in place with procedures on how to verify identity and we saw examples of this on inspection.
- The provider had carried out appropriate premises risk assessments within the previous 12 months including those for Legionella. However, we found some action points had not been completed, including where water temperatures were out of range.
- The provider conducted fire drills every six months and the last fire drill was carried out in February 2022. We saw appropriate documentation of fire drill records.
- We reviewed staff training records and identified some gaps regarding regular training. For example, fire safety and health and safety training. We saw that one clinician had last completed their fire safety training in 2019 and four members of staff had last completed their health and safety training in 2018 and 2019.
- We saw the provider had carried out portable appliance testing (PAT) and calibration testing on all medical equipment in the practice in March 2022.
- The practice had a system to manage infection prevention and control (IPC) and healthcare waste. The practice had completed a usage and storage of sharps assessment, a clinical waste audit, a Covid-19 risk assessment and an in-house infection prevention and control audit in June 2022.
- The practice appeared clean and tidy. However, we found some of the sinks in the consulting rooms and flooring in the treatment rooms did not meet current guidance regarding infection prevention and control. There were carpeted

clinical rooms and the practice provided evidence to show the carpets were cleaned annually. They were last cleaned in June 2022 and appeared visibly clean and in good condition. However, infection control guidance states this should be carried out every six months and following the inspection, the practice provided evidence to show updated policies with regards to frequency of carpet cleaning.

- All staff were up to date with their infection control training.
- The provider carried out other environmental risk assessments such as the control of substances hazardous to health (COSHH). We saw this risk assessment covered substances regarding the management of Covid-19 and included all substances stored in the practice.

Risks to patients

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

- There were appropriate arrangements for planning and monitoring the number and mix of staff needed in the practice
- We saw there was an effective induction system for staff tailored to their role.
- We reviewed evidence that the provider had appropriate medical indemnity arrangements in place, including for those services which are not in our scope of regulation.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention and they were aware of the location of the emergency equipment. The practice had a 'heart attack' action plan in place and staff had received training in relation to this. All staff had completed basic life support training in the previous 12 months.
- We saw there were five different policies on managing medical emergencies in the practice and we found this may potentially be confusing for non-clinical staff. Following this, the practice told us these policies will be streamlined into one policy to avoid confusion for staff.
- In-house training had been provided for staff to enable them to identify and manage patients with severe infections, for example sepsis. However, they had not maintained training records to demonstrate which staff had completed this training. Sepsis training records provided did not include those for all staff.
- The practice had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records were mostly written and managed in a way that kept patients safe. The care records we saw were stored on a cloud-based system and showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- On inspection we reviewed 12 patient records and found four patient records had not been recorded contemporaneously following consultation. We found their notes were in the form of a written letter to the patient one to three days after the consultation. Whilst the lead GP managed most of the private patient consultations and knew the patients well, there was risk, that in the event of the GP's absence, other staff would not have access to these notes.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Requires Improvement

Are services safe?

- The practice had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. They were also registered with the Information Commissioners Office.
- Clinicians made timely referrals when required. However, the practice could not demonstrate they had safety netted their referral system to follow-up patients to ensure they had been seen by the secondary care team or specialist.

Safe and appropriate use of medicines

There were gaps in the systems for appropriate and safe handling of medicines.

- We found the provider had appropriate systems in place to monitor and manage vaccines, controlled drugs, emergency equipment and blank prescriptions. During our inspection, we observed that blank prescription forms were stored securely in the practice premises.
- The provider had the appropriate emergency medicines and risk assessments were in place for the medicines not held such as naloxone (used for drug overdose) and morphine (used for severe pain).
- We found the practice did not carry out regular medicines audits, to ensure prescribing was maintained in line with national guidance, regarding safe prescribing.
- Staff mostly prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, the processes in place were not robust as where there was a different approach taken from national guidance, there was no clear rationale for this that protected patient safety. For example, two of the patients records we reviewed where patients were prescribed high risk medicines, the prescriber had not checked that blood test monitoring was up to date as per national guidance before issuing the prescription. One patient prescribed thyroxine had been issued with a six-month prescription prior to their annual blood test which was two months overdue. Despite some patients being stable on these medicines, improvement was required to reduce any risk of harm.

Lessons learned and improvements made

The system in place for significant events and shared learning when things went wrong required improvement.

- A significant event policy was in place. The provider told us they had a low number of significant events and they provided evidence to show a recorded significant event; however, minutes of meetings provided, did not show discussions of significant events and any learning points.
- We reviewed evidence that when a significant event occurred, the provider offered patients appropriate support, truthful information and a verbal and written apology. For example, one of the two significant events reported by the practice related to an incident where a patient had been incorrectly missed from a diagnostic list. Following this significant event, the provider had issued an apology to this patient and sent them a gesture of goodwill. However, they could not demonstrate what changes they had made to their system to prevent an incident such as this from happening again.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The provider had a system in place to monitor and manage patient safety alerts that may be relevant to patients in the practice population. Clinicians were aware of the latest relevant safety alert regarding polio detection. We saw there was an appropriate logging system to ensure all the team had read, reviewed and actioned the alerts where appropriate.

Requires Improvement

Are services effective?

We rated the provider requires improvement for providing effective services because:

- Care and treatment was not always delivered in line with current legislation, standards and guidance.
- Clinicians did not receive formal clinical supervision.
- There was limited quality improvement activity.
- There were some gaps in practice systems regarding consent to care and treatment.

Effective needs assessment, care and treatment

The provider had some systems in place to keep clinicians up to date with current evidence-based practice. However, care and treatment was not always delivered in line with current legislation, standards and guidance.

- We found the provider did not always deliver care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guideline. We have documented evidence regarding this in the key question for 'safe'. We saw examples of good practice regarding the management of care for patients with diabetes and hypertension, in line with national guidance.
- We reviewed evidence that clinicians had sufficient information to make or confirm a diagnosis. Information relating to the patient's previous medical history, relevant family medical history, NHS GP where relevant and whether patient consent to information being passed to them and allergies, were obtained before the GP commenced a consultation.
- We saw no evidence of discrimination when making care and treatment decisions.
- We saw arrangements were in place to deal with regular patients. The provider used a primary care software system to manage patient records which meant clinicians had instant access to medical records to support regular patients. This patient record system allowed them to recall their patients with long-term conditions, for vaccines or screening requirements and prescriptions.
- Staff assessed and managed patients' pain where appropriate.
- The practice used technology to improve patient treatment and access. They have implemented a new paper-free software system that enabled them to scan and store patient notes and prescriptions. In addition, this system facilitates appointment booking and recall of patients with long-term conditions, vaccine or screening requirements.

Monitoring care and treatment

There was limited quality Improvement activity. Further action was required to ensure they reviewed the clinical effectiveness and appropriateness of the care provided.

- We found clinical audit activity was limited. The provider showed us two audits they had carried out, one of which was a clinical audit. This was a single cycle pregabalin (used to treat epilepsy and anxiety) audit carried out in June 2022, to review women of childbearing age who were prescribed this medicine and to ensure they received an appointment to discuss the risks identified with this medicine. The audit did not find any patients who were eligible for a recall and the outcome was to repeat this audit in 12 months.
- We saw the provider had carried out other quality improvement activity in the practice. For example, feedback which was obtained via completed patient questionnaires.
- Following the inspection, we saw evidence the provider had implemented a clinical audit programme.

Effective staffing

Requires Improvement

Are services effective?

Clinical staff had the skills, knowledge and experience to carry out their roles. There was lack of oversight regarding regular training for all staff.

- We saw evidence of training records for clinical staff and found that staff were appropriately trained and qualified, except for some gaps in safety related training and training including equality and diversity. The provider had a comprehensive induction programme for all newly appointed staff. We saw evidence of a detailed induction handbook for doctors.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/Nursing and Midwifery Council (NMC) and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them.
- An external specialist speaker provided training at the practice to facilitate continuing professional development requirements, which included chaperone and consent training.
- Staff told us they received annual appraisals and were encouraged and given opportunities to develop.
- Staff received annual appraisals and they were encouraged and given opportunities to develop. Staff told us they were able to suggest areas of professional development during their appraisals which were listened to. However, we were not assured of how clinical supervision or peer reviews were taking place in the practice. Following the inspection, the provider developed a clinical supervision policy and programme which will be reviewed at the next inspection.
- We reviewed evidence that staff whose role included vaccine administration had received appropriate specific training. For example, venepuncture, yellow fever vaccinations and wound care.

Coordinating patient care and information sharing

Staff worked together and worked well with other organisations, to deliver care and treatment.

- Patients received coordinated and person-centred care. Staff referred to and communicated effectively with other services when appropriate. The provider had a long-standing relationship with private hospital-based consultants who would frequently visit the practice to provide educational talks to the doctors and update them on latest guidance. The provider also had direct access to clinical advice from consultants who led on respiratory issues; for example, tuberculosis management.
- Before providing treatment, doctors at the practice ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the practice.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. Protocols were in place to provide the appropriate support. For example, the provider had a good relationship with a home nursing and care service who provided carers or nurses for some of their patients.
- Patient information was shared appropriately (this included when patients moved to other professional services) and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. For example, a patient summary was provided to out of hours services providers as it was not possible for them to access practice systems.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

Requires Improvement

Are services effective?

- Where appropriate, staff gave people advice so they could implement self-care measures. For example, disease prevention and lifestyle advice was provided to patients during consultations.
- Patients were offered annual general health screening tailored to their individual needs, dependent on personal circumstances and risk factors. This included comprehensive blood tests, electrocardiogram (ECG) monitoring, chest X-rays and other additional tests such as 24-hour blood pressure monitoring if indicated.
- Risk factors were identified and the practice; for example, through active recalls to monitor blood pressure and cholesterol levels. These were highlighted to patients and where appropriate, highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the practice, staff redirected them to the appropriate service for their needs. For example, the practice no longer prescribed high-risk medicines such as warfarin and methotrexate. This was managed by secondary care specialists, unless they had received very specific and clear instructions from them to provide this service.

Consent to care and treatment

There were some gaps in practice systems regarding consent to care and treatment.

- Staff understood the requirements of legislation and guidance when considering consent and decision making. For example, we found that staff supported patients to make decisions and where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- There was a consent policy in place. However, not all staff had completed training regarding mental capacity and consent.
- The provider ensured do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed and provided to patients for home use to ensure they were available to emergency services and out of hours care providers. However, we saw that the practice system regarding DNACPR processes was not formalised within a practice policy.

Good

Are services caring?

We rated caring as Good because:

- Staff treated patients with kindness, respect and compassion.
- Staff helped patients to be involved in decisions about care and treatment.
- The practice respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The practice sought feedback on the quality of clinical care patients received. The practice told us they sent out online questionnaires to GP patients every six months.
- Feedback from patient questionnaires were positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Staff told us that interpretation services were available for patients who did not have English as a first language. For example, by access to 'Language Shop', a telephone interpreter service. However, we did not see evidence of patients information notices in the practice premises or website, alerting patients to the availability of this interpreter service.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. We saw there was a hearing loop available at the reception desk.
- We saw evidence that patients were able to choose a consultant of their choice and could be referred to an appropriate service provider of their choice.

Privacy and Dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

The practice is rated as good for providing responsive services because:

- The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.
- Patients were able to access care and treatment within an appropriate timescale for their needs.

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 provider understood the needs of their patients and improved services in response to those needs. For example, they recently signed up to a telephone answering service that managed the bulk of their appointment bookings. This practice followed guidelines to manage specific appointment types and they held regular meetings with the provider to review and act on any concerns in relation to appointment booking.
- Patients could book appointments and triage calls online and by telephone.
- The provider was proactive in undertaking screening for patients aged 50 and over. This included screening for mammograms, colonoscopy and fibro scans.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, the practice had made suitable arrangements for patients with a disability or reduced mobility, to be seen at the nearby healthcare practice premises. Home visits, where appropriate, were available on request.

Timely access to the practice

Patients were able to access care and treatment within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Appointments were generally offered within 24 hours and patients were offered 30-minute slots for pre-booked appointments and one hour for full check-up appointments.
- Waiting times, delays and cancellations were minimal and managed appropriately. Patients were also offered to telephone or video consultations in addition to face to face appointments.
- Patients with the most urgent needs had their care and treatment prioritised. The lead GP provided an on-call service during out of hours times and weekends. Telephone consultations and home visits were provided by GPs from the practice and other GP on-call visiting service.
- No patient views were gathered on inspection; however, online patient reviews reported the practice provided an efficient service.

Listening and learning from concerns and complaints

The practice complaints system was inconsistent in its response to patients complaints.

- Information about how to make a complaint or raise concerns was available and there were procedures in place. There was a complaints policy on the provider website dated 2017 and an updated patients complaints leaflet was available.
- The practice informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.

Good

Are services responsive to people's needs?

- The practice provided us with a complaints log that showed seven complaints had been received since January 2022. It was unclear what learning and improvements had been made from the documentation we reviewed. For example, in relation to two staff-related complaints, it was not clear what learning points had been identified, or what improvements had been made, when patients were not happy with their consultation.
- We reviewed further patient complaints and saw that appropriate action had been taken. For example, four complaints were received by the practice in relation to bruising following venepuncture. Patients had received an apology and an information leaflet, regarding this specific concern, was created by the practice to distribute to patients. This leaflet provided information on possible bruising after venepuncture and action to take to minimise any discomfort.

Requires Improvement

Are services well-led?

The provider is rated requires improvement for well-led because because:

- The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective.
- We found that some structures, processes and systems to support good governance were not effective. In particular, we found concerns around the management and monitoring of training, safety netting for secondary care and other referrals.
- The service had had a vision and credible strategy to deliver high quality care and promote good outcomes for patients; however, monitoring was required.
- Further improvement was required to ensure a culture of high-quality sustainable care.

Leadership capacity and capability

Leaders demonstrated limited capacity and skills to deliver high-quality, sustainable care.

- Senior staff in the practice team understood the challenges to delivering care within a primary care setting; however, monitoring was required to ensure they had an effective action plan to address those challenges.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had some processes to develop leadership capacity and skills, including succession planning.
- Although the provider could demonstrate they had a vision and set of values, they could not assure us they monitored progress of any strategy to drive improvements.
- Doctors working at the practice had a wide range of specialist skills and some were NHS based doctors. Clinicians had specialist experience in dermatology, cardiovascular medicine, women's health, acute illness and chronic disease management.
- The lead GP had practising privileges at the London Clinic and would often provide appointments there for practice patients at that location, if they could not access the practice premises. They provided on-call arrangements, where necessary, during out of hours and weekends, to provide continuity of care for patients.

Vision and strategy

Although the practice had a vision and credible strategy in place to deliver high quality care, there was limited oversight in monitoring its progress.

- There was a clear vision, strategy and set of values. Their strategy was to offer safe and effective, evidence-based practice for the treatment and long-term management of those conditions which may affect the patient.
- The practice developed its vision, values and strategy jointly with staff and external partners. Their aim was to provide high quality patient care and work with the patients taking into account their views and wishes.
- The provider could demonstrate they had a strategy in place to address any challenges they had identified and concerns we found on inspection. However, we found that there were gaps relating to the safety systems in place, staff training provision and governance structures, all of which had the ability to compromise the quality of care provided by the practice and impact on its vision, aims and objectives.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

Improvement was required to ensure a culture of high-quality sustainable care.

Requires Improvement

Are services well-led?

- Staff felt respected, supported and valued. They were proud to work for the practice.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- The provider had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could 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 appraisals and career development conversations. For example, we saw that all staff had received regular annual appraisals in the last year.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and revalidation.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity; however, there were gaps in equality and diversity training as records showed not all staff had completed this. Staff felt they were treated equally.
- Staff told us there were positive relationships between staff and teams. They stated they felt the practice was well-run and the practice management team operated an open-door policy for staff.

Governance arrangements

There were gaps in governance arrangements.

- There were gaps in the structures, processes and systems to support good governance and management to ensure they were clearly set out and effective. These were in relation to clinical supervision and significant events.
- There were gaps in training such as fire and health and safety, sepsis for staff.
- The provider had practice policies in place which were regularly updated. We saw evidence where there were shortfalls, the provider took action to update their policies.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear regarding their roles and accountabilities and had designated lead roles within the practice. For example, regarding x-rays.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

- During the inspection, we identified risks in relation to medicines management, health and safety, safety risk assessments, some aspects of infection control and oversight regarding the management of secondary care referrals.
- We were not assured that comprehensive and effective systems and process had been identified, were in place and regularly reviewed to manage risk and some performance data. For example, the provider could not demonstrate that it proactively identified and responded to all risks and assessed the impact on safety and quality.
- There was limited evidence of quality improvement activity such as clinical audit and we found this had not been embedded in practice systems.
- The provider had plans in place and had trained staff for major incidents. However, not all staff were aware of a business contingency plan in place.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Requires Improvement

Are services well-led?

- Performance information was combined with the views of patients.
- The practice were aware of their responsibility to submit data or notifications to external organisations as required.
- There were appropriate arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. All patient records had been transferred onto a cloud-based system.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- The practice encouraged and heard views and concerns from patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback; for example, through team meetings and directly to the leaders whom they found approachable. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We saw staff engagement in responding to these findings.
- The practice was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning, continuous improvement and innovation.

- There was some focus on continuous learning and improvement.
- Further improvement was required the internal and external reviews of significant events and complaints. This related to shared learning with all staff in order to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff could access the shared folder with business objectives and understood that patient care was their top priority.
- There were some systems to support improvement and innovation work. We saw several examples of where the practice had made technological improvement that benefited their patients; for example, the implementation of their patient record software where patient records dating back 50 years were successfully transferred onto the new system.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Governance and monitoring systems were not established and operated effectively.** • The provider did not have an effective system in place to manage regular staff training. • Clinical staff did not receive formal clinical supervision of their practice. **This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Some legionella risk assessment action points had not been completed, including where water temperatures were out of range. • Some of the sinks did not comply with infection prevention and control recommended guidelines. • The clinicians had not recorded contemporaneous notes in four of the records we reviewed. • There were gaps in relation to medicines prescribing. • Learning from significant events was not always clear.