Temple Cowley Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Temple Cowley Medical Group on 14 July, 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, we found that not all clinical staff had received recent training in the Mental Capacity Act 2005.
- Patients said they were treated with compassion, dignity and respect, but were not always satisfied with access to appointments or the time and attention that clinicians were able to provide.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Urgent appointments were available the same day.
- The practice was equipped to treat patients and meet their needs. The practice was aware of the limitations placed on it by its aging premises, and had plans in place to address this
- The practice had recently experienced an extended period of staff shortages. While this had significantly improved, it acknowledged the impact this had had on staff and patients. It had identified the link between this challenging period and below average results in some areas of clinical outcome and patient satisfaction. Action plans had been drawn up to address these issues.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- The practice was working to proactively seek feedback from patients to assist with its planning how to improve services.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

The practice had 176 patients on its mental health register, which represented 2% of its patient list, with more than a third living in controlled residential environments. The practice was proactive in its liaison with local community and residential mental health services to ensure that the needs of these patients were met. This included allocating a named GP for a residential home for patients with mental health illnesses and a named practice nurse to undertake care plan reviews at the practice or through home visits to patients unwilling or unable to attend the surgery.

The practice was in regular communication with the organisation which provided other supported accommodation for patients with mental health conditions, and it ensured that patients prescribed high risk anti-psychotic medicines were closely monitored under a shared care pathway. Annual care plan review rates for patients with mental health conditions and dementia were above local and national averages and the majority of its mental health care plan reviews were completed in conjunction with local psychiatric teams.

The practice used the care plan review process to undertake opportunistic work to address patients' other health issues, including flu vaccination and smoking cessation support, which had resulted in 13 patients on the mental health register giving up smoking.

The areas where the provider must make improvements are:

- Ensure that all planned work is undertaken to increase patients' attendance of reviews for long-term conditions, child immunisations and cancer screenings.

In addition, the provider should:

- Establish an audit trail to ensure that medicine and equipment safety alerts are acted on by clinicians.
- Continue to ensure that the practice premises meets accessibility expectations for patients with disabilities through the installation of an automatic entrance door and a hearing loop.
- Continue to work to improve patient satisfaction through patient feedback to ensure it meets the needs of the patients and the practice.
- Ensure that all clinical staff have training in the Mental Capacity Act 2005, so that consent to treatment is sought appropriately for all patients.
- Follow up children who have failed to attend booked hospital appointments or immunisation appointments, and identify adult patients known to be subject to safeguarding concerns on their records, as a safeguarding responsibility.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, although it did not routinely identify the reasons for children's non-attendance of hospital appointments or identify adults known to have safeguarding concerns on their patient records.
- Medicine and equipment safety alerts, such as those issued by the Medicines & Healthcare Products Regulatory Agency (MHRA) were received and disseminated to clinical staff but were not audited to ensure that any action required had been taken.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below the national average for some elements of the care of long-term conditions. Exception reporting rates for some long term conditions were above the national average.
- Cancer screening data showed the uptake for the bowel cancer screening programme was below the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Not all clinical staff had received recent training in the Mental Capacity Act 2005, or related legislation and guidance relevant to patient consent and decision making.

Summary of findings

Are services caring?

Good

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

- Data from the national GP patient survey showed patients rated the practice lower than others for several aspects of care. The practice had drawn up an action plan to address issues identified in the survey.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice was aware that the layout of the waiting room made patient confidentiality a challenge at the reception desk. It had installed a radio in the waiting area and telephone calls were taken away from the front desk.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group to secure improvements to services where these were identified. The practice shared a care navigator with other local GP practices to support elderly and vulnerable patients access local services, and was able to refer homeless people to a specialist medical centre in central Oxford
- The practice demonstrated that it was responsive to the needs of its patient population, including the high number of patients on its list with mental health issues. The practice liaised closely with mental health community and residential services to ensure that these patients were provided with the additional support required.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- Access for disabled patients was limited in some areas of the practice owing to the age and structure of the building. Patients were seen in more accessible rooms when required and the practice provided evidence they had been in negotiations with the building owner to have an automatic entrance door installed.

Are services well-led?

Good

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was a governance framework which supported the delivery of the strategy and good care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice had experienced a challenging period owing to severe staff shortages in both the clinical and non-clinical teams. This had improved, and a number of clinical staff members were scheduled to further increase their hours by autumn 2016 to improve appointment availability.

The practice demonstrated a clear understanding of its lower than average achievements in some areas of QOF, the national GP patient survey and some immunisation and cancer screening targets. While it considered that these figures were in part a result of previous staff shortage, it had drawn up action plans to address each area of concern and improve these figures.

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Each of the seven care homes served by the practice had a named GP who undertook regular extended visits. The homes also had access to a dedicated urgent access telephone number for rapid advice, to reduce the need for ambulance call-outs or hospital admissions.
- The practice was working with the East Oxford GP Cluster's practice care navigator, who visited patients at home to support care planning and advised on local services.
- Carers were signposted to local support services, such as Carers Oxfordshire.
- The practice held regular multi-agency end of life care meetings with district nurses palliative care nurses and other professionals. One of the GP partners was the lead for the Oxford City Locality for end of life care and maintained close links with the palliative care team at the local hospice.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was mainly above the clinical commissioning group (CCG) and national average with 99% of patients with diabetes receiving influenza immunisation in the preceding 12 months, compared to the CCG average of 96% and the national average of 94%, and 81% of patients with diabetes achieving a target blood level of 64mmol or below compared to the CCG average of 79% and national average of 78%.

Summary of findings

- The practice's asthma and COPD lead nurse was a nurse prescriber, and the diabetes lead nurse had undertaken specialised training. Both liaised with nominated GPs to review medicines and ensure that current guidelines were being followed.
- However, exception reporting rates in some clinical domains for patients who were unable to attend a review meeting or be prescribed certain medicines were high, compared to CCG and national averages. These included patients with diabetes and chronic kidney disease.
- The practice had recently installed software to streamline the recall process for all long term conditions and support patients' management of their own conditions.
- All patients with long term conditions had a named GP. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Longer appointments and home visits were available when needed.

Families, children and young people

Good

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

- 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 A&E attendances. The practice kept a register of children who had failed to attend booked hospital appointments, but did not routinely chase up with families to find out the reason for non-attendance.
- Immunisation rates were in line with, or slightly below national average for standard childhood immunisations. The practice was working with health visitors to improve its pre-school immunisation rates by encouraging attendance.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- 82% of female patients aged 25 to 64 had received a cervical screening test in the preceding five years, compared to a CCG average of 83% and a national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies, and
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Summary of findings

- GPs met regularly with health visitors to identify and review vulnerable families and children on the child protection register.
- GPs carried out new baby checks if these were not done in hospital.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

- 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.
- The practice had achieved a rate of 60% attendance of those invited for NHS health checks with practice nurses and health care assistants, compared to an Oxford city rate of 42% and a county-wide rate of 48%. Patients attending these health checks were referred as required to smoking cessation services, exercise schemes and dietary advice.
- A smoking cessation specialist had recently joined the practice team, integrating the practice with Oxfordshire-wide services.

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 travellers and those with a learning disability. All patients living in care homes were also included on the register. Homeless people were referred to a medical centre in central Oxford which offered a specific service for this population group provided by the county's clinical commissioning group.
- The practice offered longer appointments for patients with a learning disability. The practice held a learning disability register of 37 patients, who were invited to attend for an annual health check. The practice had achieved an attendance rate of 62% in the last year, and was working to improve these figures by following up on non-attendance.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Vulnerable patients were prioritised for same-day GP and nurse appointments.

People experiencing poor mental health (including people with dementia)

Outstanding 

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

- The practice had a higher than average number of patients with diagnosed schizophrenia, bipolar affective disorder and other psychoses on its list, including a large number living in care homes or supported accommodation in the area. The care homes each had a link GP and the practice was in close liaison with the organisation which ran the supported accommodation.
- The practice had a link GP for the local nursing home for people with dementia. The GP undertook fortnightly ward rounds and undertook additional visits as required to avoid these patients having to attend the practice.
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  93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who had their care reviewed in a face to face meeting in the last 12 months, which is above the CCG average of 89% and the national average of 88%
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It was in close liaison with the local forensic psychiatric team, and held regular lunchtime meetings with the adult mental health team to discuss cases and possible referrals.
- The practice had a higher than average number of patients prescribed high risk anti-psychotic medicine, and ensured that these prescriptions were closely monitored under a shared care pathway.
- The practice carried out advanced end of life care planning for patients with dementia, and was due to hold a patient group education session on this subject.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had an understanding of how to support patients with mental health needs and dementia, although staff had not received recent training in the Mental Capacity Act 2005, which could impact on their ability to assess patients' capacity to give consent for care and treatment.
- A counsellor attended the practice to see patients via the local Improving Access to Psychological Therapies (IAPT) pathway. The practice referred patients to group and individual treatments such as cognitive behavioural therapy via IAPT. The IAPT team had provided a training course in psychological treatment for clinical staff at the practice in 2014.

Summary of findings

What people who use the service say

- The national GP patient survey results were published in July 2016. Two hundred and seventy five survey forms were distributed and 118 were returned. This represented 1% of the practice's patient list. 74% of patients described the overall experience of this GP practice as good, which was below the clinical commissioning group (CCG) average of 90% and the national average of 85%. However, other responses about making appointments and general patient experience were in line with national averages:
- 73% of patients found it easy to get through to this practice by phone compared to the CCG average of 84% and the national average of 73%.
- 82% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and the national average of 85%.
- 76% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 83% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 19 comment cards. Eight of these were wholly positive about the standard of care received and nine others included positive comments about the attitude of staff and the service provided. The majority of negative comments referred to the difficulty in getting appointments with GPs without a long wait, particularly if the patient wished to see a specific GP.

We spoke with three patients during the inspection, and received 15 questionnaires completed by patients on the day. Patients thought that staff were approachable, committed and caring. The majority of patients said that they were happy with the care they received, other than the long wait for a GP appointment, particularly with a preferred GP. A number acknowledged that they were offered a telephone call by the GP as an alternative, although not all patients felt that this provided the same level of service.

The most recent published Friends & Family Test results showed that 76% of patients would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that all planned work is undertaken to increase patients' attendance of reviews for long-term conditions, child immunisations and cancer screenings

Action the service SHOULD take to improve

- Establish an audit trail to ensure that medicine and equipment safety alerts are acted on by clinicians.
- Continue to ensure that the practice premises meets accessibility expectations for patients with disabilities through the installation of an automatic entrance door and a hearing loop. .
- Continue to work to improve patient satisfaction through patient feedback to ensure it meets the needs of the patients and the practice.
- Ensure that all clinical staff have training in the Mental Capacity Act 2005, so that consent to treatment is sought appropriately for all patients.
- Follow up children who have failed to attend booked hospital appointments or immunisation appointments, and identify adult patients known to be subject to safeguarding concerns on their records, as a safeguarding responsibility.

Summary of findings

Outstanding practice

The practice had identified that it had a higher than average number of patients on its list with mental health issues, and was proactive in its liaison with local community and residential mental health services to ensure that their needs were met. This included allocating a named GP for a residential home for patients with mental health illnesses, regular communication with the organisation which provided other supported accommodation for patients with mental health conditions and ensured that patients prescribed high risk anti-psychotic medicines were closely monitored under a shared care pathway. Annual care plan review rates for patients with mental health conditions and dementia were above local and national averages.

Temple Cowley Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector, who visited the practice with a GP specialist adviser.

Background to Temple Cowley Medical Group

Temple Cowley Medical Group provides GP services to nearly 8,000 patients in the Cowley area of Oxford. The practice serves an area with a high level of minority ethnicities and residents who were born outside of the UK. Its level of income deprivation affecting children is above the national average. The practice has more patients on its list with long-term health conditions than the clinical commissioning group (CCG) and national average.

The practice has a higher than average number of patients with diagnosed mental health issues on its list. Patients with schizophrenia, bipolar affective disorder and other psychoses represent 2% of the patient list. There is a large mental health hospital in the practice area, and a large number of patients with enduring mental health conditions live in supported housing in the locality. The practice also serves three care homes for patients with mental health issues. The practice is based in part of the ground floor of a building owned by NHS Property Services, with flats on the upper floors. The building is ageing and while the practice has been able to undertake some adaptions to meet patient needs, such as a dedicated toilet and parking spaces for patient with disabilities, other plans to improve accessibility and provide a more pleasant patient environment have been limited by structural considerations.

The practice has five GP partners (four female and one male) and two male and one female salaried GP. The weekly sessions provided are equivalent to 4.3 working time equivalent (WTE) GPs. There are three practice nurses, including one nurse practitioner, equivalent to 2.2 WTE nurses. The practice also has two health care assistants, equivalent to 0.7 WTE. The practice had faced recent challenges recruiting GPs, nurses and a practice manager, and this had led to an extended period of additional pressures on the existing team. At the time of inspection there were still some staff shortages, however, one of the salaried GPs and two of the nurses are planning to increase their hours by October 2016.

In addition to its primary care service provision, the practice is involved in national clinical research studies and encourages patients to volunteer for these. It also provides a teaching environment for undergraduate medical students at Oxford University for clinical primary care placements

The practice is open from 8.30am to 6.30pm Monday to Friday. The practice has opted out of providing out of hours services to its patients. The out of hours service is provided by Oxford Health NHS Foundation Trust and is accessed by calling NHS 111. Advice on how to access the out of hours service is contained in the practice leaflet, on the patient website and on a recorded message when the practice is closed.

Services are delivered from:

Detailed findings

Temple Cowley Medical Centre

Temple Road

Oxford

OX4 2HL.

The practice has not been previously inspected by the CQC.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 July 2016.

During our visit we:

- Spoke with a range of staff, including four GPs, a nurse and health care assistant, and members of non-clinical staff, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an incident involving the missed collection of controlled drugs led to a review of the tracking and audit records by the practice. Following staff consultation, a new signing out process was established.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- The practice had undertaken a recent health and safety audit which included infection control. It had identified premises issues related to age of the building and facilities, including degrading pipework, flooring and work surfaces, and accessibility issues impacting on patients with disabilities, such as no automatic entrance door It was in ongoing negotiations with NHS Property Services to have these addressed.
- The new infection control lead nurse had recently undertaken training, and was ensuring that all policies were up to date and relevant.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been

adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. This process had recently been reviewed and improved following the identification of a significant event involving a missed collection of controlled drugs. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Medicine and equipment safety alerts, such as those issued by the Medicines & Healthcare Products Regulatory Agency (MHRA) were received and disseminated to clinical staff, but were not audited to ensure that clinicians had responded appropriately.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available. Exception reporting in 10 out of the 16 clinical domains was above the clinical commissioning group (CCG) and national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had excepted 24% of patients with diabetes compared to the CCG average of 13% and the national average of 11%. It had excepted 27% of patients with chronic kidney disease compared to the CCG and national average of 8%. Its exception rate for the primary prevention of cardiovascular disease was also high, at 67% compared to the CCG average of 31% and national average of 30%.

The overall QOF exception rate for 2014-15 was 17%, which was above the CCG average of 10% and the national average of 9%. The practice provided us with its data for 2015-16, which has now been submitted to QOF, but not yet published. This showed that the practice had an overall exception rate for 2015-16 of 18%.

Data from 2014-15 showed:

- Performance for diabetes related indicators was mainly above the CCG and national average. 99% of patients with diabetes had received influenza immunisation in the preceding 12 months, compared to a CCG average of 96% and a national average of 94%. However, the percentage of patients with diabetes who had received a foot examination and risk classification in the past 12 months was 85%, compared to a CCG average of 90% and a national average of 88%.
- Performance for mental health related indicators was above the CCG and national averages. 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had received a face-to-face care plan review in the preceding 12 months, compared to a CCG average of 89% and a national average of 88%.

  The practice had acknowledged that exception reporting rates and review rates for some long-term conditions were high, and were working to address these. It had identified that the low review rates had arisen during a period when the clinical team experienced considerable staff shortages and sickness. Now that its staffing levels had increased, and with two of the nurses planning to increase their hours by the autumn, the practice was looking to introduce more nurse-led clinics to regularly review and support patients with long term conditions. It was also reviewing its process for deciding which patients would be excepted from the QOF calculation. The decision to except a patient was made by GP partners.

  There was evidence of quality improvement including clinical audit.
- There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. The practice involved undergraduate medical students studying at the University of Oxford to assist in some of this work.
- Findings were used by the practice to improve services. For example, as a result of an audit on the long-term

prescribing of a medicine used to treat a bone density condition, six patients had their prescriptions reviewed to ensure it was appropriate that they continued to take the medicine.

Information about patients' outcomes was used to make improvements such as an audit into dermatology prescribing which highlighted that patients with dermatological conditions could sometimes also experience low mood or depression. The GPs were advised to refer to emotional wellbeing and any medicines prescribed for this when writing initial referral letters to hospital dermatology departments.

Effective staffing

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety, confidentiality, basic life support, information governance and human rights. Staff had access to and made use of e-learning training modules and in-house training. The practice's nurse practitioner was qualified to provide in-house life support training to all new staff on induction and at regular periods.
- Staff received role-specific training and updating. One nurse had nearly completed training to become a nurse mentor for other nursing staff, and another was due to commence the course. Nursing team members had undertaken specialist training in long-term conditions such as diabetes and asthma, and one nurse had completed a diploma in contraception and had updated the practice's contraception templates for patient records as a result. A health care assistant who had joined the practice at the beginning of June 2016 was undertaking the Care Certificate.
- However, not all clinical staff had received recent Mental Capacity Act (MCA) 2005 training, to ensure that they were capable of seeking appropriate consent for care and treatment from all patients. MCA 2005 training was not included on staff training schedules as a routine training requirement.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. The process for seeking consent was monitored through patient records audits. However, not all clinical staff had received recent training in the Mental Capacity Act 2005, or related legislation and guidance, to ensure that they were fully up to date with issues surrounding patient consent and decision making.

Requires improvement

Are services effective?

(for example, treatment is effective)

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients were encouraged to attend NHS health checks with nurses or assistants, and the practice had achieved an attendance rate of 60% for those invited, compared to an Oxford city rate of 42% and a county-wide rate of 48%. Patients attending these health checks were referred as required to smoking cessation services, exercise schemes and dietary advice.
- A smoking cessation specialist had recently joined the practice team, integrating the practice with Oxfordshire-wide services. A benefits advisor also held regular sessions on site with patients referred by the practice. Patients diagnosed with a long term medical condition and those caring for relatives received additional support, including education and signposting to other services.
- The practice had designed a system of multi-agency end of life care planning, and was inviting other local practices to become involved in this.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 83% and the national average of 82%. However the practice's exception rate was 14%, which was above the CCG average of 7% and the national average of 6%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for breast and bowel and cancer screening. The practice's uptake for the breast cancer screening programme was 73%, which was comparable to the CCG average of 75% and the national average of 72%. However, its uptake for the bowel screening programme was 51%, which was below the CCG average of 59% and the national average of 58%. The practice had identified that this figure was low and was working to encourage more patients to participate in the programme.

Childhood immunisation rates for the vaccines given in 2014-15 were slightly below CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 88% to 96% compared to the CCG average of 90% to 97%, and five year olds from 87% to 98%, compared to the CCG average of 92% to 98%. The practice demonstrated that it had undertaken work to address this, including a meeting attended by GPs, the immunisation lead nurse and health visitors to draw up a strategy to improve its immunisation rates by encouraging attendance. The practice provided evidence that since October 2015, it had increased its lower rate for under two year olds to 90%, and its lower rate for five year olds had increased to 89%.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Seventeen of the 19 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service, and that staff were helpful and caring and treated them with dignity and respect. The majority were positive about the attitude of staff and the service provided. The majority of negative comments referred to the difficulty in getting appointments with GPs without a long wait, particularly if the patient wished to see a specific GP.

Results from the national GP patient survey showed the majority of patients felt they were treated with compassion, dignity and respect. However, the practice was below average for some satisfaction scores on consultations with GPs. For example:

- 80% of patients said the GP gave them enough time compared to the average of 89% and the national average of 87%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 88%.

Satisfaction scores for nurses in these areas were in line with local and national averages:

- 93% of patients said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.

Other satisfaction scores were comparable with CCG and national averages. For example:

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The practice had drawn up an action plan to address issues identified in the survey, and this work was ongoing. The work included re-establishing the patient participation group (PPG) to more clearly identify patient need, and assist with patient communication. The practice was also increasing its use of GP-led telephone triage to assess if patients requiring urgent appointments could be seen by a member of the nursing team or offered a telephone GP consultation. It provided emergency appointment slots throughout the day so that vulnerable patients and children could be seen at a convenient time.

The practice had also analysed its Friends & Family Test data, and found that the percentage of patients who would recommend the practice had been above 80% for most months of 2016. It had identified that its lowest results had been at the time of staffing difficulties in late 2015. The practice was attempting to increase Friends & Family Test response numbers by prompting patients to respond to the test by text after they had attended appointments.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. We saw that care plans, including those for end-of-life care, were personalised.

Good

Are services caring?

Results from the national GP patient survey showed that most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. However, some results were below local and national averages. For example:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice's action plan to address issues identified by the GP patient survey included work to improve patient involvement in their care and treatment. It had planned a series of patient education sessions, with the first one to be held soon on the theme of advanced end of life care planning for patients with dementia.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that telephone and face-to-face translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 224 patients as carers (3% of the practice list).Patients identified as carers were signposted to the Carers Oxfordshire Service for additional support, and written information was available. The practice did not provide carers with a specific medical assessment of their own health.

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

Vulnerable patients, carers, older patients and those with long term conditions were referred to the East Oxford GP Cluster's practice care navigator. Referrals were made directly by GPs, and from the list of unplanned hospital admissions.

The practice provided examples of ways it had provided individual patient care, such as arranging for one of its medical students to accompany a patient with partial sight to a hospital appointment, to provide one-to-one support and to become more aware of the challenges that patients with disabilities might face when receiving secondary care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and (CCG) to secure improvements to services where these were identified. The practice shared a care navigator with other practices in the East Oxford cluster, who visited patients at home to support care planning and advise on local services. The practice was able to refer homeless people to a medical centre in central Oxford which provided a specific service for this population group.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice had some disabled patient facilities including a toilet and dedicated parking spaces However, it did not have an automatic entrance door or a hearing loop, and some of the corridors leading to GP consultation rooms were narrow. Where necessary, clinicians would see patients in the rooms towards the front of the building, which had easier access. The practice provided evidence that it had been in lengthy negotiations with NHS Property Services, which owned the building, to have an automatic entrance door installed.
- Each of the seven care homes served by the practice had a named GP who undertook regular extended visits. The homes also had access to a dedicated urgent access telephone number for rapid advice, to reduce the need for ambulance call-outs or hospital admissions.
- The practice was working with the East Oxford GP Cluster's practice care navigator, who visited patients at home to support care planning and advise on local services.
- The practice held regular multi-agency end of life care meetings with district nurses palliative care nurses and other professionals.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It was in close liaison with the local forensic psychiatric team, and held regular lunchtime meetings with the adult mental health team to discuss cases and possible referrals.
- The practice had a higher than average number of patients prescribed high risk anti-psychotic medicine, and ensured that these prescriptions were closely monitored under a shared care pathway.
- The practice carried out advanced end of life care planning for patients with dementia, and was due to hold a patient group education session on this subject.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- A counsellor attended the practice to see patients via the local Improving Access to Psychological Therapies (IAPT) pathway, and the practice also referred patients to group and individual treatment such as cognitive behavioural therapy via IAPT. The IAPT team had provided a training course in psychological treatment for clinical staff at the practice in 2014.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 9am to 12.10pm every morning and 3pm to 6pm daily. An emergency duty GP was available from 8am daily. The practice did not offer extended hours access as part of its General Medical Services contract. In addition to pre-bookable appointments that could be booked up to six

Good

Are services responsive to people's needs?

(for example, to feedback?)

weeks in advance, urgent appointments were also available for people that needed them, with slots available at different times of the day to enable patients to attend around family or other commitments.

- Results from the national GP patient survey regarding access to care and treatment showed that 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 76%.
- 73% of patients said they could get through easily to the practice by phone compared to the CCG average of 84% and the national average of 73%.

The practice told us that it had recently changed the telephone system so that patients were told that they were in a queue to be spoken to, and it was planning to introduce more telephone options to improve patients' experience of telephoning the practice.

People told us on the day of the inspection that they were able to get appointments when they needed them, although it could be a wait of up to three weeks to see a preferred GP.

The practice had a system in place to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, in a leaflet and on the practice's website.

We looked at seven complaints received in the last 12 months and found that these were dealt with in a timely way and with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following a miss-communication with a patient about how to prepare for a blood test in pregnancy, the practice developed an information leaflet for midwives to give to patients who required the test.

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 vision to deliver high care and promote outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The practice had identified the challenges it faced, including patient satisfaction, the suitability of premises, reviewing long term conditions and had re-established a the patient participation group (PPG), and had action plans to address these areas. For example, it was considering future options regarding relocation if the existing premises could not be made entirely suitable to meet current and future patient need.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The practice had undertaken a staffing restructure in 2015, and established a team leader role in the nursing, reception and administration teams, to provide a stronger link between staff and management. The team leaders had undertaken responsibility for regular line management meetings with staff, and to manage the rota systems and annual leave allowances for their teams.
- Practice specific policies were implemented and were available to all staff, and the practice manager was in the process of ensuring that these were all updated.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, the practice had failed to identify the risks associated with not ensuring that all clinical staff received Mental Capacity Act 2005 training, not auditing the actions of medicine and equipment alerts, and not following up children who had failed to attend hospital appointments. It did not routinely identify adults known to have safeguarding concerns on their patient records

Leadership and culture

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

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings, including daily lunchtime GP meetings. All staff were invited to attend significant event meetings, and full general team meetings were planned. Each team held its own regular meetings, which were led by the team leader. Minutes from meetings were shared with staff members who had been unable to attend.
- The nursing, salaried GP and non-clinical teams each had a named GP partner for liaison.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

- Staff said that the last two years had been a challenging time for all owing to severe staff shortages, and although this had improved considerably in recent months, a number of staff commented to us that this had affected the work of all teams and continued to have an impact. There was also a current receptionist vacancy, and the non-clinical team reported that they struggled with staff numbers at times of holiday and sickness. However, staff felt that they were listened to by the partners and management team.

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

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

- The practice had recently revitalised the PPG, and the practice manager and a GP partner had attended its first meeting. The practice was drawing up plans with the PPG regarding how it could best be used to more clearly identify patient need, such as through surveys and proposals, and to improve communication with patients.
- The practice had identified that its figures from the national GP patient survey were lower than local and national averages, and was working through an action plan to improve patient satisfaction.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us they felt involved and engaged to improve how the practice was run. Staff gave examples of improvements made on their suggestion, such as a radio in the waiting room to improve patient confidentiality at reception, the installation of an appointment touchscreen and the planned employment of an additional staff member to undertake document scanning.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice participated in a number of national clinical research studies, both by identifying participants and leading research at a practice level. Studies which the practice was involved in included supporting patients with diabetes in managing their condition through weight loss, providing patients with osteoporosis with specialist physiotherapy, managing urinary tract infections without antibiotics and identifying valvular heart disease and chronic kidney disease.

Nursing staff had undertaken Good Clinical Practice research nurse training, with a view to undertaking research and audit work, and the health care assistant we spoke to, who had joined the practice two weeks previously, was already involved in the practice's osteoporosis and heart disease studies.

The practice manager had attended a leadership course funded by the clinical commissioning group (CCG) and non-clinical staff were provided with the opportunity to undertake training to expand their role or to give them a wider understanding of clinical issues which may impact their work.

The practice provided a teaching environment for undergraduate medical students from the University of Oxford, and was hoping to provide a similar service for trainee practice nurses, paramedics, health visitors and pharmacists in future. The practice had received high scores in the evaluation of teaching completed by students after their placements at the practice.

The practice was part of the OxFed GP practice federation, which was currently looking to establish an urgent care hub to allow practices to focus on its patients with long term conditions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users through ensuring patients' attendance of reviews for long-term conditions, child immunisations and cancer screenings. This was in breach of regulation 12(1)(a)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.