The Hove Practice

Inspection report

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Date of inspection visit: 23 & 24 November 2021
Date of publication: 01/02/2022

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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at The Hove Practice on 23 and 24 November 2021 as part of our inspection programme. This was the provider's first inspection since their registration on 17 April 2020.

The medical director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards and one person provided feedback about the service directly to CQC. The comments we received were consistently positive. Patients told us that there were treated professionally, and in a caring manner.

Our key findings were:

- The service delivered care and treatment according to evidence-based guidelines. They routinely reviewed the effectiveness of the care it provided.
- The service involved and treated people with compassion, kindness, dignity and respect.
- Individual care records were written and managed in a way that kept patients safe. Patients received personalised care that was tailored to their individual needs.
- Patients could access care and treatment from the service within an appropriate timescale for their needs. Patients had timely access to initial assessment, test results, diagnosis and treatment.
- The service proactively sought feedback from patients. The feedback from patients was consistently positive.
- Information about services and how to complain was available. There were processes to manage and investigate complaints.
- Staff felt respected, supported and valued. They were proud to work for the service.
- The leadership team was in a period of transition at the service. The provider had processes to develop leadership capacity and skills to address current and future risks.

We rated the service as **requires improvement** for safe because:

- The safeguarding policy was not comprehensive, up to date or containing relevant information.
- The systems and processes for infection prevention and control were not yet established. This included a staff immunisations programme, audit schedule, and the ongoing assessment and mitigation of the risk of Legionella.

Overall summary

- The systems in place to maintain the safe storage of refrigerated medicines and vaccines were not implemented and operating effectively.

We rated the service as **requires improvement** for well led because:

- The systems for assessing, monitoring and improving the quality and safety of the service were not always effective. Leaders lacked oversight of some processes and therefore failed to identify risks when those processes did not operate as intended.

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

- Ensure that care and treatment is provided in a safe way.
- Establish effective systems 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:

- Review and improve the systems to maintain ongoing oversight of staff registration.
- Continue to review and improve the facility to raise an alarm within the patient toilet if assistance is required.
- Continue to review and streamline service policies.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector and a GP specialist advisor. The GP specialist advisor carried out inspection activity remotely.

Background to The Hove Practice

The Hove Practice is a private general medical practice service based in Hove, East Sussex. The registered provider is Private General Practice Ltd.

The service is provided from: 40 Wilbury Rd, Hove, BN3 3JP.

The service is run from a suite of rooms in the basement and ground floor of the building, which is leased by the provider. The service provides a range of GP services including consultation, chronic disease management, child and adult immunisations, cervical screening, travel vaccinations, well man and well woman screening and advice, sexual health advice and testing, home visits and health assessments. If required, following a consultation, a private prescription is issued to the patient, which is dispensed at a community pharmacy.

The service is available to any person and whilst most patients are from the local area, the service sees people from any part of the country.

Further information about the service can be found on their website: www.thehovepractice.co.uk

The opening times are 8:30am to 6pm Monday to Friday. If care is required outside of these times an answerphone message directs patients to the NHS 111 service. There are currently four GPs (two female, two male), three of which work in the NHS as well as at The Hove Practice. The clinicians are supported by a practice manager, an assistant manager, and small team of administration staff.

The Hove Practice was registered with the Care Quality Commission on 17 April 2020 to deliver the following regulated activities: diagnostic and screening procedures; treatment of disease, disorder or injury.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way that enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

• Conducting staff interviews using video conferencing.

• Reviewing patient records to identify issues and clarify actions taken by the provider.

• Requesting evidence from the provider, which was reviewed remotely.

• A short site visit.

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?

We rated safe as Requires improvement because:

- The safeguarding policy did not contain accurate and up to date information. Emergency safeguarding contacts displayed at the clinic were not all accurate.
- The systems and processes for infection prevention and control were not yet established. This included a staff immunisations programme, audit schedule, and the ongoing assessment and mitigation of the risk of Legionella.
- The systems in place to maintain the safe storage of refrigerated medicines and vaccines were not implemented and operating effectively.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse, however some of these were not established or operating effectively.

- The provider had appropriate safety policies, which were communicated to all staff, including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- The service had systems to safeguard children and vulnerable adults from abuse, including a safeguarding register used to monitor and action any concerns. The lead GP was the safeguarding lead. All staff had received training to the appropriate level on safeguarding children and vulnerable adults. Staff we spoke with demonstrated an understanding of how to identify and raise a safeguarding concern. There was a safeguarding policy in place, however we noted it did not contain some up-to-date information. For example, there was limited information about how to recognise abuse of adults, there was no information about radicalisation and no record of the designated Prevent lead (PREVENT is about recognising when vulnerable individuals are at risk of being exploited for extremist or terrorist-related activities). Contact details to report a concern for both adults and children were for a different local authority, or outdated, within the policy and on a poster at the reception desk. This could delay or prevent proper safeguarding procedures being carried out to safeguard a child or adult at risk. We spoke with the practice manager about the policy at the time of inspection. They were relatively new in post and explained that part of their role was to complete a process of updating and streamlining all policies. This was in progress. They told us that some patients were from out of area, however, we found the majority of patients were within the local authority. They took our concerns seriously and told us they would review the safeguarding policy as a priority. Following our inspection, the provider sent us evidence to demonstrate they had begun updating their safeguarding policy, for example we saw they had added information about PREVENT.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Clinicians that we spoke to provided us with examples where they had responded to information requests from statutory agencies. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. There were systems in place to assure the clinician that an adult accompanying a child had parental authority.
- We reviewed three staff recruitment files during our inspection. The provider demonstrated they had carried out staff checks at the time of recruitment. We saw that checks had been carried out to ensure the registration of GPs with the General Medical Council (GMC). However, we noted the systems to maintain ongoing oversight of staff registration could be improved. For example, there was no central oversight of when checks needed to be carried out or if they had been completed. We provided feedback to the provider at the time of inspection. They told us they would review and improve this process immediately. Following our inspection, the provider told us they had included GMC checks as part of staff annual reviews.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Due to a national delay, we saw the provider had carried out and recorded a risk assessment for any staff who had outstanding DBS checks.

Requires Improvement

Are services safe?

- Staff who acted as chaperones were trained for the role and had received a DBS check. We saw posters in consulting rooms and information in the waiting room advising patients that chaperones were available on request.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The service had a general cleaning schedule and daily task checklists. We saw that cleaning of the premises was recorded. We saw and were told about appropriate measures that had been put in place to minimise the risk of COVID-19 transmission, including temperature checks of patients on arrival and screens at the reception desk. The lead GP was the infection prevention and control (IPC) lead. All staff had received appropriate training, including for handwashing techniques. The provider was aware that some systems and processes for IPC were not yet established. For example, the practice manager and IPC lead were in the process of reviewing the infection control policy. We noted this did not describe an audit schedule, and that the provider had not yet completed an infection control audit. There were systems for managing healthcare waste except that the external clinical waste bin, although locked, was not securely fastened to the premises to minimise risk to the public. We raised our concerns with the provider at the time of inspection. They took prompt action and contacted their health and safety consultancy firm. Following our inspection, the provider told us they had conducted an IPC audit. They had also reviewed their healthcare waste systems and told us the external clinical waste bin was now secured.
- We also saw that the provider had processes to check staff immunisation status at the time of recruitment. However, there was a lack of evidence to demonstrate how ongoing oversight of staff vaccinations would be maintained, in line with current Public Health England (PHE) guidance, as relevant to the staff role. For example, during our inspection we reviewed three staff files and saw that the vaccination or immunisation status had been recorded at the time of recruitment for some, but not all, infectious diseases listed in the Green Book, chapter 12. Following our inspection, the practice sent us evidence that they had created a document to centrally record the immunisation status for all staff.
- The provider had completed a risk assessment for Legionella in July 2021 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The risk assessment showed a low risk of Legionella. We saw that a legionella risk assessment had been conducted by an external company in 2018, which stated monthly temperature checks should be carried out along with outlet flushing. The provider had a Legionella policy which stated the person responsible was the practice manager and caretaker. The policy stated water temperature monitoring should be carried out monthly, to ensure temperatures were within recommended limits. However, we noted that the service had not conducted any temperature monitoring in line with their own policy. We spoke with the provider about our concerns and they explained they would review the risk assessment and policy.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.
- The provider ensured that equipment was safe and maintained according to manufacturers' instructions. This included records of equipment calibration and of portable appliance testing.
- The service used rooms within a shared building. The landlord was responsible for the maintenance and safety of the overall building. The provider evidenced they had sought assurances about the safety of the building. For example, a fire safety risk assessment had been conducted by an external company, the fire alarms were being regularly tested and the provider had carried out their own fire drills. We saw evidence of gas safety records, and fire and smoke alarm servicing. We also saw there were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals and data sheets for the products in use.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.

Requires Improvement

Are services safe?

- There was an effective induction system for all staff, including locum and bank staff, tailored to their role. We saw that the provider had developed a staff handbook and a doctor induction handbook, to help them settle into the role and ensure they had relevant information readily accessible.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. This included oxygen and a defibrillator which were available and easily accessible.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- We reviewed six clinical records and saw consistently clear, comprehensive and legible information had been recorded. We saw consultation summaries that had been completed in a timely manner and records of comprehensive, personalised letters that had been sent to the patient, fully explaining any findings or suggested follow up arrangements.
- The service had systems for sharing information with staff, the patient's NHS GP (if the patient consented to that sharing) and other agencies to enable them to deliver safe care and treatment. For example, during our review of clinical records we saw that a GP was concerned about a patient, following receipt of test results. We saw they had promptly liaised with the patient and their own NHS GP about their concerns. They had then ensured an urgent cancer referral was processed quickly.
- The service 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.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. The service also integrated with NHS GP practices where this would benefit the patient.

Safe and appropriate use of medicines

The service had some systems for the appropriate and safe handling of medicines.

- There were arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment that minimised risks. However, some of these arrangements were not operating as intended. We saw that the service carried out and recorded temperature checks twice daily of the refrigerator used to store medicines and vaccines, to ensure the temperature remained within the minimum and maximum recommended range (usually above 2C and below 8C) in accordance with their policy. We noted periods of temperature readings that had not varied, which could have been a result of failing to follow correct procedures to reset the thermometer at every reading. We also saw that within some of these periods, the refrigerator had appeared to exceed the maximum temperature up to 8.5C, which can affect the effectiveness of vaccines. The staff we spoke with did not demonstrate an understanding of how to monitor the temperatures. Staff confirmed that no action had been taken at the time, to escalate that the temperature of the refrigerator had exceeded the recommended range. However, the provider also had a data logger, a device that electronically records the temperature of the refrigerator. Staff explained that neither the data logger nor refrigerator had raised an alarm to indicate temperatures had fallen outside of the recommended

range. We saw evidence that the temperatures recorded by the data logger had remained within the recommended range. However, the provider was unable to demonstrate there was a process to routinely check the data logger. We discussed our concerns with the provider at the time of inspection. The provider took our concerns seriously and told us they would seek prompt advice and guidance from appropriate agencies.

- The service occasionally prescribed Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). They also prescribed schedule 4 or 5 controlled drugs. We found that prescribing was in line with national guidance and there were appropriate policies and protocols in place. We saw there were systems and processes to monitor prescribing. The service kept prescription stationery securely and monitored its use.
- The service had completed medicines reviews to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- There were effective protocols for verifying the identity of patients, including children, at the point of registration and at the time of consultation.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service.
- 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 service had systems in place for knowing about notifiable safety incidents
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team, including locum staff.

Good

Are services effective?

We rated effective as Good.

Effective needs assessment, care and treatment

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

- The provider assessed needs and delivered 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 guidelines.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. For example, the provider had created a comprehensive chronic disease register to monitor patients. This included detailed information tracking the patient's journey and any required actions, such as follow up appointments and whether a review is due. This was regularly monitored to ensure patients received the care and treatment they required for their condition. There were also registers for long term conditions including for patients with diabetes, asthma and chronic obstructive pulmonary disease (COPD).
- Where a follow up appointment was required, this was booked at the time of the initial consultation. Staff monitored attendance to ensure that follow up appointments were not missed.
- GPs assessed and managed patients' pain where appropriate.
- Due to the COVID-19 pandemic, the service offered virtual consultations via telephone or video. They had ensured that digital communication was securely transmitted.

Monitoring care and treatment
The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements.
- As a relatively new service, their audit programme was at an early stage. The provider sent us examples of two audits where they had made improvements as a result. For example, we saw an audit had been carried out about prostate cancer screening. We saw the service had used the audit to ensure appropriate referrals and follow up had taken place in line with national guidance. As a result, the audit recommendations were; to complete the audit annually and to set recalls for patients at six months. The provider had conducted training to ensure actions were completed accurately.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. The provider had recently employed a new GP who was receiving regular clinical supervision and support.
- Relevant professionals were registered with the General Medical Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.

Good

Are services effective?

Coordinating patient care and information sharing
Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- The provider ensured that patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. During our inspection we reviewed six clinical records and saw the provider fully supported integration with other services, including within the NHS as well as other private services. We saw that clinicians had taken time to ensure they researched the most appropriate specialists to provide patients with a personalised recommendation.
- Before providing treatment, doctors at the service 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.
- Details of the patient's NHS GP were obtained when they consulted with the service. Consent was sought to share information about treatments at each appointment, and contact was established with the patient's regular GP if any medical history needed clarifying. A letter was sent to the GP, in line with GMC guidance, following treatment being given (if the patient consented) to ensure a complete medical history could be maintained.
- The provider 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.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, the provider described how they had provided services to refugees and asylum seekers and ensured they would receive ongoing care and treatment at an NHS GP practice.
- 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. There were clear and effective arrangements for following up on people who had been referred to other services.

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.

- Where appropriate, staff gave people advice so they could self-care and maintain a healthy lifestyle.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where a patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Consent was documented in the registration form and in the ongoing patient care record. The service monitored the process for seeking consent appropriately.
- All GPs had completed Mental Capacity Act 2005 training. Clinicians demonstrated an understanding of the requirements of legislation and guidance when considering consent and decision making.

Good

Are services caring?

We rated caring as Good.

Kindness, respect and compassion
Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. The provider sent us evidence of a patient survey completed between March and June 2020. We saw they had conducted a survey about the clinical care provided by two GPs, as well as a general survey. The results were positive and showed that patients were happy with the care and treatment received.
- Feedback from patients was 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 service gave patients timely support and information.
- We observed some staff interactions with patients on the day of our site visit, both in person and on the telephone. We found that staff treated patients with kindness, respect and professionalism.
- Prior to the inspection we reviewed publicly available information regarding patient experiences at the service. At the time of our review, we saw there were 39 reviews on Google, which rated the service as 4.7 out of 5 stars. The comments were consistently positive including; caring and reassuring staff, professional service, and praise for understanding and knowledgeable GPs.
- We received seven comment cards and one person provided feedback about the service directly to CQC. We saw positive comments about the level of attention received and the knowledge of GPs. We saw comments that highlighted patients felt listened to, cared for and understood. Many patients wanted to personally thank their GP for their care and treatment.

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. Information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment.
- Interpretation services were available for patients who did not have English as a first language. Staff told us that information in languages other than English was available.
- Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs, the family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Chaperones were available should a patient choose to have one.
- 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?

We rated responsive as Good.

Responding to and meeting people's needs

The service 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, the provider supported people with additional needs by ensuring a low sensory environment where required.
- The facilities and premises were appropriate for the services delivered. Patients with limited mobility were able to access the premises at street level. We saw that the patient toilet did not have an emergency assistance alarm, however the provider demonstrated they had raised this prior to our visit and were awaiting installation. Following our inspection, the provider told us that the installation of a physical and visual emergency assistance alarm has been completed. They also told us that a hearing loop has been installed.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Patients commented that they were given plenty of time at appointments. Patients told us their appointments were always running to time.
- Referrals and transfers to other services were undertaken in a timely way. For example; where possible, the service contacted specialists directly to book appointments when a referral was made. The provider told us that referrals were sent within one working day of a patient consultation. They told us that patients were usually seen by a specialist within approximately two weeks following a non-urgent referral. Following an urgent referral, the provider told us that patients could be seen within one day if indicated.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The service was a member of the Independent Doctors Federation (IDF) as well as the Independent Sector Complaints Adjudication Service (ISCAS). They provided patients with information how to contact the IDF or ISCAS should they not be satisfied with the response to their complaint.
- The service had a complaints policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. This included verbal comments that were not submitted as formal complaints.

Good

Are services responsive to people's needs?

- The service acted as a result of complaints and feedback to improve the quality of care. For example, as a result of a complaint, the practice reminded all staff to record any interaction or phone call with patients.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because some of the systems for assessing, monitoring and improving the quality and safety of the service were not always effective. Leaders lacked oversight of some processes and therefore failed to identify risks when those processes did not operate as intended. This included infection prevention and control, and cold chain protocols.

Leadership capacity and capability;

Leaders were developing the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- 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 leadership team was going through a period of transition. The provider had processes to develop leadership capacity and skills, including planning for the future leadership of the service. The registered manager was the lead GP at the service, which had been registered with CQC for 17 months. The lead GP recognised that they had responsibility and accountability for most roles within the service, which was not sustainable. They explained that there was a period of time where the service did not have a practice manager, which affected their capacity for oversight of all governance processes at the practice. However, they had recruited a new practice manager who had been in post for three months. There was also an assistant practice manager who was newly promoted from within the service. Both post holders were in the process of taking over lead roles, with ongoing support from the lead GP.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The provider told us their aim was “to provide unparalleled medical expertise, care and service”.
- There was a clear vision and set of values. They told us their vision was to be “the GP surgery we want our family to be part of”, with evidence-based medicine applied to the individual patient, and to account for unique conditions, beliefs, experiences and requirements.
- The service had a realistic strategy and supporting business plans to achieve priorities. The provider told us about their future plans and potential services they were planning to offer.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Requires Improvement

Are services well-led?

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. Staff told us they felt encouraged by the lead GP to reach their potential. All staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the well-being of all staff. All staff we spoke with felt they were supported and cared for, especially during the COVID-19 pandemic.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Staff told us they felt it was a friendly workplace and everyone helped each other.

Governance arrangements

There were developing structures of responsibilities, roles and systems of accountability to support governance and management.

- There were developing structures, processes and systems to support good governance and management.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Leaders were in the process of establishing proper policies, procedures and activities to ensure safety. We noted that the safeguarding policy, the infection prevention and control policy, and the legionella policy were not always up to date and containing relevant information. We spoke with the practice manager and provider about the policies at the time of inspection. The practice manager was relatively new in post and explained that part of their role was to complete a process of updating and streamlining all policies. This was in progress.
- The service used performance information which was reported and monitored. For example, there were annual audits of laboratory results, including cervical smear screening.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, but some of these were not yet established.

- We found that there were some processes to identify, understand, monitor and address current and future risks. However, we found there were some systems and processes that were not yet established or implemented effectively. This included infection prevention and control, and cold chain protocols. The provider explained they were developing these processes with their new leadership team. Whilst on inspection and following our visit, the provider demonstrated they took our concerns seriously and took immediate action. They also sought assistance from appropriate agencies for advice.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. The provider had recently employed a new GP who was receiving regular clinical supervision and support.
- The leadership team had oversight of safety alerts, incidents, and complaints.

Requires Improvement

Are services well-led?

- There were regular management, practice and clinical meetings. We saw minutes of meetings where topics including significant events, complaints, audits and safety updates were discussed as a team.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- There were systems to support improvement and innovation work. For example, the provider had signed up to take part in benchmarking activity with other private healthcare providers, through the Independent Doctor Federation. This was due to commence in December 2021.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider was unable to demonstrate effective systems or processes to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. This included a comprehensive policy, staff immunisation programme, an audit schedule, management of clinical waste, and the ongoing assessment and mitigation of the risk of Legionella. • The systems in place to maintain the proper and safe storage of medicines and vaccines requiring refrigeration were not implemented effectively. • The systems and processes to safeguard children and adults from abuse were not all established and operating effectively. This included ensuring that the service policy was comprehensive, regularly reviewed, up to date and contained relevant information. This was in breach of regulation 12(1) 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 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.