Dr Jedth Phornnarit (Garway Medical Practice)

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Jedth Phornnarit (Garway Medical Practice) on 3 September 2015. The overall rating for the practice was requires improvement. The full comprehensive report on the 3 September 2015 inspection can be found by selecting the 'all reports' link for Dr Jedth Phornnarit on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 14 September 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 3 September 2015. This report covers our findings in relation to those requirements and any improvements made since our last inspection.

Overall the practice is rated as requires improvement.

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

- Although the practice had addressed all the issues identified as requiring improvement at our previous inspection we found additional concerns relating to some aspects of infection prevention and control and medicine management.
- Staff were aware of current evidence based guidance and were trained to provide them with the skills and knowledge to deliver effective care and treatment. However, clinical protocols were not available to support the entire scope of responsibility undertaken by some clinical support staff and there was no regular or formal mentoring and clinical supervision in place.
- The practice had not undertaken formal staff appraisals since 2014.
- Data showed patient outcomes were low compared to the local and national averages for cervical screening uptake and childhood immunisations.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events and acting upon patient safety alerts.

Summary of findings

- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvement are:

- Continue to monitor patient outcomes in relation to the childhood immunisation and the cervical screening programme.

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?

Requires improvement

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

- Although the practice had addressed all the issues identified as requiring improvement at our previous inspection we found additional concerns relating to some aspects of infection prevention and control and medicines management.
- From the sample of documented examples we reviewed, we found there was an effective system 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 were informed as soon as practicable, 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.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

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

- Data showed patient outcomes were low compared to the local and national averages for cervical screening uptake and childhood immunisations.
- Staff were aware of current evidence based guidance and were trained to provide them with the skills and knowledge to deliver effective care and treatment. However, clinical protocols were not available to support the entire scope of responsibilities undertaken by some clinical support staff and there was no regular or formal mentoring and clinical supervision in place.
- The practice had not undertaken formal staff appraisals since 2014. However, we saw that these had been organised for October 2017.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. End of life care was coordinated with other services involved.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice comparable to others for several aspects of care. For example, 85% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 86%; national average 86%) and 83% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 83%; national average 82%).
- Information for patients about the services available was easily accessible in the practice and on the practice website which included information in other languages aligned to the practice demographic.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- Data from the national GP patient survey showed patients rated the practice comparable to others for access. For example, 87% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment (CCG average 84%; national average 85%) and 80% of patients said their last appointment was convenient (CCG average 81%; national average 81%).
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with told us they could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

Summary of findings

- Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements were not implemented well enough to ensure patients were kept safe.
- Staff had not received appraisals and performance reviews since 2014.
- 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 policies and procedures to govern activity and held regular governance meetings.
- The provider was aware of the requirements of the duty of candour. In two examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.

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

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example, the practice hosted the My Care, My Way team (an integrated care service providing support to those aged 65 and over to keep them well, closer to home).

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- Clinical staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 78% (CCG average 74%; national average 78%) and the percentage

Summary of findings

of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 81% (CCG average 76%; national average 78%).
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. 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.
- Patients could access smoking cessation advice and a health trainer on site.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were below local and national averages for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice actively publicised Chlamydia testing and access to contraceptive services.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 81% (CCG average 77%; national average 76%).
- The practice's uptake for the cervical screening programme was 60%, which was below the CCG average of 75% and the national average of 81%.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, on-line booking of appointments, prescriptions and extended opening hours two evening per week.
- 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.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- We saw that staff had undertaken domestic violence and learning disabilities training.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice carried out advance care planning for patients living with dementia.
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 82% (CCG average 85%; national average 84%).
- Patients at risk of dementia were identified and offered an assessment.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 76% (CCG average 91%; national average of 89%) and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 83% (CCG average 89%; national average 89%).
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice had recently undertaken a dementia audit of the practice to make the premises more dementia friendly and saw that staff had undertaken dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017 for the most recent data. Three hundred and seventy-one survey forms were distributed and 108 were returned. This represented approximately 3 % of the practice's patient list and a completion rate of 29%.

- 84% of patients find it easy to get through to the surgery by phone compared to the CCG average of 84% and the national average of 71%.
- 84% of patients said they could get through easily to the practice by phone compared to CCG average of 84% and the national average of 71%.
- 87% 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 84% and the national average of 84%.
- 70% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area as compared with the CCG average of 81% and the national average of 77%.
- As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards, 13 of which were positive about the standard of care received. Patients told us the practice was excellent, staff were amazing, courteous and helpful. The three negative comments included perceived rudeness of the reception team.

We spoke with two patients during the inspection both of which were satisfied with the care they received. They told us they felt involved with their care and treatment and thought staff were approachable, committed and caring.

Results of the Friends and Family Test (FFT) for the period January to August 2017 based on 74 responses showed that 74% of patients were extremely likely or likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Action the service SHOULD take to improve

- Continue to monitor patient outcomes in relation to the childhood immunisation and the cervical screening programme.

Dr Jedth Phornnarit (Garway Medical Practice)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Dr Jedth Phornnarit (Garway Medical Practice)

Dr Jedth Phornnarit, also known as Garway Medical Practice, operates from a purpose-built healthcare facility at Pickering House, Hallfield Estate, London W2 6HF. The property is owned and maintained by NHS Property Services. The practice has access to five consulting rooms located on the ground floor.

The practice provides NHS primary care services to 4116 patients and operates under a Personal Medical Services (PMS) contract (an alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract). The practice is part of NHS West London Clinical Commissioning Group (CCG).

The practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services, family planning and surgical procedures.

The practice staff comprises of a male principal GP (eight sessions per week) and one male and one female salaried GP (totalling 12 sessions per week). The clinical team is supported by a nurse prescriber (12 hours per week) and a healthcare assistant (25 hours per week). The administration team is led by a practice manager (30 hours per week) and six administration/reception staff.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available Monday to Friday between 8am and 12.45pm and 2pm and 6.20pm. Extended hours appointments are available on Tuesday and Wednesday from 6.30pm to 8pm.

The Information published by Public Health England rates the level of deprivation within the practice population group as four on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice area has a higher percentage than national average of male and female patients aged between 25-29, 30-34 and 35-29 years.

Why we carried out this inspection

We undertook an announced comprehensive inspection at Dr Jedth Phornnarit (Garway Medical Practice) on 3 September 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was requires improvement. The full comprehensive report on the 3 September 2015 inspection can be found by selecting the 'all reports' link for Dr Jedth Phornnarit on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow-up announced comprehensive inspection of Dr Jedth Phornnarit (Garway Medical Practice) on 14 September 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

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 September 2017. During our visit we:

- Spoke with a range of staff which included the principal GP, salaried GP, practice nurse, healthcare assistant, practice manager and administration and reception staff.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Spoke with patients who used the service and reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including policies, written protocols and guidelines, recruitment and training records, safeguarding referrals, significant events, patient survey results, complaints, meeting minutes and performance data.

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 living 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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 3 September 2015, we rated the practice as requires improvement for providing safe services as the arrangements in respect of the management in the event of a medical emergency, the process to ensure all significant incidents were recorded and reviewed and some aspects of fire safety required improvement.

At our follow-up inspection on 14 September 2017, we found that the practice had addressed all the issues identified at the previous inspection as requiring improvement. However, we found that some aspects of infection prevention and control and medicine management required improvement.

The practice remains rated as requires improvement for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- There was a lead for significant events and staff had access to an operational policy. 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).
- The practice had recorded seven significant events for the past 12 months. From a sample of two documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice had reviewed the process of checking the correct labelling of specimens sent for pathology testing following an incident where a urine sample had been sent to the laboratory without patient identifiable information.
- The practice also monitored trends in significant events and evaluated any action taken.

The practice had a system in place for the receipt and dissemination of patient safety alerts and MHRA (Medicines and Healthcare Regulatory Agency) alerts. We saw that the practice maintained a log of alerts received and action taken. We reviewed minutes of meetings where alerts had been discussed.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding 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 and staff we spoke with knew who this was. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child safeguarding level 3, the healthcare assistant to level 2 and administration staff to level 1. We noted that one of the GPs was due for a three-year child safeguarding refresher course and we saw evidence that an external course had been booked.
- The practice maintained a register of vulnerable children and adults and demonstrated an alert system on the computer to identify these patients. All staff we spoke with were aware of the safeguarding alert system.
- We observed safeguarding key contact details and referral flowcharts displayed in consultation and treatment rooms.
- Notices throughout the practice advised patients that chaperones were available if required. There was a chaperone policy and guidelines accessible to all staff. 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. Staff we spoke with on the day who acted as a chaperone understood their role and responsibilities.

Although the practice had processes in place to maintain standards of cleanliness and hygiene these required improvement.

- The practice engaged an external cleaning contractor. Although the premises appeared clean and tidy we noted heavy high level dust around door frames and moderate dust on curtain rails and couches in the consultation rooms. The cleaning company had not provided the practice with a cleaning schedule so it was not possible to ascertain the cleaning frequency of high and low level areas. Immediately after the inspection the practice told us they had alerted the cleaning company to the findings and an intensive clean had been scheduled.
- The healthcare assistant was the infection prevention and control (IPC) clinical lead in conjunction with the practice manager. There was an IPC protocol which included waste management and the safe handling of sharps and spillages.
- The practice had undertaken an IPC audit in August 2017. The practice had not at the time of our inspection produced an action plan to evidence that action had been taken to address the improvements identified.
- We saw evidence that all staff had undertaken on-line IPC training. However, the lead for IPC had not undertaken any enhanced training to support the responsibilities of the role. However, the practice provided evidence that a course had been booked in December 2017.
- We observed that each consulting room had information displayed on good handwashing techniques, how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities.
- All staff we spoke with knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk. We saw that antibacterial gel was available in all patient and staff areas.

Although there were arrangements in place for managing medicines, including emergency medicines and vaccines, to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal) these required improvement.

- The practice had two dedicated vaccine storage fridges. We saw evidence that the minimum, maximum and actual temperatures of the fridge in the healthcare assistant's treatment room had been recorded on a daily basis in line with guidance. However, the main vaccine storage fridge had only had the actual temperature recorded on a daily basis. The daily temperature was recorded by the receptionists who had not been instructed to record the maximum and minimum temperatures and were not aware this was required. There was no oversight of this procedure. There was a secondary thermometer installed and data we reviewed on the day of the inspection for the period May to September 2017 showed that the temperature had not deviated out of the recommended range of 2-8oC.
- During our inspection we noted that clinical staff did not have access to all the appropriate colour-coded sharps containers required for the disposal of the range of medicines administered at the practice. Furthermore, some sharps bins in use had been opened since November 2016 which exceeded the guidance that sharps bins should be closed and disposed of three months after first use even if not full. As a result of our findings the practice immediately contacted their clinical waste supplier to order appropriate colour-coded sharps bins and sent evidence after the inspection that posters had been displayed in each consultation room regarding appropriate waste segregation and disposal in line with guidance.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

Requires improvement

Are services safe?

- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use in line with guidance. All blank prescriptions were removed from the printers each evening and securely stored.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise.
- The healthcare assistant had been trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and two locum staff files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and a health and safety poster located in the staff room.
- At our previous inspection on 3 September 2015 the fire risk assessment was due for review. At our inspection on 14 September 2017 we saw that the practice now had an up-to-date fire risk assessment and had taken action to address the identified findings. For example, all staff had received fire safety awareness training. There was a fire alarm warning system and firefighting equipment in place and these were regularly maintained by an external contractor. The practice had nominated and trained three fire marshals and all staff we spoke with knew who these were. There was a fire evacuation plan in place and this was displayed throughout the premises. Staff we spoke with confirmed there had been a fire evacuation drill undertaken in July 2017 and all confirmed the location of the fire evacuation assembly point.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, health and safety and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Each clinical room was appropriately equipped and we saw evidence that all electrical and clinical equipment was checked and calibrated on an annual basis to ensure it was safe to use and was in good working order.
- The practice had processes in place for the cleaning of specific equipment used in the management of patients, for example, an ear irrigator and spirometer (an instrument for measuring the air capacity of the lungs).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.
- The practice had a defibrillator available on the premises and all staff had received annual basic life support training.
- At our inspection on 3 September 2015 the practice did not have access to medical oxygen for the use in a medical emergency and had not assessed the risk of this. At our inspection on 14 September 2017 the practice had medical oxygen available with adult and children's masks. We saw there was appropriate medical gas warning signage on the door where the oxygen was stored.
- 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.
- A first aid kit and accident book were available and all staff we spoke with knew the location of these.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice had established a 'buddy' system with a neighbouring practice. The practice manager confirmed that a copy of the plan was kept off site.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 3 September 2015, we rated the practice as good for providing effective services. However, at our follow up inspection on 14 September 2017, we found additional concerns in relation to staff appraisals, clinical protocols and supervision. The practice is now rated as requires improvement for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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.

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 86% of the total number of points available (CCG 91%; national 95%) with 5% overall exception reporting (CCG 6%; national average 6%). 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 was not an outlier for any QOF (or other national) clinical targets, except for the practice's uptake for the cervical screening programme which was below local and national averages. Data from 2015/16 showed:

Performance for diabetes related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 78% (CCG average 74%; national average 78%) with a low practice exception reporting of 5% (CCG average 12%; national 12%);
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 81% (CCG average 76%; national average 78%) with a practice exception reporting of 11% (CCG average 10%; national average 9%);
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 82% (CCG average 76%; national average 80%) with a practice exception reporting of 10% (CCG average 11%; national average 13%).

Performance for mental health related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 76% (CCG average 91%; national average of 89%) with a practice exception reporting of 6% (CCG average 9%; national average 13%);
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 83% (CCG average 89%; national average 89%) with a practice exception reporting of 2% (CCG average 7%; national average 10%);
- The percentage of patients diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 82% (CCG average 85%; national average 84%) with a practice exception reporting of 6% (CCG average 7%; national average 7%).

Performance for respiratory-related indicators was comparable to the CCG and national averages. For example:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 81% (CCG average 77%; national average 76%) with a practice exception reporting of 0.6% (CCG average 4%; national average 8%);

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness was 81% (CCG average 89%; national average 90%) with a practice exception reporting of 11% (CCG average 11%; national average 12%);
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 95% (CCG average 95%; national average 95%) with a practice exception reporting of 1% (CCG average 1%; national average 1%).

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, both of which were completed audits where the improvements made were implemented and monitored. The practice has also undertaken a single-cycle audit as part of its ongoing audit programme.
- Findings were used by the practice to improve services. For example, we reviewed one audit which was part of a CCG initiative to reduce non-elective admissions (emergency admissions) to secondary care. The practice had been identified as an outlier for emergency admissions with approximately 89 per 1000 population in 2014/15. To address this the practice changed its model of care in relation to the daily duty doctor and has the same doctor on-call every week. This has impacted on continuity of care and enabled poorly compliant patients and those at risk of emergency admission to be effectively monitored. Patients we spoke with gave good feedback about this system. In addition, the practice works closely with the My Care My Way team who hold sessions at the practice and focus on supporting the over 65 year olds, in particular the vulnerable and housebound. Currently for 2016/17 the practice has on average 21 emergency admissions per 1000 patients which is a significant reduction and below the CCG target of 49 emergency admissions per 1000 patients.

Effective staffing

Although staff had the skills and knowledge to deliver effective care and treatment this required improvement.

- The practice had an induction programme for all newly appointed staff. This covered such topics as fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Furthermore, 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.
- We saw that a healthcare assistant had been trained to undertake procedures within the scope of her role, for example, influenza immunisation and some out of hospital services, such as ambulatory blood pressure monitoring. However, the practice had not put in place clinical protocols defining all aspects of the role, for example, wound management. Although staff we spoke with told us that patients would be referred to the doctor if there were any concerns, the practice did not have in place a clear framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment to support this. Furthermore, there was no regular or formal mentoring or clinical supervision in place.
- There had been no formal appraisals of staff since 2014. Prior to our inspection the practice had scheduled appraisals for October 2017 and we saw that staff had been given pre-appraisal self-assessment forms to complete prior to this.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 operated a 'buddy' system for when clinicians were absent from the surgery.

Requires improvement

Are services effective?

(for example, treatment is effective)

- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice used an IT interface system which enabled patients' electronic health records to be transferred directly and securely between GP practices. This improved patient care as GPs would have full and detailed medical records available to them for a new patient's first consultation.
- The practice utilised Coordinate My Care (a system which allows healthcare professionals to electronically record patient's wishes and ensures their personalised urgent care plan is available 24/7 to all those who care for them).
- The practice promoted the distribution of the Message in a Bottle (MIAB) packs which is vital health information stored in a white plastic bottle to be used by emergency services. The bottle is placed where emergency services are trained to look, in the refrigerator door. A green cross sticker is placed on the inside of the main house door, or where it is considered would be most obvious and another sticker on the door of the fridge.

The practice maintained a register of its two-week wait referrals and contacted patients to ensure they had received an appointment and had attended the appointment. Two-week wait referral data for the period 1 April 2015 to 31 March 2016 showed that the practice was comparable with local and national averages. For example, the percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two-week wait referral pathway was 20% which was statistically comparable with the CCG average of 54% and the national average of 50%. This gives an estimation of the practice's detection rate, by showing how many cases of cancer for people registered at a practice were detected by that practice and referred via the two-week wait pathway. Practices with high detection rates will improve early diagnosis and timely treatment of patients which may positively impact survival rates.

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. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis, which were minuted, when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005.
- 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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. In particular:

- The practice hosted the My Care My Way (MCMW) team three days per week which is an integrated care service providing support to those aged 65 and over to help keep them well, closer to home.
- There was a smoking cessation advisor available at the practice once a week. We reviewed data of patients referred for 2016/17 and saw that there was a quit rate of approximately 50%.
- The practice hosted a health trainer once a week. The practice referred 60 patients in the period September 2016 to September 2017. Health trainers help individuals assess their lifestyles and wellbeing, set goals for improving their health, agree action-plans, and

Requires improvement

Are services effective?

(for example, treatment is effective)

provide practical support and information that will help people to change their behaviour. For example, promoting the benefits of taking regular exercise and eating healthily.

- The practice liaised with local pharmacies regarding dossette boxes (a pill container and organiser for storing scheduled doses of a patient's medication) and repeat dispensing for the elderly and vulnerable patient cohorts.
- The practice had extended the role of one of the medical secretaries to assist patients with referrals, chasing appointments, and preparing for procedures. Patients could book an appointment to see the staff member, who liaised directly with community and hospital services if there were any issues with appointments or if the patient needed further information.

The practice's uptake for the cervical screening programme was 60%, which was below the CCG average of 75% and the national average of 81%. We asked the clinical team if there was a reason for the negative variation and they told us they had recently identified that cervical screening was not being coded accurately in their clinical system. They were currently reviewing all cervical screening data from the national data base. The practice told us they had a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Childhood immunisation rates for the vaccinations given to the under two year olds for the period 1 April 2015 to 31 March 2016 were below the national average. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice had not achieved its target in any of the four areas. The practice's achievement ranged from 47% to 68%. These measures can be aggregated and scored out of 10, with the practice scoring 5.8 (compared to the national average of 9.1). Immunisation rates for five year olds ranged from 53% to 65% (CCG average ranged from 62% to 83% and national average ranged from 88% to 94%).The practice told us they were currently reviewing their immunisation registers and had identified that some children had received immunisation privately and some children had left the area and were in the process of being deducted from the patient list which could impact on future uptake data.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our previous inspection on 3 September 2015, we rated the practice as good for providing caring services. At our follow up inspection on 14 September 2017 we also found the practice was good for providing caring services.

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards, 13 of which were positive about the standard of care received. Patients told us the practice was excellent, staff were amazing, courteous and helpful. The three negative comments included perceived rudeness of the reception team.

We spoke with two patients including two members of the patient participation group (PPG). They told us they felt involved with their care and treatment and were treated with dignity and respect. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 79% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 86%.
- 93% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 95% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

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 and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised and comprehensive.

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.

Good

Are services caring?

- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language which included British Sign Language (BSL). We saw notices around the practice and information in the practice leaflet informing patients this service was available.
- The practice website had the functionality to translate to other languages and the patient check-in screen was available in other languages aligned to the practice demographic.
- Information leaflets were available in easy read format which included leaflets in other languages. Furthermore, the practice had placed posters regarding safeguarding, sexual health and mental health in all patient toilet facilities to enable information to be obtained discretely.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

There was a carers' board in the waiting area which included information on the local carers' network and leaflets to direct carers to the various avenues of support available to them. Patient information leaflets and notices were also available which guided patients to a number of support groups and organisations. The practice website also had information about support groups.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 69 patients as carers (1.7% of the practice list).

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw that there was information regarding bereavement services available in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 3 September 2015, we rated the practice as good for providing responsive services. At our follow up inspection on 14 September 2017 we also found the practice was good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday and Wednesday from 6.30pm to 8pm for working patients who could not attend during normal opening hours.
- 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms and was visible from reception. There was enough seating for the number of patients who attended on the day of inspection. The waiting room was decorated with brightly coloured pictures and collages from children of a local primary school depicting their experience of 'going to the doctors.'
- Patients had access to baby changing and breast feeding facilities and these were advertised in the waiting room.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 8am to 12.45pm and 2pm to 6.20pm. Extended hours appointments were offered on Tuesday and Wednesday from 6.30pm to 8pm. In addition to pre-bookable appointments that could be booked up to five weeks in advance, urgent appointments and telephone appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 84% of patients said they could get through easily to the practice by phone compared to CCG average of 84% and the national average of 71%.
- 87% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 80% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.
- 65% of patients said they usually got to see or speak with their preferred GP compared with the CCG average of 59% and the national average of 56%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system 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 a system for handling complaints and concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice had a complaints handling policy and process flowchart available to all staff.

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. For example, information in the waiting room and complaint form and leaflet.

The practice had recorded eight complaints in the past 12 months of which five were written complaints directly to the practice, two had been sent to NHS England and one had been posted on the NHS Choices website. The practice also recorded verbal complaints but there had been none made in the past 12 months. We looked at two complaints received in the last 12 months in detail and found these had been handled satisfactorily and in a timely manner. We saw evidence of apology letters to patients which included further guidance on how to escalate their concern if they were not happy with the response. All complaints were included as a standing agenda item at practice meetings to enable practice learning and we saw evidence of minutes of meetings.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 3 September 2015, we rated the practice as requires improvement for providing well-led services as the arrangements in respect of the overarching governance framework required improvement.

At our follow-up inspection on 14 September 2017 we found that the practice had addressed the issues identified as requiring improvement at the previous inspection, for example, arrangements in respect of the management in the event of a medical emergency, the process to ensure all significant incidents were recorded and reviewed and some aspects of fire safety. However, we found additional concerns in relation to the overarching governance framework in relation to medicine management, infection prevention and control, staff appraisal, clinical protocols and supervision.

The practice remains rated as requires improvement.

Vision and strategy

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

- The practice had a mission statement to 'provide high quality, responsive, flexible and person-centred services that are tailored around the diverse needs of the whole community'. We saw that the statement was displayed around the practice and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements were not implemented well enough to ensure patients were kept safe. For example:

- Arrangements in relation to infection control did not mitigate the risk of spread of infection and the provider had failed to ensure adequate cleaning arrangements.
- The storage and disposal of medicines was not in line with recommended guidance.
- Staff had not received a formal appraisal since 2014, clinical protocols were not available to support the entire scope of responsibility undertaken by some clinical support staff and there was no regular or formal mentoring and clinical supervision in place.
- Some patient outcomes were below local and national averages which included cervical screening uptake and childhood immunisations.

However, we saw that the practice had structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

The principal GP and practice manager told us they prioritised safe, high quality and compassionate care. Staff spoke highly of the GPs and the management team and told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems 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). The principal partner encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems 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 and staff felt supported by management.

Are services well-led?

Requires improvement

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held team meetings. We saw that minutes were comprehensive and were available for practice staff to view.
- 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 GPs and the practice manager.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- The NHS Friends and Family test, complaints, compliments and NHS Choices.
- The patient participation group (PPG) had been active for 15 years and met every two months. The PPG members we spoke with told us the group consisted of approximately 20-25 patients, of which 12-15 attended regularly. The agenda was set by the PPG chair and the practice manager and attended by the principal GP and practice manager. The PPG spoke positively about the practice and felt they were involved decision-making and that the practice responded positively to suggestions and proposals.
- Staff through meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice were participating in an out of hospital services initiative designed to bring services closer to the patient in the primary care setting.

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 **How the regulation was not being met:** The provider was failing to ensure that care and treatment was provided in a safe way for patients: • Arrangements in relation to infection control did not mitigate the risk of spread of infection. The provider had failed to ensure adequate cleaning arrangements. • Arrangements in relation to the storage and disposal of medicines were not in line with recommended guidance. • Clinical protocols were not available to support the scope of responsibility undertaken by some clinical support staff. 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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** There were governance systems and processes in place however these were not always effective and compliant with the requirements of the fundamental standards of care, specifically in relation to medicine management, infection prevention and control, staff appraisal, clinical protocols and clinical supervision. Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The provider was failing to ensure persons employed in the provision of the regulated activity had received the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

- The practice had not undertaken formal appraisals and performance reviews with staff since 2014.
- There were no regular and formal mentoring and clinical supervision in place for some clinical support staff.

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.