St Philips Medical Centre

Quality Report

Floor 2 Tower 3,
Clements Inn,
London,
WC2A 2AZ
Tel: 020 761 15131
Website: www.lse.ac.uk/medicalCentre

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Philips Medical Centre on 2 August 2016. This was to follow up a comprehensive inspection we carried out on 12 November 2015 when we found the practice was not meeting the fundamental standards of quality and safety in a number of areas. Overall the service was rated as inadequate and placed in special measures.

St Philips Medical Centre drew up a special measures turnaround action plan to improve its performance in response to the findings of the previous inspection. At the follow up inspection we reviewed the practice's progress in implementing this plan. The practice had made improvements in some areas but much of the action plan remained to be implemented. Overall, it had not addressed sufficiently concerns identified at our previous inspection and we identified additional concerns at our latest inspection. Overall the practice is rated as inadequate as insufficient improvement has been made.

Specifically, we found the practice to be inadequate for providing, safe, effective, and well-led services, and requires improvement for providing caring and responsive services.

The concerns which led to a rating of inadequate in safe, effective, and well-led apply to all population groups using the practice. Therefore, all population groups have been rated as inadequate.

Our key findings were as follows:

- Although the practice carried out investigations when there were unintended or unexpected safety incidents, there was limited documentary evidence that lessons learned were communicated throughout the practice to ensure that safety was improved. No minuted practice meetings had been put in place to facilitate this.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There were

Summary of findings

continuing deficiencies in the systems and training for safeguarding, infection control, medicines management, dealing with medical emergencies and ensuring the safety of medical equipment.

- Action had been taken to improve recruitment processes, especially in relation to pre-employment checks, but not all the actions required had been implemented in full.
- There was still limited evidence of a multidisciplinary approach to patient care and treatment.
- The practice carried out clinical audit but there was no evidence of completion of the full audit cycle to improve patient outcomes.
- The practice promoted good health and prevention and provided patients with advice and guidance. However, the practice had not introduced care plans for older people and at risk groups.
- There was limited documentary evidence that learning from complaints had been shared with staff.
- Staff felt supported in their roles but there were continuing gaps in key areas of the training and appraisal they had received.
- There was limited progress in implementing systems to monitor and improve the quality and safety of the services provided.

The areas where the provider must make improvements are.

- Ensure care and treatment is provided in a safe way, through further improvements in the safety of infection control processes, medicines management and emergency and medical equipment.
- Ensure continuing gaps in staff training in safeguarding, infection control, and medical emergencies are addressed and completion of the induction process.
- Ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out and recorded prior to a staff member taking up post. Where Disclosure and Barring Scheme (DBS) checks are not carried out for some staff, this should be risk assessed and documented to evidence why.
- Ensure patients are protected from abuse and improper treatment through the completion of Disclosure and Barring Scheme (DBS) checks for staff who carry out chaperoning duties or risk assess the need and put in place mitigating arrangements.
- Put in place a formal process for disseminating NICE guidelines to all GPs working at the practice to ensure guidelines are implemented for the practice as a whole.
- Ensure there are appropriate arrangements in place to assess, monitor and improve the quality and safety of the services provided, including the introduction of formal governance arrangements and further development of the systems for assessing the quality of the experience of service users in receiving those services.
- Review the system in place for the use and storage of liquid nitrogen to ensure that the practice is fully compliant with the guidance, including a risk assessment for Control of Substances Hazardous to Health (COSHH).

In addition the provider should:

- Document in all cases the discussion and action agreed in communicating lessons learned from incidents and complaints to practice staff.
- Introduce care plans for patients over 75 and patients with chronic mental health issues.
- Make more systematic use of the information collected for QOF to review performance and improve quality.
- Introduce a programme of quality improvement including clinical audits and re-audits to ensure improvements in patient outcomes have been achieved improve.
- Foster greater participation in multidisciplinary working to co-ordinate patient care.

Summary of findings

- Ensure locum (non-principal) doctors are informed of the outcome of hospital referrals or the results of tests they initiated.
- Review systems to improve the identification of carers and provide support.
- Develop a more robust planning process to address identified patient needs and determine the way services are delivered to meet all patients' needs.
- Develop the practice vision and values further and ensure they are communicated to staff and patients.

This service was placed in special measures in February 2016. Insufficient improvements have been made such that there remains a rating of inadequate for providing safe, effective and well-led services. I have decided to place the service in special measures for a further period to allow the provider more time to implement planned improvements. The service will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. It had not addressed sufficiently concerns identified at our previous inspection and additional concerns were identified at our recent follow up inspection.

- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe:
- Outcomes and actions were recorded in incident reports but there was limited documented evidence of wider discussion within the practice of lessons learned.
- Omissions in the practice's safeguarding policies had been addressed but gaps remained in safeguarding children training coverage. Staff who acted as chaperones were now trained for the role and but had not received a disclosure and barring check (DBS check).
- Some improvements had been made in the practice's infection control arrangements but we found continuing shortcomings in these arrangements and there were still gaps for some staff in the infection control training they had received.
- The practice had addressed some of the concerns in medicines management arrangements we identified at our previous inspection. However, we found continuing shortcomings in these arrangements with regard to prescription security, the processes for ensuring that medicines were kept at the required temperatures and in the disposal of expired medicines.
- Action had been taken to improve recruitment processes, especially evidence of pre-employment checks, but the action had not been implemented in full. DBS checks remained outstanding for non-clinical staff but arrangements were in hand to complete these.
- Some improvements had been made in the arrangements for dealing with medical emergencies but they still did not meet national guidance in some respects.
- Training in basic life support was still not up to date for some locum (non-principal) doctors. Emergency medicines were now stored securely, and all such medicines were available or within expiry dates. However, some recommended medicines were missing from the kit and it contained three not recommended.

Summary of findings

- Emergency equipment was available and staff now knew where all of the equipment was stored. Ancillary equipment (for example, masks) was now kept close to the oxygen cylinder and all equipment was now functional and up to date.
- The storage of liquid nitrogen did not follow published guidance.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. It had not addressed sufficiently concerns identified at our previous inspection.

- There was no formal process for disseminating NICE guidelines to all GPs working at the practice to ensure guidelines were implemented for the practice as a whole.
- There were no care plans in place for patients over 75 or for patients with chronic mental health issues.
- The practice did not systematically use the information collected for QOF to review performance and improve quality.
- The practice carried out clinical audit but there was no evidence of completing audits through the full audit cycle to drive improvement in performance to improve patient outcomes.
- There was limited participation in multidisciplinary working to co-ordinate patient care.
- There were arrangements in place for staff to receive mandatory training and additional learning and development. Some gaps in training identified at our previous inspection had been addressed but some gaps remained in training infection control, basic life support and safeguarding of children. No appraisals had been completed for non-clinical staff due them.
- Locum (non-principal) doctors were not systematically informed by the principal GP of the outcome of hospital referrals or the results of tests they initiated.
- Childhood immunisation rates for the vaccinations given were mostly above CCG averages for under 12 months but below average for 24 months and five year age groups, although the number of children on the register was low.
- The practice's uptake for the cervical screening programme was also much lower than CCG and national averages.

Are services caring?

Requires improvement

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

Summary of findings

- Data from the national GP patient survey showed patients were broadly happy with how they were treated and the care they received. However, of 414 survey forms distributed, only 20 (5%) were returned, so it was difficult to draw meaningful conclusions from the data.
- All of the patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- There was some information for patients about the services available. However, written health promotion information at the practice was limited and on-line information was brief.
- Staff treated patients with kindness and respect, and maintained confidentiality.
- The practice provided emotional and bereavement support. Carers were signposted to the local CCG carers support services. However, the practice did not proactively identify patients who were carers to determine their specific support needs.

Are services responsive to people's needs?

Requires improvement

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

- The practice sought to respond to patients' needs and maintain the level of service provided. However, there was no formal planning system to address identified needs in determining the way services were delivered. There was limited evidence of coordination of care and treatment with other services.
- Patients could get information about how to complain in a format they could understand. However, there was limited documentary evidence that learning from complaints had been shared with staff.
- The practice did not have its own website at the time of the inspection but brief details of the services provided by the practice were available on the London School of Economics website.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made. There was a detailed action plan in place to address concerns identified at our previous inspection but limited progress had been made in implementing action and there was insufficient improvement.

Summary of findings

- There had been limited progress in developing further the practice vision and values or articulating them to staff or patients.
- The provider had initiated a process of change but governance arrangements remained limited. The principal GP's approach to the management of the practice did not provide the rest of the clinical team with a full opportunity to share responsibility for clinical quality and standards. There were plans to hold regular, minuted practice team meetings but these were not yet in place. Most communication continued to be through undocumented, informal, one to one meetings or cascade briefing.
- Given the size of the patient list, the governance structure in the practice did not promote best management practice.
- There was still a limited approach to obtaining the views of people who used the services. The practice took account of and acted on complaints and responses to the NHS friends and family test. However, the planned patient participation group, to engage patients in decision making and the identification of improvements in service delivery, had not yet been established.
- There was lack of clarity about the position of patients on the practice register who had moved away from the practice vicinity, for example when they left the university or moved abroad. There was no systematic identification and review of these patients to check they should remain on the practice list.

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

Inadequate

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Older people did not have care plans where necessary.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were below CCG averages, for example, QOF performance for chronic obstructive pulmonary disease (COPD); mental health; osteoporosis and coronary heart disease (CHD). There were few patients with these conditions.
- Longer appointments and home visits were available for older people when needed.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Longer appointments and home visits were available for patients with long-term conditions when needed. However, none of these patients had a personalised care plan or structured annual review to check that their health and care needs were being met.
- Performance for diabetes related QOF indicators was lower than the CCG and national averages.
- There was limited multidisciplinary case working with other health and social care professionals to case manage patients in this group, although the practice did work with the CCG's Diabetes Integrated Care Unit to optimise the care of patients with type 2 Diabetes.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given were mostly above CCG averages for under 12 months but below average for 24 months and five year age groups, although the number of eligible children on the register was low.
- Appointments were available outside of school hours and there were two walk in clinics daily for urgent appointments which patients in this group could access.
- The practice's uptake for the cervical screening programme was significantly below CCG and national averages.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The profile of patients at the practice was predominantly students and the services available were mainly geared to the needs of this group. However, there were areas where their needs and the needs of this patient group as a whole were not adequately addressed:

- No extended opening hours were offered for appointments and, despite being advertised as available on the NHS Choices website, patients could not book appointments online. However, repeat prescriptions could be ordered by email.
- Health promotion advice was offered and some health promotion material was available at the practice. Patients had access to appropriate health assessments and checks. These included health checks for new patients and to a limited extent 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.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

- It had not carried out annual health checks for people with a learning disability, although there were few such patients registered.
- There was limited multidisciplinary case working with other health and social care professionals to case manage vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. However, there were still some gaps in their safeguarding training. Information was now readily available about relevant agencies to contact in the event of safeguarding concerns arising in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance for mental health related QOF indicators was lower than the CCG and national averages.
- There were no care plans produced within the practice for people experiencing poor mental health, although the majority of such patients who resided at a local supported housing project had received an annual GP consultation where weight, blood pressure and a range of blood tests were carried out.
- The practice worked in conjunction with care workers and community psychiatric nurses to encourage diabetic patients at the project to improve compliance with medication, diet and other interventions.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing broadly in line with national averages in some areas and above in others. However, of 414 survey forms distributed, only 20 (5%) were returned (less than one percent of the practice list), so it was difficult to draw meaningful conclusions from the data. Of those received:

- 93% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 100% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 96% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were mostly positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. There were two cards with negative comments, one expressing dissatisfaction with the hospital referral system and another about the difficulty of getting appointments.

We spoke with 11 patients during the inspection. All 11 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Feedback from the most recent responses to the NHS Friends and family test showed 44% of patients would recommend the practice, from nine responses received; 22% were neutral and 33% would not recommend the practice.

St Philips Medical Centre

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, a second CQC inspector and an Expert by Experience.

Background to St Philips Medical Centre

St Philips Medical Centre provides primary medical services through a General Medical Services (GMS) contract. The practice is located within the London Borough of Westminster in central West London but is contracted to provide GP services by NHS Camden Clinical Commissioning Group. The services are provided from a single location within premises leased from the London School of Economics (LSE). There are historical reasons for this location as it grew out of a former University of London health centre. Although most patients are students at LSE, the practice is also contracted to provide NHS services to the local population. There are about 11,000 patients registered with the practice, with a high turnover as many are postgraduate students who move away from the area after their year of study is complete. We were told there are also patients who registered with the practice when living in the UK who now live abroad but who have retained their registration and are still supported by the practice. It was unclear, however, how these patients were supported.

The practice is open between 8:30am to 6:30pm Monday to Friday. Appointments were from 9:30am to 12:30pm every morning and from 1:30pm to 6:30pm daily. The practice also runs walk-in clinics daily between 11:00am and 12:00 noon and 3:00pm to 4:00pm for emergency treatment. In addition, pre-bookable appointments can be booked and provided within 48 hours.

At the time of our inspection, there was one permanent GP (the principal GP - male), and four long-term locum (non-principal GPs - all female) amounting to 3.52 whole time equivalent (WTE) GP staff. They were supported by an acting practice manager and five full-time and one part-time administrative staff at the practice. There were no nursing or health care assistant staff employed by the practice.

There are also arrangements to ensure patients receive urgent medical assistance when the practice is closed. Out of hours services are provided by a local provider. Patients are advised to call 111 who will direct their call to the out of hours service to provide telephone advice or make a home visit. The practice also provides information to patients about a local NHS Walk-In Centre which was open between 8:00am and 8:00pm Monday to Friday and 10:00am to 8:00 at weekends.

The inspection was carried out to follow up a comprehensive inspection we carried on 12 November 2015 when we found the practice was not meeting the fundamental standards of quality and safety in several areas. We rated the practice as Inadequate overall. Specifically, we found the practice to be inadequate for providing safe, effective, and well-led services and requires improvement for providing caring and responsive services. We placed the service in special measures.

Detailed findings

Why we carried out this inspection

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

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

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 liaised with NHS England and NHS Camden CCG. We carried out an announced visit on 2 August 2016. During our visit we:

- Spoke with a range of staff (including the principal GP, two locum (non-principal) GPs, the acting practice manager, and reception/administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. The practice had recorded fourteen incidents in the last two years. Staff told us they would inform the GP of any incidents and there was a recording form available on the practice's computer system.

- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records and incident reports which included action taken and lessons learned to improve safety in the practice. For example, following a delay in submitting a sample for laboratory analysis a more robust process was put in place to ensure improved communication between doctors and the reception team and more thorough checking of samples ready for despatch. However, we saw limited evidence that the practice had taken action since our last inspection of 12 November 2015 to communicate lessons learned from incidents to all practice staff and document the discussion and action agreed and no formal practice meetings had been initiated to facilitate this.

Overview of safety systems and processes

Although the practice had made some improvements since our inspection of 12 November 2015, to assess risks to patients who used services, the systems and processes to address these risks were still not implemented well enough to ensure patients were kept safe:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and the safeguarding policy was accessible to all staff. The policy had been updated in response to our previous inspection to include details of who to contact for further guidance if staff had concerns about a patient's welfare. These details were also now available to staff on the practice's computer system. The principal GP was the lead member of staff for safeguarding. The GP attended safeguarding meetings when possible and provided reports where necessary for other agencies. Such occurrences were rare, given the predominantly student patient population. Staff demonstrated some understanding of safeguarding issues and had received some training relevant to their role. Some of the gaps in training coverage identified at our previous inspection had been addressed. The practice provided evidence that showed the principal GP and all of the locum (non-principal) GPs were now trained to level 3 in child safeguarding, as required,. However, as found at our previous inspection, none of the administrative staff, including the practice manager had been trained in child safeguarding. The practice showed us that they had been trying, without success, to identify a training provider for face to face training but they had not considered on-line training. The majority of staff, apart from those recently recruited, had now received training in safeguarding of vulnerable adults within the last two years. However three administrative staff remained to complete formal training.
- A notice in the waiting room advised patients that they could request a chaperone, if required. At our previous inspection none of the administrative staff who acted as chaperones were trained for the role nor had they received a disclosure and barring check (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). All four staff who now acted as chaperones had now been trained in the role but they had still not received a DBS check and no there was no documented risk assessment regarding this. We saw evidence though, that the practice manager had set up an account with a checking organisation to arrange checks for these staff.
- The practice had arrangements in place to maintain cleanliness and hygiene. Cleaning services were provided by an external contractor and there was a cleaning schedule in place. In response to our previous inspection, there was now a record to show the schedule had been completed and the practice manager audited the schedule. On the day of the inspection the practice was generally clean but we found high level dust in three consulting rooms. In addition, it was untidy in some areas, for example, the 'sluice room' where the specimen fridge and other

equipment was stored was cluttered and the access to the fridge was inhibited. The principal GP was the infection control clinical lead and there was an infection control policy in place which included a protocol for sharps/splash injuries and accidental exposure to blood borne viruses. In response to our previous inspection, four of the seven administrative staff had completed infection control training. However, there were still gaps in the infection control training clinical staff had received. The practice had arranged an external infection control audit, completed in March 2016. We were told all necessary actions had been completed. However, when we reviewed the action plan we found in some cases the evidence did not support this. Sharps bins were not dated and signed; there was a red mop (used to clean sanitary fittings) inverted in a sink used for hand washing and an MMR risk assessment had not been completed. There was a waste management contract for collection and disposal of clinical and other waste.

- The practice had a cryogenic storage flask containing liquid nitrogen, used for minor surgery. However, there was no signage to warn liquid nitrogen was stored on the premises and no a risk assessment Control of Substances Hazardous to Health (COSHH) had been completed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice were intended to keep patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had addressed some of the concerns identified at our previous inspection. However, we found continuing shortcomings in these arrangements. There were expired vials of two medicines in an unlocked cupboard in a security key pad controlled sluice/store room. One of these was a controlled drug which we were told were not kept at the practice. The principal GP told us the room had remained locked for some time and he had only gained access to it two days before the inspection. He had not taken action to dispose of these medicines at the time but took immediate action to do so on the day of our inspection. Prescription pads were securely stored and a record was now kept of serial numbers to monitor their use; printable prescriptions were also now kept securely, but no serial numbers were logged for these.
- A specific policy was now in place for ensuring that medicines were kept at the required temperatures. Checks of fridge temperatures were carried out daily by the principal GP and records of these checks were now completed and up to date. Medicines in the fridge were within expiry dates and test samples were now appropriately stored in the separate sample fridge. The practice had purchased a new fridge to replace the deficient fridge found at our last inspection. However, when we were shown the new fridge during our initial tour of the practice we found it was switched off and the vaccines stored in it may have been compromised. The provider explained that the fridge had been unplugged to enable the use of other electrical equipment but inadvertently had not been switched on again. The fridge was not 'hard wired' as recommended in national guidance, which would have prevented this. The provider took immediate action to dispose of and secure the rapid replacement of potentially compromised vaccines.
- At our previous inspection we found deficiencies in the completion and documentation of pre-employment recruitment checks including proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. In the action plan in response to our previous inspection, the provider stated they would put in place by the end of May 2016 a staff files pre-employment checklist; all relevant documents would be on file and a master copy filed on the shared computer drive. All staff files would be regularly checked for completeness. Each file would have an individual checklist. However, limited progress had been made in implementing these actions. The recruitment policy had not been updated to include the comprehensive checklist and we were told that no new staff had been appointed requiring the enactment of this. In addition, there had been no retrospective review of the files of existing staff against the checklist. However, we saw the documentation for the recent employment of an agency locum GP which included the majority of the paperwork on the new checklist, with the exception of references.
- In the action plan in response to our previous inspection, the provider stated DBS checks would be completed for existing staff members or risk assessments carried out where it was determined that a check was not needed. None of the non-clinical staff, including the practice manager had since undergone a criminal records check. However, in July 2016 the

practice manager had set up an account with a checking organisation to arrange this for the staff who undertook chaperone duties. The practice manager told us that they had determined a check was not needed on the basis of staff roles for three other staff. However, this risk assessment had not been documented.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The landlords of the building were responsible for carrying out annual health and safety and fire risk assessments and we saw the records for this. This included a rolling programme of fire drills for the whole building so that all areas were covered within the course of a year, including the practice premises. The building landlords also had a variety of other risk assessments in place to monitor safety of the premises such as a legionella assessments. The practice arranged for all clinical equipment to be checked to ensure it was working properly and we saw the records for this. In response to our previous inspection an up to date portable appliance test (PAT) had been completed to ensure the equipment was safe to use.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for both clinical and non-clinical staffing groups to ensure that enough staff were on duty. The principal GP told us of the review he was currently carrying out of the arrangements for employing long term locum doctors with a view to them becoming permanent salaried doctors. This was leading to a reduction in the number of these doctors, some of whom had either left or would be leaving the practice. This would lead to a shortfall in GP resources at a critical time when a large new intake of patients was expected at the start of the new university year in September. The principal GP anticipated the need to secure GP cover via a locum agency to meet the demand for services, pending the completion of the current review of GP contracts. At our previous inspection we noted the absence of any nursing staff, given the relatively large patient list size. The principal GP explained that no action had been taken to consider further the need for a nurse and nursing type tasks continued to be distributed amongst him and the long term locum doctors.

Arrangements to deal with emergencies and major incidents

Although the provider had made some improvements since our previous inspection, shortcomings remained in the practice's arrangements in place to respond to medical emergencies.

- In response to our previous inspection non-clinical staff had now received basic life support training. However, no action had been taken in relation to three of the locum doctors who we found at the previous inspection had not updated their training within the last year, as required under UK Resuscitation Council guidelines.
- There were emergency medicines available within the practice and these were within expiry dates and were now readily accessible and appropriately stored. However, there was still no record kept of any checks carried out to ensure that medicines were in date. In addition, there were six medicines recommended in national guidance that were not in in the emergency medicines kit and no risk assessment had been completed for not including them. In addition, there were three medicines in the emergency kit that were not recommended in national guidance. The principal GP took immediate action to dispose of these. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. There were also arrangements to move services to a buddy practice in the event of the service could not continue to operate.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice sought to assess needs and delivered care using relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The principal GP kept up to date with guidelines from NICE through podcasts and the local CCG website and used this information to deliver care and treatment that met people's needs. The provider's action plan in response to our previous inspection stated that the practice would put into place a formal process for disseminating NICE guidelines to all GPs working at St Philips to ensure the guidelines were implemented for the practice as a whole. However, at our latest inspection we found this action had not been implemented and there was still no formal process in place.

At our previous inspection we found the arrangements to assess patients' ongoing and changing needs were ad hoc and conducted opportunistically during appointments. The practice did not participate in the local enhanced service scheme for patients over 75 and there were no care plans in place for this group, although there were only 18 such patients. There were also no practice-based care plans for the 27 patients at the supported housing project for individuals with chronic mental health issues to whom the practice provided primary care services. In response to our previous inspection the provider's action plan stated that care plans would be introduced and offered to patients over 75, and patients with chronic mental health issues and/or learning disabilities. This action had not been implemented at the time of our latest inspection.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). In response to our previous inspection the provider's action plan stated a commitment to make more systematic use of the information collected for QOF to review performance and improve quality. This would include a systematic review of QOF data, putting systems in place to bring about an improvement in QOF performance. However, the practice had not implemented this action at the time of our latest inspection. The most recent published results (2014/15) were 56% of the total number of points available (38% below the CCG average and 39% below the national average), with 15.6% exception reporting. For the majority of indicators, the practice therefore scored very low or no points, for example, for chronic kidney disease (CKD), heart failure, osteoporosis and palliative care. Data from 2014/15 showed:

- Performance for diabetes related indicators was lower than the CCG and national average: 51% compared to 89% respectively.
- The percentage of patients with hypertension having regular blood pressure tests was above the CCG and national average: 84% compared to 78% and 80% respectively.
- Performance for mental health related indicators was below the CCG and national average: 70% compared to 89.9% and 92.8% respectively.
- The new dementia diagnosis rate was below the CCG and national average: 0% compared to 87% and 82% respectively. However, the practice informed us that there were currently no patients with dementia on the patient register.

The practice participated in clinical audits with a view to securing quality improvement.

- At our previous inspection we were shown four clinical audits which had been carried out in the last two years prior to that inspection; none of these was a completed full cycle audit but two included plans to carry out a repeat audit to follow up the original audit outcomes. The provider's action plan in response to the previous inspection stated the practice would carry out more clinical audits and re-audits with the aim of improving patient outcomes. Planned action also included the creation of a timetable of clinical audits detailing the date of audit, the actions resulting, and the date the actions were discussed. Dates for re-audit would be included as appropriate. However, the practice had not implemented this action at the time of our latest inspection. We asked for the practice to submit evidence before our latest inspection of two completed clinical audit cycles and a summary of any other audits completed. The practice did not provide this information until after the inspection when the principal GP submitted details of audits done to check adherence

to NICE Guidelines on stool sample analysis; monitoring of hypothyroidism in patients; and to check the rate of inadequate specimens in cervical smear samples taken at the practice. However, none of these were completed second cycle audits to demonstrate quality improvements were made and were implemented and monitored.

Effective staffing

At our previous inspection we found improvements were needed in the appraisal and training arrangements to ensure staff had up to date skills, knowledge and experience to deliver effective care and treatment. The provider's action plan in response to these findings stated the aim to introduce adequate arrangements to support staff in relation to their duties and responsibilities, and ensure that there were no gaps in training or development of staff.

At our latest inspection we found the practice had made some progress in implementing this action but further improvement was needed.

- There was an appraisal system for non-clinical staff which identified learning and development needs. Appraisals were due on the anniversary of each staff member's appointment. However, no appraisals due had been completed and no arrangements had been made for this.
- We were told that all GPs had been revalidated or had a date for revalidation, although we did not see documentation to confirm this. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).
- There were arrangements in place for staff to receive mandatory training. As a result of gaps identified at our previous inspection: fire safety training had now been provided for all staff apart from one recently returned from maternity leave; chaperone training had been completed by the four staff who carried out this role; infection control and basic life support training had been provided for non-clinical staff; and all GP staff were now up to date with training in safeguarding of children at level 3 as required. However, there were still gaps in training staff had received. For example:

- GP staff had not updated their infection control training, although we were told the principal GP and three of the locum GPs were due to complete on line update training shortly;

- Administrative staff had still not completed child protection training. The practice had been trying without success to identify a training provider for face to face training but they had not considered on-line training;

- Three of the locum doctors had not updated their basic life support training within the last year.

The practice re-iterated their view stated at our previous inspection, that the onus was on locum staff to keep their knowledge and skills up to date. However, we reminded the practice again at our latest inspection that it is the responsibility of the provider to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system.

This included care medical records and investigation and test results. However, at our previous inspection we found the regular locum doctors were not systematically informed of the outcome of hospital referrals or the results of tests they initiated by the principal GP who received the results. They either kept a personal reminder or found out the outcome when the patient returned for a further appointment. All pathology results were processed by the principal GP who actioned them and ensured details were recorded in patient records. In response to the previous inspection the provider committed to putting in place a system and protocol to ensure that locum doctors are informed of the outcome of hospital referrals or the results of tests which they have initiated. However, this action had not been implemented at the time of our latest inspection.

The practice shared relevant information with other services in a timely way, for example when referring people to other services.

The practice worked in conjunction with care workers and community psychiatric nurses to encourage diabetic patients at a local supported housing scheme with chronic schizophrenia to improve compliance with medication, diet

Inadequate

Are services effective?

(for example, treatment is effective)

and other interventions. However, at our previous inspection we saw limited evidence that the practice engaged on a regular basis more widely with other health and social care professionals at multi-disciplinary team meetings to plan, review and update care and treatment for other patients. The provider's action plan stated that the practice would foster greater participation in multi-disciplinary working so as to co-ordinate patient care and work more closely with external agencies such as mental health services, health visitors, palliative care teams, and others as appropriate. At our latest inspection we saw no evidence of this apart from an annual multidisciplinary meeting with the local community mental health trust to review mental health patients the practice supported at the local housing scheme.

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 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.
- The process for seeking consent was recorded in patient records.

Health promotion and prevention

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation, and patients with chronic mental health conditions. Patients were signposted to the relevant service. Guidance and advice to students about substance and drug misuse and sexual health was provided by the university counselling services. There were no patients requiring palliative care.
- The doctors provided advice on diet and exercise and referred patients to a local weight management programme where appropriate. They also provided smoking cessation advice including motivation, techniques, substitute nicotine products and pharmacological treatments.

The practice's uptake for the cervical screening programme was 33%, which was significantly below the CCG average of 73% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice told us that the figure was low as there were a number of eligible patients whose home was outside of the UK who had their screening abroad at an earlier age or were from cultures where they did not engage in sexual activity when young, which would require them to have a smear test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were mostly above CCG averages for under 12 months but below average for 24 months and five year age groups. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 50% to 100% and five year olds from 20% to 40% (compared to CCG averages of 78% to 93% and 79% and 94% respectively). However, the number of eligible children on the register was low and we were told children often moved from the area before their immunisation cycle was complete.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and to a limited extent 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.

Health promotion advice was offered and but there was limited written health promotion material available at the practice.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

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

The majority of the 25 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. There were two cards with negative comments, one expressing dissatisfaction with the hospital referral system and another about the difficulty of getting appointments.

We also spoke with 11 patients during the inspection. Their experience aligned with that highlighted in the comments cards we reviewed. They told us their dignity and privacy was respected.

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

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 83% and the national average of 87%.
- 94% 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%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

However, of 414 satisfaction questionnaires sent to patients (out of a list size of 11,026), a total of 20 responded (5%), so it was difficult to draw meaningful conclusions from the survey.

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.

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:

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

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

- Staff told us that translation services were available for patients who did not have English as a first language but this was rarely used as the vast majority of patients spoke good English. If patients needed help in translation, staff spoke several different languages including Swedish, French, Spanish, Arabic, Russian and Portuguese.

Patient/carer support to cope emotionally with care and treatment

Requires improvement

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Student patients were able to access a counselling service provided by the university.

The practice's computer system was not set up to alert GPs if a patient was also a carer and consequently the practice had not proactively identified such patients to offer them additional support as carers. Written information was, however, available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, a GP contacted them to provide support and give them advice on how to find a support service. For example, patients were advised to contact a charity which offered a range of bereavement support and counselling services.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

At our previous inspection we found the practice sought to respond to patients' needs and maintain the level of service provided. However, this was largely achieved opportunistically at patient appointments, rather than through a formal planning system to address identified needs in determining the way services were delivered. We found this remained the case at our latest inspection. The practice had not taken the action we said it should take to develop a more robust planning process to address identified patient needs and determine the way services are delivered.

- The practice ran an urgent, walk-in clinic twice daily for emergency appointments, on a first come first served basis.
- There were longer appointments available for people with a mental health problem.
- Home visits were available for older patients / patients who would benefit from these, although in practice very few visits were made given the small number of patients within this group.
- There were disabled facilities available, including wheelchair access, a lift and a disabled toilet.
- The practice worked with the CCG's Diabetes Integrated Care Unit to optimise the care of patients with type 2 diabetes.
- The practice provided primary care services to a local supported housing project for individuals with chronic mental health issues, including consultations where weight, blood pressure and a range of blood tests were carried out.

Access to the service

The practice was open between 8:30am to 6:30pm Monday to Friday. Appointments were from 9:30am to 12:30pm every morning and from 1:30pm to 6:30pm daily. The practice also ran walk-in clinics daily between 11:00am and 12:00 noon and 3:00pm to 4:00pm for emergency treatment. In addition, pre-bookable appointments could be booked and provided within 48 hours. There were no extended hours surgeries available.

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.

- 90% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 93% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

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

However, in practice very few visits were made given the patient population. 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.

The practice did not have its own website at the time of our previous inspection but brief details of the services provided by the practice were available on the London School of Economics website. We were told that a practice website site had been developed and was expected to be made available in the near future. The website was still not available at the time of our latest inspection and we were informed that this was imminent.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a sign at the reception desk and the practice leaflet provided relevant information.

We looked at the information provided by the practice on four written complaints received in the last 12 months. We

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

found these were satisfactorily handled, dealt with in a timely way, and showed openness and transparency in dealing with the complaint. Complaints were discussed with staff involved but the practice had not implemented its action plan in response to our previous inspection to provide documented evidence that the outcomes, lessons learned and any action taken to improve the quality of care were communicated more widely within the practice. There were still no minuted clinical governance or practice meetings in place to demonstrate this.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

At our previous inspection we found the practice did not have a clear vision and strategy. The practice aims and objectives and a pledge to patients were set out in its statement of purpose and in the practice leaflet the practice's stated aim was to provide services to a high standard, tailored to the needs of the practice population. However, this had not been communicated to patients and staff we spoke with were unaware of the statement.

In its action plan in response to these findings the practice stated its aim to develop and document a clear vision and strategy which would be discussed at practice meetings so that all staff were fully aware of and shared ownership of it. It would also be disseminated to patients via a patient newsletter, publicity in the waiting room and via the planned Patient Participation Group (PPG). At our latest inspection we found the practice had made limited progress in achieving this aim. We were told that this process had been initiated with the drafting of an updated statement of purpose, which the practice sent us after the inspection. However, the aims and objectives and patient pledge stated in this document were largely unchanged from the previous version and it had not yet been shared with staff or patients.

Governance arrangements

At our previous inspection we told the provider that it must take action to ensure there are appropriate arrangements in place to assess, monitor and improve the quality and safety of the services provided, including the introduction of formal governance arrangements and further development of the systems for assessing the quality of the experience of service users in receiving those services.

The provider's action plan to address these concerns stated the intention to introduce and implement an effective governance framework to support the delivery of their strategy and good quality care; comprehensive assurance systems and performance measures which are reported and monitored; and robust arrangements for identifying and managing risks, key issues, and mitigating actions.

However, at our latest inspection we found limited progress in the implementation of this action. The principal GP told us he had initiated a review of the arrangements for employing long term locum doctors with a view to them becoming permanent salaried doctors and engaged within formal governance arrangements. However, no overarching governance framework or formal quality assurance and risk management arrangements had yet been put in place. We found that some improvement had been made since the previous inspection but the action plan to address many of the shortcomings identified had not yet been implemented. Services to patients were still not adequately monitored to ensure they were provided with safe care which effectively met their needs:

- There was no formal staffing structure but staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- Planned arrangements to ensure a comprehensive understanding of the performance of the practice was maintained were not yet in place. The practice undertook clinical audits which it used to monitor quality. However, the practice had not completed the second cycle of audit for any of the audits completed within the last year. The practice participated in QOF but, despite a stated action plan to do so, still did not systematically use the data to gain an understanding of the performance of the practice. There was a low overall QOF performance for 2014/15, compared to GP practices within the CCG and nationally.
- There was still limited participation in multidisciplinary working to co-ordinate patient care
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions remained insufficiently robust.
- Some shortcomings in safeguarding, infection control processes, medicines management, emergency equipment had been addressed but we found continuing deficiencies in these areas.
- Some improvements had been made to staff recruitment practices but the changes had not yet been implemented in full.
- Additional and update training had been provided in several areas but some gaps in training remained.
- The arrangements to assess patients' ongoing and changing needs continued to be ad hoc and conducted opportunistically during appointments. There was still no formal process for ensuring the practice assessed needs and delivered care in line relevant and current evidence based guidance and standards.

Are services well-led?

Inadequate

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

At our previous inspection, we were particularly concerned that there were not appropriate arrangements in place to assess, monitor and improve the quality and safety of the services provided for patients on the practice list who lived overseas. There was limited evidence to demonstrate how these patients were supported by the practice. This remained the case at our latest inspection. In addition there was lack of clarity about the continuing registration of patients who had moved away from the practice vicinity, for example when they left the university. There was no systematic identification and review of these patients to check they should remain on the practice list.

Leadership, openness and transparency

Although the principal GP had initiated the process of changing the leadership and governance structures, there was to date limited change to the findings at our previous inspection. The principal GP continued to exercise close control over the clinical management in the practice. Clinical oversight of, and communication with the regular locum GPs remained informal and on a one to one basis. As found previously such an approach did not foster effective leadership. It imposed a demanding workload on the principal GP and did not provide the rest of the clinical team with full opportunity to share responsibility for clinical quality and standards. It also did not make adequate provision for unexpected absences or leave of the principal GP.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).There was a 'Duty of Candour' policy in place and the practice had systems in place for knowing about notifiable safety incidents. 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.

At our previous inspection we found that given the size of the patient list, the governance structure in the practice did not promote best management practice. There were no regular, minuted practice team meetings. Most communication was through informal one to one meetings or cascade briefing. Some staff felt that there should be formal practice meetings but they nevertheless felt able to raise any issues with managers, who they said were accessible. They also felt respected, valued and supported in their work. In the action plan in response to these findings the provider stated the intention to introduce regular documented clinical and practice meetings as part of a new formal governance structure. However this action had not been implemented at the time of our latest inspection.

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

The practice took account of feedback from patients, the public and staff but the scope of this remained limited.

- In the action plan in response to our previous inspection, the provided stated the intention to make a special effort to gather patient feedback by creating a 'virtual' patient participation group (PPG), via patient surveys, the NHS Friends and Family Test, and an in-house suggestions box. It had gathered feedback from patients through the NHS Friends and family test and acted upon this. However, at our latest inspection no progress had been made in the setting up of the 'virtual' PPG and no wider patient surveys had been initiated. Nevertheless, students had representative groups within the university and the practice would be made aware of any concerns raised about the service provided by the practice.
- The practice had gathered feedback from staff generally in informal staff and one to one meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management about how the practice was run.

Continuous improvement

There was currently no systematic focus on continuous learning and improvement within the practice. However, the action plan in response to our previous inspection set out the provider's aim to develop a culture which supported learning and innovation, team based working, high levels of staff engagement, and patient and carer engagement.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Patients were not fully protected against the risks associated with the recruitment of staff, in particular in ensuring all appropriate pre-employment reference and criminal records checks are carried out and recorded prior to a staff member taking up post. Regulation 19 (1)

This section is primarily information for the provider

Enforcement actions

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 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 did not have adequate arrangements in place to ensure care and treatment to patients was provided in a safe way. There were shortcomings in staff training, safeguarding, infection control processes, medicines management, and emergency equipment and in ensuring the safety of medical equipment. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have appropriate arrangements in place to assess, monitor and improve the quality and safety of the services provided. There were no formal governance arrangements and the systems for assessing the quality of the experience of patients in receiving those services needed further development. Regulation 17(1)