St Philips Medical Centre

Quality Report

Floor 2 Tower 3,
Clements Inn,
London,
WC2A 2AZ
Tel: 020 761 15131
Website: www.stphilipsmedicalcentre.co.uk

Date of inspection visit: 20 April 2017
Date of publication: 22/06/2017

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?	Requires improvement
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 12 November 2015. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. We inspected the practice again on 2 August 2016. The overall rating for the practice was again inadequate and the practice was placed in special measures for a further period of six months. The full comprehensive reports on the November 2015 and August 2016 inspections can be found by selecting the 'all reports' link for St Philips Medical Centre on our website at www.cqc.org.uk.

This inspection was undertaken following the second period of special measures and was an announced comprehensive inspection on 20 April 2017. Overall the practice is again rated as Inadequate due to ongoing non-compliance.

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 it had taken the action it said it would take in its action plan in response to our previous inspections to communicate lessons learned from incidents to all practice staff and document the discussion and action agreed. No formal minuted practice meetings had been initiated to facilitate this at the time of our latest inspection.
- The provider had addressed the majority of concerns identified at our previous inspections relating to deficiencies in the systems and training for safeguarding, infection control, medicines management, dealing with medical emergencies and ensuring the safety of medical equipment. There were now systems, processes and practices to keep patients safe and minimise the risk of harm.
- Action had been taken to improve recruitment processes, especially in relation to pre-employment checks.
- The practice could not demonstrate that it used information about its performance to monitor and improve the quality of care. For example, the practice

Summary of findings

no longer fully participated in the Quality and Outcomes Framework and had not set up its own systems for monitoring its management of long term conditions.
- There was still limited evidence of a regular multidisciplinary approach to patient care and treatment.
- The practice carried out clinical audit and there was now evidence of completion of the full audit cycle to show improved patient outcomes.
- The practice promoted good health and prevention and provided patients with advice and guidance. However, there was no system in place to ensure there were practice initiated care plans in place for older people (aged 75+) and at risk groups such as those with chronic mental health issues.
- Patients were positive about their interactions with staff and said they were treated with compassion, dignity and respect. However, the practice did not have an effective system for proactively identifying patients who were carers to offer them additional support.
- There was limited documentary evidence that learning from complaints had been shared with staff.
- Staff felt supported in their roles and gaps identified previously in key areas of the training and appraisal they received had been addressed.
- There was limited progress in implementing systems to monitor and improve the quality and safety of the services provided.

Importantly, the provider must:

- Ensure there are effective 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.

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.
- Develop a written policy for the management of controlled drugs.
- Complete and record on personnel files the retrospective review currently in progress of staff pre-employment documentation.
- Introduce care plans for patients who would benefit from coordinated care and multidisciplinary input, for example patients over 75 and patients with chronic mental health issues.
- Foster regular participation in multidisciplinary working to co-ordinate patient care.
- 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 for a second consecutive period in October 2016. Insufficient improvements have been made such that there remains a rating of inadequate for providing effective and well-led services. CQC is taking further action against the provider, Dr Rajan Olof Magnus Naidoo, in line with its enforcement policy, subject to a right of appeal.

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. The provider had addressed the majority of concerns identified at our previous inspections relating to deficiencies in the systems and training for safeguarding, infection control, medicines management, dealing with medical emergencies and ensuring the safety of medical equipment. However, there are still areas where improvements should be made.

- The practice had now implemented systems, processes and practices to keep patients safe and minimise the risk of harm.
- Staff demonstrated that they understood their responsibilities and all had now received training on safeguarding children and vulnerable adults relevant to their role.
- Further action had been taken to improve recruitment processes, especially evidence of pre-employment checks. The practice provided evidence of appropriate documentation for recently recruited staff and was undertaking a retrospective review of documentation for previously appointed staff which was nearing completion at the time of our inspection.
- The practice had arrangements in place to manage controlled drugs but there was no written policy for this.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong outcomes and actions were recorded in incident reports but there still was limited documented evidence that lessons were shared to make sure action was taken to improve safety in the practice.

Are services effective?

Inadequate

The practice is still rated as inadequate for providing effective services and improvements must be made. The practice had addressed some of the concerns identified at our previous inspections in relation to staff training and appraisal and the completion of clinical audits. However, there are still areas where improvements must be made.

- 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.

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- There were no practice initiated care plans in place for patients over 75 or for patients with chronic mental health issues.
- The practice did not systematically use QOF information to review performance and improve quality and there were no alternative arrangements in place.
- The practice carried out clinical audit and since our previous inspection had completed a number of audits through the full audit cycle.
- There was some participation in multidisciplinary working to co-ordinate patient care. However, there were no regular multidisciplinary meetings and they were held on a case by case basis.
- There were now arrangements in place for all staff to receive mandatory training and additional learning and development and appraisals had been completed for all staff due them.
- Locum (non-principal) doctors were still 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 mixed with some being below standard and some above standard in relation to 90% targets, although the number of eligible 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.

- Data from the national GP patient survey showed patients were broadly happy with how they were treated and the care they received. However, of 371 survey forms distributed, only 25 (7%) 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. Written health promotion information at the practice was limited but on-line information was now available on the practice's website, introduced since our previous inspection.
- Staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

- The practice provided emotional and bereavement support. Carers were signposted to the local CCG carers support services. However, the practice had not taken action we said it should take to 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 still no formal planning system to address identified needs in determining the way services were delivered.
- There was evidence of limited 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 now had its own website which enabled patients to book appointments and request repeat prescriptions on line.

Are services well-led?

Inadequate

The practice is still rated as inadequate for being well-led and improvements must be made. Limited progress had been made in implementing action to address concerns and there was insufficient improvement since our previous inspection.

The provider had not taken action we said they must take to ensure there were 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.

- There had been limited progress in developing further the practice vision and values or articulating them to staff or patients.
- The process of change the provider had initiated at our previous inspection had not been progressed significantly and governance arrangements remained limited. It remained the case that 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. Plans we were told of previously to hold regular,

minuted practice team meetings had not yet been implemented. 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. The planned patient participation group, to engage patients in decision making and the identification of improvements in service delivery, was now in the early stages of development but was not yet up and running at the time of our latest inspection.
- The practice had initiated the systematic identification and review of patients on the practice register who had moved away from the practice vicinity, for example when they left the university or moved abroad, to check whether 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 provider is rated as inadequate for the care of older people.

- Older people did not have care plans where necessary.
- The practice participated in a Camden Federation home visiting scheme to avoid unplanned admissions of frail / elderly patients.
- There was no up to date nationally reported data to show whether there had been any improvement in outcomes for patients for conditions commonly found in older people previously reported as below CCG averages. For example, low QOF performance for chronic obstructive pulmonary disease (COPD); mental health; osteoporosis and coronary heart disease (CHD). The practice was unable to supply its own evidence of its recent performance, although 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 provider is rated as inadequate for the care of people with long-term conditions.

- Longer appointments and home visits were available for patients with long-term conditions when needed. However, the practice did not provide patients with a personalised care plan or run a structured call-recall programme to check that their health and care needs were being met.
- There was no up to date nationally reported data to show whether there had been any improvement in outcomes for patients with diabetes where previously indicators showed QOF performance was worse 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.

Summary of findings

Families, children and young people

Requires improvement

The provider is rated as requires improvement for the care of families, children and young people. The provider was rated as requires improvement for safe, caring and responsive services. The issues identified as requiring improvement in these services affected all patients in this population group.

- 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 mixed with some being below standard and some above standard in relation to 90% targets, 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)

Requires improvement

The provider is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated as requires improvement for safe, caring and responsive services. The issues identified as requiring improvement in these services affected all patients in 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.

- No extended opening hours were offered for appointments but we were told the practice would see patients after working hours if they were unable to come in before 6.30pm.
- Patients could now book and order repeat prescriptions online via the practice's website.
- Health promotion advice was offered and some health promotion material was available at the practice.
- Patients had access to health assessments and checks. These included health checks for new patients and, although patients aged 40-74 did not attend for NHS health checks, just over a third of those eligible had received some form of health screening. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement

The provider is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requires improvement for safe, caring and responsive services. The issues identified as requiring improvement in these services affected all patients in this population group.

- At the time of the inspection there were no patients with a learning disability registered ith the practice.
- There was limited multidisciplinary case working with other health and social care professionals to case manage vulnerable patients.
- The practice had one registered patient who was currently street homeless and cared for 17 patients in a residential project for vulnerable or former street homeless people. The practice had worked with social workers, support workers and other services in delivery care to these patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children and had received relevant safeguarding training.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- There was no up to date nationally reported data to show whether there had been any improvement in outcomes for patients where previously mental health related indicators showed QOF performance was below the CCG and national averages.
- There were no care plans produced within the practice or a formal recall system for reviewing people experiencing poor mental health. 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.
- The practice liaised with the university's student mental health support services.
- There were currently no patients who had been diagnosed with dementia registered at the practice.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice was performing broadly in line with national averages in some areas and above in others. However, of 371 survey forms distributed, only 25 (7%) were returned (less than one percent of the practice list), so it was difficult to draw meaningful conclusions from the data. Of those received:

- 90% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 95% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG and national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 81% national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 58 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. In eight cards patients commented on the long waiting times when they attended for appointments and there was one expressing dissatisfaction with the hospital referral system.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

St Philips Medical Centre

Detailed findings

Our inspection team

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 10,800 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 11am and 12 noon and 3pm to 4pm 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 eight locum (non-principal GPs - all female) amounting to 3.4 whole time equivalent (WTE) GP staff. They were supported by an external primary care management consultant appointed shortly before the inspection to help the practice achieve compliance with the regulations. The former acting practice manager had left the practice shortly before the inspection. There were also four full-time and one part- time administrative staff at the practice. A full time practice nurse had been appointed in December 2016.

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 8am and 8pm Monday to Friday and 10am to 8pm at weekends.

The inspection was carried out to follow up a comprehensive inspection we carried on 2 August 2016 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 well-led services and requires improvement for providing caring and responsive services. We placed the service in special measures. We carried out an announced comprehensive inspection at St Philips Medical Centre on 12 November 2015. The overall rating for the practice was inadequate and the practice was placed in special

measures for a period of six months. We inspected the practice again on 2 August 2016. The overall rating for the practice was again inadequate and the practice was placed in special measures for a further period of six months and we served two warning notices on the practice for breaches in Regulation 12, Safe care and treatment and Regulation 17, Good governance. The full comprehensive reports on the November 2015 and August 2016 inspections can be found by selecting the 'all reports' link for St Philips Medical Centre on our website at www.cqc.org.uk.

Our inspection on 20 April 2017 was carried out as a follow up to the 2 August 2016 inspection to check whether the provider had met the requirements of the two warning notices and whether improvements had been made following the second period of special measures.

Why we carried out this inspection

We undertook a comprehensive inspection of St Philips Medical Centre on 2 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe, effective and well led services and was placed into special measures for a period of six months.

We also issued warning notices to the provider in respect of safe care and treatment and good governance informed them that they must become compliant with the law by 12 December 2016. The full comprehensive report on the August 2016 inspection can be found by selecting the 'all reports' link for St Philips Medical Centre on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of St Philips Medical Centre on 20 April 2017. This inspection was carried out following the period of special measures to check that action had been taken to comply with legal requirements, ensure improvements had been made and to assess whether the practice could come out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England to share what they knew. We carried out an announced visit on 20 April 2017. During our visit we:

- Spoke with a range of staff (including the principal GP, two locum (non-principal) GPs, a primary care management consultant supporting the practice, the practice nurse and reception/administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area 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.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

Detailed findings

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 2 August 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of learning from incidents, staff recruitment processes and training, safeguarding, infection control processes, medicines management, emergency equipment and in ensuring the safety of medical equipment were not adequate.

The practice had made improvements to the majority of these arrangements when we undertook a follow up inspection on 20 April 2017. However, we found ongoing deficiencies in the communication of lessons learned from incidents. The practice is now rated as requires improvement for providing safe services.

Safe track record and learning

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

- 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.
- We reviewed safety records and incident reports and saw the practice carried out a thorough analysis of the significant events which included action taken to improve safety in the practice. For example, following the mislabelling of a sample submitted for laboratory analysis a more robust process was put in place to ensure more thorough checking that the correct patient details were included samples ready for despatch. However, we saw limited evidence that the practice had taken the action we said it should take at our previous inspections of 12 November 2015 and 2 August to 2016 to communicate lessons learned from incidents to all practice staff and document the discussion and action agreed. No formal minuted practice meetings had been initiated to facilitate this at the time of our latest inspection, although we were told that such meetings would shortly be put in place.

Overview of safety systems and process

The practice had made several improvements since our inspection of 2 August 2016 to assess risks to patients who used services, and now had systems, processes and practices to keep patients safe and minimise the risk of harm:

- 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. 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 interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The gaps in training identified at our previous inspection had been addressed. GPs and the nurse were trained to child protection or child safeguarding level three, and administrative staff to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. At our previous inspection we found not all staff who acted as chaperones and were trained for the role had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had since addressed this and at our latest inspection all such staff had received a DBS check.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. The practice had addressed concerns identified at our previous inspection regarding cleanliness and the removal of clutter.
- The practice nurse had day to day responsibility for infection prevention and control and liaised with the local infection prevention teams to keep up to date with

best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The principal GP was the infection control clinical lead and there was an infection control policy in place. In response to our previous inspection, all administrative and clinical staff had completed infection control training. The practice had also now completed the necessary actions in response to an external infection control audit, completed in March 2016 that were outstanding at our previous inspections. Sharps bins were now dated and signed; mops were used hygienically; and staff had been offered MMR immunisations.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). The practice had addressed the concerns identified at our previous inspection.

- Blank prescription forms and pads were securely stored and there were now appropriate systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The vaccine storage fridge was now wired in such a way to avoid it inadvertently being switched off and there was prominent signage warning not to do so.
- The practice now held a small stock of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had arrangements to manage them safely, although there was no written policy for these arrangements.

At our inspection of 2 August 2016 we found the practice had made limited progress in implementing its action plan to address deficiencies found in our inspection of 15 November 2015 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). At our latest inspection the practice provided evidence that it had recently initiated a retrospective review of the pre-employment recruitment documentation of all staff. We saw that this was complete on the personnel files we sampled for all five administrative staff and appropriate documentation was now in place, including that for a member of staff appointed since our previous inspection. The review was in still in progress for clinical staff but appropriate checks had been made and documented for the nurse appointed since our previous inspection. Three locum (non-principal) doctors had also been appointed via an agency and the practice had ensured appropriate checks had been made by the agency.

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.
- 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 assessment.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- In response to our previous inspection, the practice had reviewed the system in place for the use and storage of liquid nitrogen to ensure that the practice was fully compliant with the guidance, including a risk assessment for Control of Substances Hazardous to Health (COSHH). Appropriate safety signage was in place, a view port had been added to the door to enable people outside the storage room to check if the liquid nitrogen tank was in use and additional ceiling ventilation installed.
- 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. At our two previous inspections we noted the absence of any nursing staff, given the relatively large patient list size. However, at our latest inspection we noted a nurse had been appointed in December 2016.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The provider had addressed the concerns identified at our previous inspection in the practice's arrangements in place to respond to medical emergencies.

- All staff had now received up to date basic life support training.
- There were emergency medicines available within the practice which were now consistent with those recommended in national guidance and record was now kept of any checks carried out to ensure that medicines were in date. 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

At our previous inspection on 2 August 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of the dissemination of NICE guidelines within the practice; use of formal care plans; the review of performance and improvement in quality in areas of weakness relating in particular to people with long term conditions and those with poor mental health; clinical audit; participation in multidisciplinary working; and staff training and appraisal were inadequate.

There had been improvement in some of these arrangements when we undertook a follow up inspection on 20 April 2017, including staff training and appraisal and clinical audit and, to a lesser degree, multidisciplinary working. However, there were ongoing deficiencies, particularly in the dissemination of NICE guidelines, the use of care plans, and the systems for reviewing performance and improving quality. The provider is still rated as inadequate for providing effective services.

Effective needs assessment

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

- The provider's action plan in response to our inspection in November 2015 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. At our August 2016 inspection we found this action had not been implemented and there was still no formal process in place. This remained the case at our latest inspection. Individual clinicians had access to NICE guidelines but there was no process for co-ordinating their implementation across the practice or monitoring that these guidelines were followed.
- In response to our November 2015 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 August 2016 inspection and this remained the case at our latest inspection. The arrangements to assess patients' ongoing and changing needs continued to be ad hoc and conducted opportunistically during appointments. There were no care plans in place for patients over 75 and no practice-based care plans for patients at the supported housing project for individuals with chronic mental health issues, to whom the practice provided primary care services.

Management, monitoring and improving outcomes for people

The practice had previously 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 November 2015 inspection the provider stated a commitment to make more systematic use of the information collected for QOF to review performance and improve quality. However, the practice had not implemented this action at the time of our August 2016 inspection. The most recent published results available at that time (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 had 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 worse than the CCG and national average: 51% compared to 89% respectively.
- Performance for mental health related indicators was worse than the CCG and national average: 70% compared to 89.9% and 92.8% respectively.

At our latest inspection it remained the case that the practice had not fulfilled its stated commitment to make more systematic use of the information collected for QOF to review performance and improve quality. Prior to the inspection there were no updated published QOF results for the practice for 2015/16. Unpublished data provided by NHS England based on QOF returns completed by the practice up to the end of February 2016 indicated the practice had achieved 28% of the total number of points available for 2015/16 and to the end of February 2017 34% for 2016/17. Both of these results were significantly below CCG and national averages. The principal GP informed us that the practice no longer fully participated in QOF as the

majority of indicators did not apply readily to the predominantly student practice population; he told us improvements in quality of patient care were managed on a case by case basis. There were therefore no arrangements to ensure a comprehensive understanding of the performance of the practice was maintained.

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

At our previous inspections of November 2015 and August 2016 the practice submitted evidence of clinical audits undertaken. However, none of these were completed second cycle audits to demonstrate quality improvements were made and were implemented and monitored. At the second inspection we said the practice should take action to introduce a programme of quality improvement including clinical audits and re-audits to ensure improvements in patient outcomes have been achieved. At our latest inspection the practice had not introduced a formal audit programme or plan but submitted six audits which had been undertaken in the last two years. Four of these were completed two cycle audits and the practice had used some audit findings to improve services. For example, it carried out an audit of patients who for historical reasons were dual/duplicate registered at the practice. After the second cycle audit the number of these registrations had been reduced from 265 to 12. There was ongoing work to reduce this number further.

Effective staffing

At our inspection of August 2016 we found the practice had made some progress in implementing action to improve staff training and appraisal but further improvement was needed. No appraisals due for non-clinical staff had been completed and no arrangements had been made for this. In addition there were gaps in staff training: administrative staff had not completed child protection training; and some GPs were not up to date in training in infection control and basic life support. There was no documentary evidence of the completion of new staff induction.

At our latest inspection we found the practice had resolved these concerns. All staff due one had received an appraisal and gaps in training had been addressed. An induction checklist had been completed for new members of staff and refresher induction and a checklist completed for existing administrative staff. Evidence reviewed now demonstrated that staff had the skills and knowledge to deliver effective care and treatment.

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 inspections 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 our November 2016 inspection the provider told us they would put in place a system and protocol to ensure that locum doctors were informed of the outcome of hospital referrals or the results of tests which they had initiated. However, this action had not been implemented at the time of our August 2016 inspection and this remained the case at 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 and other interventions. However, at our previous inspections 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. In response to these previous findings, the provider said 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 some evidence of this. However, there were no regular multidisciplinary meetings

Inadequate

Are services effective?

(for example, treatment is effective)

and they were held on a case by case basis. For example, the principal GP had attended a 'best interests' case review and also a multidisciplinary meeting regarding potential risks to an unborn child.

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.

Supporting patients to live healthier lives

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.

In 2015/16 the practice's uptake for the cervical screening programme was 22%, which was significantly below the CCG average of 72% and the national average of 81%. 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. Since our previous inspection, the practice had employed a practice nurse. The nurse was actively seeking to improve screening uptake for example by following up patients who did not respond to their screening invitation by telephone.

Performance in 2015/16 for meeting 90% targets for childhood immunisation rates for the vaccinations given was below standard at 33% for children aged 1 with a full course of recommended vaccines; and at 67% for children aged 2 with Haemophilus influenzae type b and Meningitis C booster vaccine. However, it was above standard at 100% for both children aged 2 with pneumococcal conjugate booster vaccine and with Measles, Mumps and Rubella vaccine.

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 health screening for patients aged 40–74. Although at the time of our inspection patients were not being invited for the NHS health checks, 37% of those eligible underwent some form of screening in the past 12 months. 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 there was some written health promotion material available at the practice.

Requires improvement

Are services caring?

Our findings

At our previous inspection on 2 August 2016, we rated the practice as requires improvement for providing caring services as 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.

We found that the practice had still not reviewed it systems to improve the identification of carers to determine their specific support needs when we undertook a follow up inspection on 20 April 2017. The practice is still rated as requires improvement 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 sex.

All but one of the 58 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.

We spoke with seven patients including one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. 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 above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 89% and the national average of 92%
- 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%.
- 96% of patients said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

However, of 371 satisfaction questionnaires sent to patients, only 25 responded (7%), 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:

- 95% 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%.
- 100% 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:

Requires improvement

Are services caring?

- 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 and carer support to cope emotionally with care and treatment

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

At our previous inspection of August 2016 we found 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. At our latest inspection the provider had not taken the action we said he should take to review systems to improve the identification of carers and provide support based on their specific needs.

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

At our previous inspection on 2 August 2016, we rated the practice as requires improvement for providing responsive services as there was no formal planning system to address the identified needs of patients in determining the way services were delivered; limited evidence of coordination of care and treatment with other services; and limited documentary evidence that learning from complaints had been shared with staff.

The practice had made limited progress in improving these arrangements when we undertook a follow up inspection on 20 April 2017. The practice is still rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

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. At our inspection in August 2016 we found the practice had not taken the action we said it should take at our inspection in November 2015 to develop a more robust planning process to address identified patient needs and determine the way services are delivered. This remained the case at our latest inspection, although the provider told us this would be addressed through the support provided by an external primary care management consultant appointed shortly before the inspection to help the practice achieve compliance with the regulations.

- 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 had recruited a practice nurse to provide a range of services including travel vaccinations contraception, cervical smear testing, and wound care to patients.
- 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 11am and 12 noon and 3pm to 4pm for emergency treatment. In addition, pre-bookable appointments could be booked and provided within 48 hours. There were no extended hours surgeries available but the practice saw patients on an individual basis after working hours if they were not unable to come for an appointment before 6.30pm

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.

- 69% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 71% and the national average of 76%.
- 90% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 95% 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 76% and the national average of 76%.
- 88% of patients said their last appointment was convenient compared with the CCG average of 88% and the national average of 92%.
- 82% of patients described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 73%.
- 71% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 56% and the national average of 58%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

However, of 371 satisfaction questionnaires sent to patients, only 25 responded (7%), so it was difficult to draw meaningful conclusions from the survey.

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.

Since our previous inspection the practice had set up its own website and brief details of the services provided by the practice were available on the London School of Economics website. As well as accessing a range of practice and healthcare information, patients were able to book on line appointments and request repeat prescriptions though the website.

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 complaints received since our last inspection in August 2016. We found these were satisfactorily handled, dealt with in a timely way, and showed openness and transparency in dealing with the complaint, although in two cases the final outcome was not readily evident from the paperwork on file. Complaints were discussed with staff involved but the practice had not implemented the action we said it should take in response to our two 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. However, the provider told us minuted meetings would be set up shortly as part of the action plan drawn up with support of the external primary care management consultant appointed shortly before the inspection to help the practice achieve compliance with the regulations.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 2 August 2016, we rated the practice as inadequate for providing well-led services as the practice did not have appropriate arrangements in place to assess, monitor and improve the quality and safety of the services provided, including formal governance arrangements and fully developed systems for assessing the quality of the experience of service users in receiving those services.

We issued a warning notice in respect of these issues and found arrangements had not significantly improved when we undertook a follow up inspection of the service on 20 April 2017. The practice is still rated as inadequate for being well-led.

Vision and strategy

At our inspection in November 2015 we found the practice did not have a clear vision and strategy. 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 inspection in August 2016 we found the practice had made limited progress in achieving these aims and this remained the case at our latest inspection. The practice had drawn up a mission statement which was on display in the reception area but there had been limited further development and communication of its vision and values and there was no clear strategy and supporting business plans which reflected these.

Governance arrangements

At our two previous inspections we told the provider that he must take action to ensure there were 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.

However, at our latest inspection we found there was still limited progress in the implementation of action to address these concerns. 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 practice's 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 safely and in line with current guidelines and standards care to effectively meet their needs:

- There was no formal staffing structure but staff were aware of their individual 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 and there was now some evidence of completed second cycle audits. The practice had previously participated in QOF but there was no completed QOF data for 2015/16 or 2016/17. Despite a previously stated intention to do so, the practice did not systematically use QOF data or alternative measures to gain an understanding of the performance of the practice. The most recently published data for the practice (2014/15) showed a low overall QOF performance compared to GP practices within the CCG and nationally. This remained the case based on the incomplete data for 2015/16 and 2016/17.
- There was still limited participation in regular multidisciplinary working to co-ordinate patient care.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions remained insufficiently robust.
- 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.

Although there had been insufficient improvement in these areas, the practice had addressed some of the concerns identified at previous inspections:

Are services well-led?

Inadequate

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

- Shortcomings in safeguarding, infection control processes, medicines management, and emergency equipment had been addressed.
- Improvements had been made to staff recruitment practices, although a retrospective review to ensure the updating of staff recruitment records for clinical staff was ongoing.
- Additional and update training had been provided in several areas to address the gaps in training identified previously.
- The practice had recruited a practice nurse.

At our previous inspections, 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. At our previous inspections there was also a 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. However, at our latest inspection the practice provided evidence that the patient list was being reviewed in this respect and patients taken off the list where appropriate. We were told the review would be ongoing.

Leadership and culture

At our August 2016 inspection we found the practice had made limited progress since our inspection of November 2015 to address concerns we raised about the leadership and governance structures to address concerns. 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. 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 planned leave of the principal GP. There was no significant change at our latest inspection. The principal GP had initiated daily end of surgery de-briefs with the locum GPs but these were not documented and did not represent any further delegation of responsibilities or tasks. Some staff members told us they would welcome more opportunities to develop their roles within the practice.

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 November 2015 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 August 2016 and this remained the case at our latest inspection. Shortly before the inspection, the principal GP secured the services of an external primary care management consultant to help the practice in meeting CQC requirements. However, at the time of the inspection plans to improve leadership and governance structures had not been implemented.

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 November 2015 inspection, the provider 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

Are services well-led?

Inadequate

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

in-house suggestions box. It had gathered feedback from patients through the NHS Friends and family test and acted upon this. However, at our August 2016 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. At our latest inspection there had been limited progress in this respect. Four PPG members had recently been identified but no virtual or face to face meetings had taken place to date. However, feedback from an initial informal meeting with one PPG member had been acted on to improve patient information messages on the display screen in reception.

- 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

At our previous inspections we found there was no systematic focus on continuous learning and improvement within the practice and this remained the case at our latest inspection. In response the provider had stated in an action plan the aim to develop a culture which supported learning and innovation, team based working, high levels of staff engagement, and patient and carer engagement. However, this remained aspirational and had not been implemented at our latest inspection.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider was not able to demonstrate good governance. • There was no effective system 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)