Poplar House Surgery

Quality Report

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

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Overall summary

Letter from the Chief Inspector of General Practice

Poplar House Surgery is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening services; family planning; maternity and midwifery services, treatment of disease, disorder or injury.

This inspection is a result of concerns raised with the CQC and are findings are:

There is no clear leadership of the practice. A lack of formal governance systems meant the monitoring of quality and identification and management of risks within the practice are ineffective. Leadership is neither visible or accessible. As a result teams work in isolation and often in a chaotic and dysfunctional way although a shared commitment to the care and welfare of patients is evident. Policies and procedures are either not in place, lack detail or require updating.

Systems and procedures to ensure the practice is safe are inadequate. There is a lack of evidence to show the practice learned from incidents. Systems to monitor safety and reduce risk are ineffective.

The practice has a Patient Representation Group (PRG). The Chair reported the practice is responsive to ideas from the group and their contribution is welcomed and valued. Response to a patient survey carried out by the practice in February 2014 in collaboration with the PRG shows that overall 85.5% of patients who responded are happy with the care they receive.

The practice does not have appropriate procedures in place to demonstrate staff are safely recruited and employed.

The practice does not have consistent systems in place to verify the training and competencies of staff or to demonstrate the skill and experience necessary for their roles and responsibilities.

The practice is not meeting regulation 10 of the Health and Social Care Act 2008: Assessing and monitoring the quality of service provision.

The practice is not meeting regulation 21 of the Health and Social Care Act 2008: Requirements relating to workers.

The practice is not meeting regulation 23 of the Health and Social Care Act 2008: Supporting workers.

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.

Professor Steve Field

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We asked the following questions.

Are services safe?

The practice was not safe.

Systems and procedures to ensure the practice was safe were inadequate. There was a lack of evidence to show the practice learned from incidents. Systems to monitor safety and reduce risk were ineffective.

Are services well-led?

The practice was not well led.

There was no clear leadership of the practice. A lack of formal governance systems meant the monitoring of quality and identification and management of risks within the practice were ineffective. Leadership was neither visible or accessible. As a result teams worked in isolation and often in a chaotic and dysfunctional way although a shared commitment to the care and welfare of patients was evident. Policies and procedures were either not in place, lacked detail or required updating.

Summary of findings

What people who use the service say

On this occasion we did not speak with any patients face to face on the day of the inspection, however we contacted the Chair of the Patient Reference Group (PRG) by telephone. The PRG was still in its infancy. The Chair told us there was a good attendance by practice staff at their meetings. We were told the practice was responsive to ideas and that the PRG's contribution was welcomed and valued.

Response to a patient opinion survey, carried out by the practice in collaboration with the PRG in February 2014, showed that overall 85.5% of patients who responded were happy with the care they received.

The most recent results available in the practice from the national GP Patient Survey 2012-2013, showed that 53.6% of those who responded would recommend Poplar House Surgery. This rating placed the practice in the banding 'amongst the worst'.

Areas for improvement

Action the service MUST take to improve

The practice must ensure recruitment procedures meet legal requirements and that information specified in Schedule 3 of the Health and Social Care Act 2008 is available. Checks must be made to ensure clinically qualified staff are registered with their relevant professional body.

The practice must ensure the effective operation of systems to regularly assess and monitor the quality of services provided.

The practice must ensure the effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of patients.

The practice must ensure suitable arrangements are in place to support staff, including appropriate training, supervision and appraisal.

The practice must ensure suitable arrangements are in place to support staff by way of an effective system of clinical governance and audit.

The practice must ensure that complaints made are fully investigated and appropriate steps taken to coordinate a response to a complaint where it relates to care or treatment that has been shared with others.

Policies and procedures were either not in place, inadequately robust or required updating.

Poplar House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP and the team included a CQC Inspection Manager.

Background to Poplar House Surgery

Poplar House Surgery sits within the Fylde and Wyre Clinical Commissioning Group (CCG) and is located in the sea side town of Lytham St Annes. There are approximately 8700 registered patients. The practice population includes a significantly lower number (17.2%) of people under the age of 18, and a significantly higher number (23.6%) of people over the age of 65, in comparison with the national and CCG average of 20.8% and 16.7% respectively. There are comparatively low levels of deprivation in the practice area.

Two GP partners work at the practice, one full time and one part time. There are also two salaried GPs. The practice has one GP vacancy, a previous partner having left the practice in June 2014. Locum GPs are used to support the GP team pending recruitment. Working alongside the GPs are a nurse practitioner, two nurses, two healthcare assistants, a practice manager, a reception manager, and teams of administrative and reception staff. Under local arrangements with the CCG the practice benefits from the support of an independent community pharmacist. The pharmacist is contracted to work at the practice approximately 20 hours per week to advise and support in relation to medicines management and prescribing.

The practice opening hours are 8am until 6pm Monday to Friday. An out of hours service is provided by Fylde Coast Medical.

Why we carried out this inspection

We inspected this service in response to information of concern raised with the Care Quality Commission

How we carried out this inspection

The decision was made to ask the following two questions of the service and provider on this occasion in order to address the concerns raised with the Care Quality Commission:

- Is it safe?
- Is it well-led?

We carried out an announced visit on 11 September 2014. During our visit we spoke with a range of staff including two GP partners and one salaried GP, the practice manager, nurse practitioner, practice nurse, reception manager, reception and administration staff. We also spoke with the community pharmacist and Chair of the Patient Reference Group (PRG) . We reviewed a range of information received from the practice both prior to and during the inspection. We spent seven hours in the practice.

Are services safe?

Our findings

Safe Track Record

We found there was inadequate information available to demonstrate the practice's track record on safety. There was no formalised system in place to report and monitor safety incidents or concerns.

There was no clear lead appointed to take responsibility in relation to safety issues and staff were unclear with whom accountability lay.

There were no clinical audits undertaken and so the practice could not demonstrate effective monitoring of safety and risk . There was no evidence of minutes of internal or external peer review of clinical practice.

Learning and improvement from safety incidents

The practice did not have an effective system in place for reporting, recording and monitoring significant events. A significant event tool kit was in place for staff guidance on recognition of a significant event and how these should be dealt with. The tool kit had a review date of August 2014. We found evidence that some significant events were recorded. Learning points had been identified but there was no evidence of analysis. There was also no evidence to demonstrate that action had been taken to implement the learning identified.

Some staff told us that incidents would be verbally communicated to them and others said these would be discussed at significant event meetings. Although we were told the practice held meetings to discuss significant events with staff, minutes were not recorded. We did not see any formalised process for lessons learned to be shared with staff.

The practice did not have a formal system in place to promptly manage national patient safety alerts in order to protect patients. The practice manager told us that historically they had reviewed incoming safety alerts before passing them on to a named GP for distribution to colleagues as appropriate. This GP had left the practice several months ago and there was no longer a clear process in place for sharing this information.

Reliable safety systems and processes including safeguarding

One of the partner GPs was nominated as the safeguarding lead for the practice. They had completed training to an appropriate level as required. The practice had policies in place for safeguarding vulnerable adults and children. The policies had not been reviewed since 2012 and contained out of date information. Not all staff we spoke with were aware of their existence.

We saw evidence that two of the GPs held a meeting in April 2014 when child and adult safeguarding had been included on the agenda. The minutes showed that only reception staff and health care assistants had attended. Staff we spoke with who had received the training spoke positively about it. One member of staff told us they had since reported a safeguarding concern and felt confident about doing so.

Notices were displayed in the practice advising patients they could have a chaperone present during their consultation if they wished. There was a chaperone policy which provided guidance and instruction to staff on carrying out this role. The reception manager told us that requests for a chaperone were common, particularly as there was not always a female GP available. We were told wherever possible a patient requesting a chaperone would be supported by a member of the clinical team. Reception staff had received internal training in acting as a chaperone.

The reception manager had compiled a log of useful information to support the reception team in carrying out their day to day functions. This was kept behind reception and readily accessible.

Monitoring Safety & Responding to Risk

At the time of our inspection there was one full time GP vacancy at the practice. A partner left and there had been no succession plan to meet such eventualities. The post had been vacant for several months. Locum GPs were used to support the permanent team but the practice manager told us of difficulties in consistently ensuring the appropriate level of cover. All the GPs we spoke with expressed concerns the surgery was medically understaffed and had an over reliance on locums.

Some reception and administrative staff worked part time hours. They had a mix of skills which enabled the practice to respond to unexpected absence using the regular staff team. Administrative staff reported directly to the practice manager. Reception staff reported to the reception

Are services safe?

manager. The practice manager did not have an appointed deputy to cover her absence. Staff were unclear where management responsibility lay when the practice manager was not on duty.

Incoming post was reviewed and distributed throughout the practice by administrative staff. Their role included scanning post into the practice system and highlighting priority issues, to bring them to the attention of the GPs in a timely manner. For example, letters received from hospitals following a patient's attendance requesting a GP take further action. A member of staff described two recent incidents where hospital letters requesting the practice to refer a patient to another service had been passed to one of the GPs for review, but no action had been taken. The member of staff told us when this had occurred they had raised their concerns with another of the GPs and asked that they deal with it.

Medicines Management

Requests for repeat prescriptions for medicines were processed by the reception team. When a patient requested a repeat prescription staff printed a draft prescription which was passed through to the GPs for authorisation and signature. The reception team had a system in place to alert GPs to unusual requests for medication. For example, if a patient requested further prescription of medicine when the need for repeat dosage had not previously been agreed, or if requests for authorised repeats were unusually frequent. A front sheet was attached to such requests to highlight a review was necessary. Once authorised, signed prescriptions were stored securely behind reception until collected.

An audit system was in place to follow up on any uncollected prescriptions. The reception manager carried out regular checks to see if any subsequent scripts had been issued and cancelled older ones as necessary to ensure duplicate quantities of medicines were not issued.

The practice had systems in place whereby prescriptions for certain types of high risk and controlled drugs had to be signed for on collection to ensure there was an audit trail in place.

The practice benefitted from the support of a community pharmacist who advised on prescribing and medicines management under a local agreement with the Clinical Commissioning Group (CCG). We were told of the positive working relationship with the reception, clinical staff and GP's who were receptive and keen to work collaboratively. We were told there were other members of senior management who were reluctant to engage and with whom the relationship was strained.

We saw that medicines were stored as required, with an organised stock level. Fridge temperatures were monitored daily to ensure that medicines were maintained at the correct temperatures. Medicine expiry dates were recorded and checked as required. Medicines for emergency use, in cases such as anaphalytic shock or suspected meningitis, were readily available.

Cleanliness & Infection Control

Care and treatment was provided in an environment which was clean and tidy. Treatment rooms were well organised and stocked with personal protective equipment such as gloves and aprons. Sharps bins were dated and kept out of reach of patients. We were told the practice generated very little clinical waste and so waste was collected by an external contractor on a weekly basis.

There was an Infection Prevention and Control (IPC) policy in place dated February 2014. One of the GPs was identified as the lead for IPC, however we were told by the practice manager and the nurse practitioner, that the lead was one of the practice nurses. The policy contained information mainly related to hand washing and did not give staff adequate guidance on other IPC issues such as disposal of clinical waste, management of sharps, needle stick injuries or action to take in cases of possible infectious illness.

There was no reference to the required staff training for IPC. We were not provided with any records of IPC training clinical staff had undertaken. Staff we spoke with said they had received training some time ago. Staff we spoke with were not aware who was identified as the lead for IPC.

We did not see any evidence of any monitoring of cleaning or infection control procedures within the practice. We did not find any audits of infection control within the practice.

Reception staff had protocols in place on how to handle specimens when brought into the practice by patients.

Staffing & Recruitment

The practice had an up to date recruitment policy. The manager told us she was aware of the recruitment checks that should be made but informed us they were not always undertaken. We looked at the recruitment records of four

members of staff. The sample included clinical and non-clinical members of the team. Some members of staff had worked at the practice for many years but there had also been a number of new staff join the team within the last 12 months.

The practice did not have effective recruitment procedures in place to demonstrate staff employed had the skill and experience necessary for their roles and responsibilities. There was not always evidence to verify that staff were required to provide a full employment history with explanation of any gaps, or that references were requested and followed up. Pre-employment checks were not always made with the Disclosure and Barring Services (DBS) to ensure that members of staff were of good character. The practice manager told us a policy decision had been taken not to require DBS checks in relation to administrative and reception staff as they never worked alone with patients. The decision was not documented and there was no evidence of a formal risk assessment. None of the files contained proof of identity or a recent photograph. There was no evidence the practice routinely made enquiries to establish that people were physically and mentally fit for the work.

The practice manager told us when a GP or nurse was recruited a check was made with their professional body, the General Medical Council or Nursing and Midwifery Council, to ensure they had valid registration. No subsequent checks were made to verify that annual registration had been undertaken. One staff member stated that no request to confirm their registration had been made since being employed a number of years ago. When locum GPs were used from an agency, the practice relied upon the agency for assurance registration was valid. Where locums were recruited in house there was no evidence that any assurances were sought.

Not all staff had contracts of employment and job descriptions setting out their role and responsibilities. Two members of staff told us they had made repeated requests for such documents but these had not been received. One person, who had a job description, told us of their increasing lack of clarity over their role. They told us additional tasks were frequently allocated to them without guidance or training. Staff told us they found the practice manager unapproachable and unwilling to discuss concerns about terms and conditions when they tried to raise them.

Dealing with Emergencies

Staff we spoke with were not aware there was a continuity plan available in the practice in the event of any emergency such as a flood, fire or loss of utilities. We had been emailed a business continuity plan by the practice manager, which stated it was for future discussion at a practice meeting in October 2014. We spoke with the practice manager who told us this was a typing error and the correct date was September 2014. We were unable to establish if this was a review of a previous plan or if it was a new plan to be implemented.

There was appropriate equipment in place to deal with emergencies. Oxygen cylinders were in date and a defibrillator was checked as required.

The practice manager told us all staff received annual training in basic life support. The reception manager held training records in relation to their team which confirmed training had been completed and was up to date. There was no system in place to record and monitor training in relation to rest of the clinical staff.

The practice carried out regular fire drills and administration staff checked the alarm system on a weekly basis.

Equipment

Equipment seen within the practice was in good condition and had been serviced and maintained as required. Portable appliance tests (PAT) had been undertaken. Contracts were in place for annual testing.

Spirometry equipment (for lung function) and an electrocardiograph (ECG) machine (for heart function) had also been calibrated and tested. We were told by staff they had received some instruction from the company supplying the equipment but there had been no formal training, or verification of their competencies when using the equipment, within the practice. No training records for equipment were available.

No issues were raised about the availability of equipment by any staff.

Are services well-led?

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

Our findings

Leadership & Culture

The practice did not have a vision or strategy for the future development of the service. Staff were unable to describe the values or ethos of the practice.

There was no clear leadership of the practice. Relationships between some of the GPs and senior staff had broken down. As a result the leadership and overall culture of the practice was chaotic and dysfunctional. Neither the GPs nor the practice manager were clear about their own roles and responsibilities within the practice or those of others.

As a result staff did not know who to contact for specific advice and support. Leadership was neither visible or accessible. Staff were not confident that they would always get help if they required it. Without a clear leadership structure they described a situation where individual personalities determined who they perceived as approachable for any help or guidance required.

The practice did not have an open culture of sharing information and learning from complaints and incidents. There were no formal practice meetings or alternative arrangements in place to facilitate this.

One staff member reported they felt bullied. Other staff independently told us they had witnessed a member of staff being spoken to in a rude and disrespectful manner on occasions.

The practice closed for half a day every second month for the purpose of staff training. Staff told us that the Clinical Commissioning Group (CCG) provided a package of on-line training they were expected to complete. This included subjects such as information governance. We saw minutes of internal training meetings for reception and clinical staff that GPs at the practice had led in February and April 2014. The minutes recorded the main topic at one meeting had been how to achieve high quality patient care. Other subjects covered included use of the hearing loop, chaperone policy, safeguarding and repeat prescriptions.

Staff who had attended the meetings spoke positively about them. A further training meeting had been scheduled for June 2014 but did not take place. By this time the GP who had organised the previous sessions had left the practice. The minutes showed staff attending training meetings were expected to keep notes in their training folders. We did not see evidence of this. There were no central training records to enable the practice to have a clear overview of the training staff had completed or their and training needs, although the reception manager maintained training records and had completed a skills analysis in relation to her team.

Staff described colleagues within their own teams as supportive. It was clear that individually members of staff were striving to provide quality care and promote good health outcomes for patients. Overall the teams within the practice were not cohesive. Staff groups worked in isolation. There were no opportunities for the whole staff team to meet together to improve upon this. Staff indicated they would welcome the opportunity to do so.

Governance Arrangements

The practice had no clear governance arrangements. Communication between members of the senior team was poor and members did not work collaboratively and steer the practice. There was no clear accountability or agreement on responsibilities.

There was no evidence to show that areas of individual responsibility, in either clinical or non-clinical key areas, had been agreed. For example, named individuals to lead the practice in relation to matters such as appraisal, information governance, risk management, cancer and palliative care.

There were no evidence of clinical audits undertaken within the practice. There was no evidence that the practice had access to quality and clinical data and information to analysis and benchmark their clinical practice.

Systems to monitor and improve quality & improvement (leadership)

There was a lack of management systems to review or monitor service improvements. Senior staff acknowledged they worked in isolation and therefore the systems within the practice were dysfunctional. There was no systematic drawing together of senior leadership to improve quality. The rest of the staff had no guidance as a result.

There was no evidence of formal internal systems to manage clinical supervision or provide support. For example, there were no meetings between the GPs to

Are services well-led?

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

discuss diagnosis and treatment. Neither did the practice have arrangements in place for external peer review. Nursing staff we spoke with confirmed a lack of clinical supervision and guidance.

Patient Experience & Involvement

The practice had produced a complaints leaflet and copies were available from reception. This explained how to go about making a complaint and the likely timescales that could be expected for investigation and resolution. Complaints were received by the practice manager in the first instance who tried to resolve matters informally. There was no GP lead on complaints, with whom the practice manager could liaise over any clinical concerns that arose. The complaints leaflet explained that if people remained dissatisfied with the outcome after internal investigation they were entitled to refer the matter onwards, for example, to the Health Service Ombudsman. The practice had a complaints procedure which set out the practice's approach to handling complaints received. This was undated so it was unclear when it was last reviewed.

We saw a complaints folder which was full of complaints letters and the practice letters of response, dated from 2007. Although most of the responses to the complaints were appropriate the practice did not have a system in place to identify trends or themes.

There was no evidence of a formal system to record receipt and monitor progress in handling the complaint. For example, a summary of dates of receipt and initial response, details of the investigation, date of conclusion and final response. There was not always evidence to show that the complaints procedure had been followed. There were not always records of the investigation or of the response to the complainant. Although the practice manager was able to advise that complaints largely fell into five broad categories there was no analysis work done with a view to learning from them and improving outcomes. It was not clear how the practice acted upon feedback received.

The practice had a small but active Patient Reference Group (PRG). Members met at the practice on a monthly basis and a virtual group was also under consideration to include patients who had expressed an interest in joining but were not able to commit to attending. One member of the PRG reported good attendance by practice staff at their meetings. They told us the practice was receptive to ideas and the PRG's contribution was welcomed and valued. For example, in February 2014 the practice had carried out a patient survey. The PRG had played an active role in the determining the questions to be included. The PRG had been instrumental in the introduction of a new telephone system to the practice whereby callers joined a queuing system rather than receiving an engaged tone if the line was busy.

Practice seeks and acts on feedback from users, public and staff

As practice meetings were not consistently recorded, we saw no evidence as to how the practice sought staff feedback or contributions from staff for the development of the practice.

The PRG was formed in October 2013 and still in its infancy. The group was actively seeking to recruit new members and was supported by the practice in doing so. One of the noticeboards in reception was dedicated to information about the PRG and how to join. Information was also available on the practice website. The chairman told us the PRG had taken part in an initiative called National Patient Participation Group Awareness Week. This involved members spending time at the practice on a rota system to increase awareness and encourage membership. An information leaflet had been created for this purpose and was available in reception.

We saw that a copy of the Patient Reference Group Report summarising their activity until end of March 2014, had been published on the practice website. The report stated that 120 patient surveys had been handed out and 69 returned. Taken overall the survey results were described as positive with 85.5% of patients happy with the care they received.

As part of our inspection we asked the practice to provide a copy of the last patient survey, the results and analysis. This information was not supplied. Neither was it available on the practice website.

Notices in reception encouraged patients to provide feedback. A suggestions box was available in reception for them to do so.

We looked on the NHS choices pages on the website www.nhs.uk. The site encourages the public to provide

Are services well-led?

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

feedback on the NHS services they use. During 2014 nine patients had posted feedback about Poplar House Surgery. The practice had not responded to any of the comments made.

Management lead through learning & improvement

Without clear leadership teams within the practice worked in isolation and often in a chaotic and dysfunctional way, although a shared commitment to the care and welfare of patients was evident. There were no team objectives set. The practice was unable to produce any documented evidence of team working, collaboration or planning together. Neither were staff we asked able to recall examples of when this had occurred.

The staff appraisal policy and procedure was not dated so it was not clear whether it was current. The policy stated all employees would have an annual appraisal but the practice manager agreed this had not occurred. The policy referred to all employees' appraisals being the responsibility of a named GP. Some staff told us the practice manager had started the process of appraisal with them earlier in the year but it had not been completed. Other staff told us they had completed an appraisal with the reception manager.

Identification & Management of Risk

We did not find any system in place for the identification and management of risks within the practice. The system in place for the recording, investigation and learning from significant events was ineffective and did not demonstrate appropriate investigation or auditing of these events.

We did not see risk assessments or a risk register to demonstrate that the practice had an appropriate understanding or recognition of potential risks to patients, staff or the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The provider did not have suitable arrangements in place in order to ensure that staff employed are consistently trained and supported to enable them to deliver care and treatment to service users safely and to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	The provider did not have appropriate systems in place to effectively monitor and assess the quality of the service provided or identify risks within the service. There was no effective system to investigate, record and action any complaints received about the service in order to identify trends and make improvements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	The provider did not have effective recruitment procedures in order to ensure that staff were safely and effectively recruited and employed. Information specified in Schedule 3 was not available.