# Longfleet 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.

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced responsive focused inspection at Longfleet House Surgery on 8 September 2017 and an unannounced comprehensive inspection on 13 September 2017. Overall the practice is rated as inadequate.

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

- The practice was purpose built with good accessibility.
- There were well managed infection control processes, with a good standard of cleanliness and hygiene.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice did not carry out routine tests for fire safety and did not check that emergency medicines and equipment were fit for purpose.
- Staff knew how to report incidents, near misses and concerns but learning from incidents and communication with staff was not always shown to be taking place.
- The practice had carried out a small number of audits to help improve patient outcomes.
- The practice did not demonstrate that there was a current understanding of quality markers or patient surveys at the inspection.
- There was a shortfall of routine appointments which had led to frequent verbal complaints from patients around appointment availability.
- Urgent appointments were available on the day but both urgent and routine appointments were subject to reception staff triage processes that could result in refusal of an appointment.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Staff were unsure who had clinical oversight on a daily basis.

# Summary of findings

- Staff absences were not covered by other staff and there was a shortfall in GP led clinics.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.

The areas where the provider should make improvement are:

- Improve processes for making appointments.
- Provide training so staff are competent to use the computer systems and procedures.
- Seek feedback from patients and work with the patient participation group.
- Assess the provision for patient confidentiality, particularly when making an appointment or conversing at the reception desk.
- Ensure there is an effective system for identifying, receiving, recording, handling and responding to complaints by patients and other persons in relation to the carrying on of the regulated activity.
- Ensure that all emergency medicines stored in the practice are monitored to ensure that they are in date.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

Special measures will give people who use the service the reassurance that the care they get should improve.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Inadequate

The practice is rated as inadequate for providing safe services.

- There were good processes in place for infection control and the practice was clean and hygienic.
- Non clinical staff undertook chaperone duties if required.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Although risks to patients were assessed, the systems to address these risks were not embedded to ensure patients were kept safe. We were informed that a legionella risk assessment had been carried out in August 2015; however there was no documentation regarding this. Since August 2015 there have been no documented water temperature checks, water sampling or flushing of water pipes in accordance with regulatory requirements.
- The fire alarm systems had not been routinely tested.
- There was no systematic procedure to ensure that emergency equipment and medicines were checked to ensure they were safe and effective for use.

**Are services effective?**

Inadequate

The practice is rated as inadequate for providing effective services.

- There was limited evidence of audits or quality improvement to help improve patient outcomes and there was no evidence that the practice was aware of their performance in comparison to other practices.
- There was minimal engagement with other providers of health and social care, although the nursing staff did attend multi-disciplinary meetings.
- The appraisal process for non-clinical staff was not always undertaken on an annual basis and there were examples of little support for any extra training that may be required for certain staff roles.
- Nurses did not benefit from a regular system of clinical supervision due to there being no regular GP at the practice every day.
- GPs did not have a formal or informal communication system to discuss patient outcomes or treatment.

# Summary of findings

- Patients with long term conditions or complex needs were not always able to make routine appointments and there was a risk that some reviews could be missed due to staff shortages.
- Patients were signposted to relevant live well initiatives.

**Are services caring?**

**Requires improvement**

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

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. This included time taken by GPs to listen to patient needs and GPs treating patients with care and concern.
- The majority of patients said they were treated with compassion and respect. However, not all felt cared for, supported and listened to.
- There was a telephone triage system in place that was undertaken by reception staff to determine whether patients could get an appointment. This meant that patients did not always get an appointment on request and there would usually be a need to tell reception staff sensitive information.
- Information for patients regarding local voluntary services was available in the reception area.
- The practice had identified a large number of carers.

**Are services responsive to people's needs?**

**Requires improvement**

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

- Although the practice had reviewed the needs of its local population, it did not have a plan to secure improvements for all the areas identified.
- The practice had accessible facilities.
- Text message reminders for appointments were sent out on request.
- Feedback from patients reported that access to a named GP and continuity of care was not always available, although urgent appointments were usually available the same day.
- Home visits were not always available for patients due to the increased reliance on locum GPs.
- The practice had identified some patient groups, including vulnerable children and those with mental health needs.
- Extended hours on a Monday evening were not currently offered due to staff shortages.

# Summary of findings

- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from written complaints had been shared with staff.
- Staff stated that there were a large number of verbal complaints. These were not logged but were generally dealt with at the time of the complaint.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led.

- The practice did not have a clear vision and strategy. Staff were not clear about their responsibilities in relation to the vision or strategy.
- There was no clear leadership structure and staff did not feel supported by management.
- The practice had a number of policies and procedures to govern activity, but these were issued by the management company and were not always practice specific or accessible.
- Whilst the practice did hold regular governance meetings these did not have action points or learning from the meetings to inform the practice of areas of good governance.
- The practice had not proactively sought feedback from staff or patients and did not have an active patient participation group.
- Staff told us they did not have clear objectives and found that their workload had increased significantly in the last year as staff left and were not replaced.
- Staff absences were not always covered and this had led to incidents where there had been a backlog of correspondence, results or reviews. The specific training needs of staff were not always addressed and there was a lack of support and mentorship.For instance a member of staff had recently joined and had little clinical induction or staff support for their first two weeks.
- There were plans to employ further staff but this was not implemented at the time of the inspection.

# 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 issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of older people.

- The safety of care for older patients was not a priority and there were limited attempts at measuring safe practice.
- Patients were unable to book routine appointments.
- The care of older patients was not always managed in a holistic way.
- Home visits were not always available.
- The practice had recently employed a health care assistant to ensure that over 75 year health checks would be undertaken going forwards.

### People with long term conditions

Inadequate

The issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people with long term conditions.

- Longer appointments and home visits were not always available when patients needed them.
- Structured annual reviews were undertaken by the nursing staff to check that patients' health and care needs were being met.
- The appointment and staffing arrangements meant that there may not be clear communication for continuity of care for these patients with regards to GP care and treatment.

### Families, children and young people

Inadequate

The issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of families, children and young people.

- There were few appointments available after school hours and a limited number of routine appointments available.
- There were systems in place to identify patients in this group who were living in disadvantaged circumstances and who were at risk.
- The practice had a dedicated area for children to play in safely.
- Some contraceptive services were undertaken at the practice.

# Summary of findings

**Working age people (including those recently retired and students)**

Inadequate

The issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of working age people (including those recently retired and students).

- The practice did not currently offer extended opening hours on Monday evenings as there was a shortfall in GP availability.
- Patients had not been able to book routine appointments in the last few weeks.
- Health promotion advice was offered but there was limited health promotion material available through the practice.
- There was a low uptake for both health checks and health screening.

**People whose circumstances may make them vulnerable**

Inadequate

The issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

- The practice identified patients whose circumstances may make them vulnerable or who had a life-limiting condition. However, their needs and preferences were not evidenced in care planning and continuity of care.
- There was a register of patients with a learning disability and this population group were evidenced to have specific annual reviews.
- All staff were trained to the appropriate safeguarding level but not all staff were sure who the practice safeguarding lead was.
- The practice nurse was aware of all documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However there was no safeguarding information easily accessible for locums at the practice.

**People experiencing poor mental health (including people with dementia)**

Inadequate

The issues identified as inadequate overall affected all patients including this population group. The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

- The practice was able to evidence that it could identify all patients

# Summary of findings

- The practice had worked with multi-disciplinary teams in the case management of patients experiencing poor mental health but there were staff shortages and a lack of GP availability to monitor all patients.
- There was evidence that the practice did not have enough clinical availability to ensure consistent advance care planning for patients with dementia.
- The practice had a shortage of routine appointments and therefore could not guarantee that patients suffering with a mental health need were able to make an appropriate appointment.
- Some staff had received training on how to care for people with mental health needs but specific training on dementia care was not provided.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in March 2017. The results showed the practice was generally performing lower than local and national averages at this time. Of the 242 survey forms that were distributed 109 were returned. This represented nearly 3% of the practice's patient list.

- 77% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 90% and the national average of 85%.
- 72% of patients described their experience of making an appointment as good compared with the CCG average of 82% and the national average of 85%.
- 66% 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 83% and the national average of 77%.

We spoke with seven patients during the inspection. Five of these patients had made urgent appointments that day, and three of them stated that they rarely booked routine appointments. Two patients were unhappy with the recent changes in staffing but all stated that generally the clinical staff were caring and that the reception staff were approachable and friendly. All felt that the surgery was clean and tidy.

Recent NHS Choices data highlighted issues patients found with continuity of care, medication given contrary to best practice, and the more general issue with difficulty in getting a routine appointment.

# Longfleet House Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

The inspection team on 8 September 2017 included a CQC Lead Inspector and a GP specialist advisor. The inspection on 13 September 2017 was led by a CQC Lead Inspector and the team included a GP specialist adviser and a practice manager specialist adviser.

## Background to Longfleet House Surgery

The practice is situated in the town of Poole in Dorset in a purpose built practice building that is privately owned.

The current patient list is approximately 4,200 and covers a diverse age group, with a larger than average percentage of elderly patients aged 80 years and over. The practice has recently undergone some staff and operational changes, with two long serving GP partners retiring in the last two years leaving two male GP partners registered at the practice. One of the remaining partners has retired from general practice but still attends the practice in an advisory role, as they are no longer on the performers list. (The performer's list is a register of GPs who are currently licensed to treat and care for patients).

The other GP partner, who is also the registered manager, does not have any regular clinical sessions at the practice. There are two male salaried GPs. One undertakes six clinical sessions per week and the other GP (who is employed from another practice in Bournemouth) undertakes two sessions in total. The practice regularly employs locum GPs to cover an additional two clinical sessions per week. At the moment there are ten GP sessions offered each week in total, although this is increased when there is additional GP availability.

There is also a pharmacist that works two mornings per week, an advanced nurse practitioner (employed by a sister practice) who works one day per week, a practice nurse who works 30 hours per week and a health care assistant who works 26 hours per week. In addition there is a practice manager (who works across another practice half the week), a deputy practice manager and a reception team.

The practice is supported by Integral Medical Holdings Ltd (IMH) who also provide personnel and training services to the practice.

The practice has a General Medical Services contract with NHS England. The practice provides regulated activities from the main site at 56 Longfleet Road, Poole, Dorset. BH15 2JD.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the local clinical commissioning group to share what they knew. We carried out a focused inspection on 8 September 2017 with twenty four hours' notice, following a specific concern regarding a shortfall in staffing levels. The inspection on 8 September 2017 led to further concerns. Therefore we carried out an unannounced comprehensive inspection on 13 September 2017.

During our visits we:

- Spoke with a range of employees including GPs, a nurse, a health care assistant, a practice manager and reception/administrative staff.We also 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 a sample of the personal care or treatment records of patients.
- 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 living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system for reporting and recording significant events but this was limited in scope as we found that not all events were being recorded:

- Staff told us they were able to inform the practice manager or deputy practice manager of incidents and there was a recording form available on the practice's computer system.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The management company had introduced a system called 'Radar' which enabled significant events to be recorded. This meant that there was a system in place that could be used for discussion at staff meetings and provide action for all incidents. However, practice meeting minutes did not demonstrate that this had recently been used.
- A significant event had occurred at the practice in August 2017 which had not been reported internally or externally.For several days the electronic prescriptions had not been sent to the relevant pharmacies and this was not identified. The issue was only rectified when one of the pharmacies told the practice they had not been receiving prescriptions. The incident was not discussed with staff in the practice to identify any learning points which could be put into place. The event was attributed to the new computer system but there was no monitoring of the system to ensure that this did not happen again. The practice could not demonstrate that patients had been informed of the event.
- Safety alerts were recorded on a spreadsheet by the practice management and this was up to date with the recent relevant alerts. For example there was a recent alert regarding the disposal of batteries within the practice that had been recorded and actioned.

**Overview of safety systems and processes**

The practice had systems, processes and practices in place but they were not always implemented to ensure that risk to patients was minimised.

- Arrangements for safeguarding reflected relevant legislation and local requirements were considered by the practice. The practice nurse demonstrated a good knowledge of processes and contacts. The safeguarding policies were accessible in each clinical room. The safeguarding lead was the retired GP partner, who still attended the practice in an advisory role and liaised with the practice manager. However not all staff were aware of who the safeguarding lead was for the practice.
- Staff interviewed at the inspection demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. For example, GPs were trained to safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones 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). However, when asked, not all staff had been trained for the role but had still undertaken the chaperone duties.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. The practice employed an outside cleaning agency and there were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who 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. Any issues were passed to the practice management.

The arrangements for managing medicines, including emergency medicines and vaccines, were not always in line

with good practice and had an implication for patient safety. This included processes with obtaining, prescribing, recording, handling, storing, security and disposal of all medicines.

- There was a procedure for ensuring that emergency medicines were monitored but errors were found.For example, on the day of inspection it was found that both adrenaline and the chlorpheniramine were out of date. Both medicines are used to treat severe allergic reactions.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a process to ensure this occurred. However there was a period of time when repeat electronic prescriptions were not being processed. Although this had been blamed on the technology changeovers at the practice, it demonstrated that the systems were not always reliable.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. These were all correctly authorised.
- There were two vaccine refrigerators. Both vaccine fridges had log of temperature checks to ensure that the temperature ranges were within the permissible levels. However one was plugged in with an extension lead and there was nothing to stop anyone accidently switching the power off.
- Personnel files and recruitment information were held by the management company. However on the day of inspection we were able to view the documentation for a directly employed locum and there was proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. (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).

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety but these were limited in scope.

- The practice did not have a health and safety policy available.
- The staff had received fire safety training but there was no evidence of fire drills having taken place. The fire alarm had not been tested since November 2016, despite the fire risk assessment recommending twice yearly checks.
- All electrical and clinical equipment had been checked and calibrated to ensure it was safe to use and was in good working order.
- The clinical waste was evidenced to be correctly disposed of and there was paperwork to demonstrate that it was regularly collected in line with regulations.We were informed that a legionella risk assessment had been carried out in August 2015. However there was no documentation regarding this to explain if any recommendations may have been made to the practice including water temperature checks or flushing water through pipes. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We were informed that there were inadequate arrangements to ensure enough staff were on duty to meet the needs of patients, since staff had left the practice in the past year. For example, there were days when not enough GPs were on duty to cover clinics. When the practice nurse was on annual leave no cover was provided. We found there was a shortage of routine appointments available and a reduction in clinician sessions on a weekly basis.

**Arrangements to deal with emergencies and major incidents**

The practice generally had adequate arrangements to respond to emergencies and major incidents but there were some shortfalls.

Inadequate

# Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room, although some of these were out of date.
- The practice had a defibrillator available on the premises and oxygen.
- The practice had a business continuity plan for major incidents such as power failure or building damage.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

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

- The practice had updated their computer systems in the last few weeks and there were policies in place to keep all clinical staff up to date. Staff had access to NICE guidelines.
- The practice could not demonstrate that they comprehensively monitored that guidelines were followed. There were no practice risk assessments, audits or random sample checks of patient records. During the previous month a software package had recently been installed on the practice computer system. This enabled the clinical staff to track and monitor alerts. This new system had the ability to provide information that would enable the GPs to monitor patient treatments more effectively in the future.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015-2016 were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95%.

For the period 2015-2016 the practice was not an outlier for any QOF (or other national) clinical targets. Data showed:

- Performance for diabetes related indicators was overall lower than the CCG and national averages. For example there were 82% of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was at or below an acceptable level. This compared to the clinical commissioning group (CCG) average of 93% and the national average of 92%.
- Performance for all mental health related indicators was lower that the CCG and national averages although there were areas where the practice scored more highly.For example, 93% of patients diagnosed with a psychosis had a documented care plan in place compared to a CCG average of 91% and a national average of 86%.
- Performance for asthma related indicators was in line with the local and national averages.For example, 73% of patients had received an asthma review in the preceding 12 months, compared to the CCG average of 77% and the national average of 76%.

For all indicators the overall exception rate was 8%. This compared to the CCG exception rate of 13% and the national rate of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

There was little evidence of quality improvement including clinical audit in the last two years:

- There was evidence that the GPs undertook their own audits for their revalidation and appraisal purposes but there was no evidence that these were used for quality improvement within the practice.
- There was a corporate clinical audit programme in development with Integral Medical Holdings Ltd, which was contracted to provide management support to the practice. However there were no practice generated clinical audits evidenced at the time of the inspection for the last year.

**Effective staffing**

The practice was contracted to be managed by Integral Medical Holdings Ltd (IMH) that held all recruitment and training profiles for all staff.

- The management company had an induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice used a software package that recorded all training that staff undertook. All staff were sent an email each week which highlighted training needs. Training was designed to be role-specific. However one member of staff had not received the correct training for the new

system and was unable to access all the information they required for their job role. Another member of staff did not have the correct passwords to access the system on the day of the inspection.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through appraisals, meetings and reviews of practice development needs. Support was given for revalidating GPs and nurses. However not all staff had received an appraisal in the last year, as per the practice policy.

**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 and their intranet system.

- Recent annual leave by the salaried GPs and nurses had not been covered by other staff. Staff highlighted to us that continuity of patient care, and co-ordination of this, had not necessarily taken place while the regular clinicians had been absent.
- Administrative staff read all hospital letters and then worked to a practice protocol that indicated which letters to file and which to pass to the GPs. This protocol allowed for changes to medicines to be made by the reception staff who passed the changes to the GP for authorisation. We were not informed of audits or processes in place to check that any changes were checked by the GPs.
- On the 8 September 2017 we found that seven outstanding cervical smear results had not been filed, and some had been held by the practice for nearly two weeks. Staff were unsure who was responsible for the filing of these. There were also medicine requests from the previous two days that had not been actioned.
- In the week prior to the focused inspection there were two days when nearly 200 outstanding pathology results that had not been looked at or filed. These were cleared during the 24 hours' notice period before the inspection on 8 September by a GP partner. However, staff were unsure who was responsible for ensuring that all pathology results were looked at and filed each day.
- Locum staff were employed at least one day a week at the time of the inspection. They were not taking responsibility for the monitoring of test results or daily patient correspondence, even if they were the only GP at the practice that day.

Practice staff aimed to work together with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence of this with the identification and reviews of patients with learning disabilities. Staff stated that they did not have adequate time each week to ensure that this was thorough. This included when patients moved between services, when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with the practice nurse and other health care professionals on a monthly basis when care plans were reviewed and updated for patients with complex needs.

**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. There was evidence that consent was gained by the GPs where needed.

**Supporting patients to live healthier lives**

The practice nurse and health care assistant provided evidence of their monitoring of certain patient groups and there was planning for health checks in the over 75 year age group. However:

- There was no evidence that there was a programme of identification for patients in need of extra support.
- Nursing staff acknowledged that they did not have time to implement health programmes such as smoking cessation advice. However the practice nurse was able to signpost patients to live well initiatives.

Inadequate

# Are services effective?

## (for example, treatment is effective)

The practice's uptake for the cervical screening programme in 2015-2016 was 84%, which was comparable with the CCG average of 83% and the national average of 81%. At the time of the inspection the unpublished data from the practice showed that the cumulative uptake over the last 66 months was now 69%.

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

During our inspection we observed that members of staff were courteous to patients.

- 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.
- The reception area was small and therefore patients could be overheard at the desk by patients in the waiting room.
- There was no female GP employed at the practice therefore patients could not always be seen by a GP of the same sex if requested.
- There was a triage system in place when patients called to make an appointment. This was led by reception staff, working to a specific practice flowchart, who would ask patients to outline their needs in order to determine if a GP appointment was necessary. This had raised issues with some staff regarding privacy and concerns surrounding refusing a GP appointment to a patient. Patient comments that were reviewed included statements that this process could be distressing. Staff stated that they sometimes found it difficult to undertake the triage process due to the resulting patient upset and complaints made.

We spoke with five patients during this inspection. They told us they were satisfied with the care provided by the practice. They were concerned that the practice had experienced staff changes recently and that there were no routine appointments available. Most patients we spoke with had urgent on the day appointments and generally had confidence in the GPs and nurses that they saw.

Results from the national GP patient survey from March 2017 showed patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs but average for consultations with nurses. For example:

- 81% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 81% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 86%.
- 95% of patients said the nurse was good at listening to them compared with the CCG average of 94% and the national average of 91%.
- 94% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

Furthermore a significant minority of patients found the service to be poor in certain areas. For example:

- 13% of patients described the overall experience as poor compared to the CCG average of 3% and the national average of 5%.
- When the patient had a preferred GP, 48% stated that they do not get to see or speak to that GP, compared to the CCG average of 33% and the national average of 40%.

There was no indication that the practice was aware of, or had a plan in place, to improve these scores.

**Care planning and involvement in decisions about care and treatment**

There was a focus on urgent appointments that were bookable on the day. There had been verbal complaints to the practice staff that they were unable to make routine

appointments. Patients were generally seen on the day, but only if they called at specific times of the day. For example, we saw that patients were told that they would have to call back later in the day in order to be seen at the end of the afternoon, and were not offered an alternative. One patient stated that it had been very difficult to make an appointment for their partner who suffered from a long standing condition. Another patient went to the practice as they were concerned that it had been several months since they had been due a specific diagnostic test and they had received no correspondence from the practice. This patient was seen that day as an urgent appointment.

Results from the national GP patient survey showed how patients responded 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 nurse related questions, but below average for GP related questions. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 82%.
- 96% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets for common complaints and patient needs were available in easy read format and clearly accessible in the reception area
- There was a clearly accessible box for repeat prescription requests and a box for complaints.
- The reception area was fitted with an induction loop for patients fitted with hearing aids.
- There was clear advice regarding where to go if the practice was closed.

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 139 patients as carers (3% of the practice list). These had been identified through opportunistic appointments, new patient registrations and by self-identification. A health care assistant was the lead for monitoring carers and there were plans to contact all carers in the coming year to assess if any extra support was needed.

Staff told us that if families had experienced bereavement it was noted on the relevant patient notes and the information was passed to the relevant organisations on behalf of the family involved. The practice was able to signpost to the relevant support and counselling services.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice understood its population profile but was not always able to meet the needs of its population:

- There were accessible facilities, which included a hearing loop, and interpretation services.
- Other reasonable adjustments were made including the lowering of the reception desk for those using a wheelchair.
- Home visits were usually available for older patients and patients who had clinical needs which resulted in difficulty attending the practice such as those with chronic breathing difficulties. However there had been occasions where a locum GP had declined to undertake home visits patients had requested.
- As part of the new computer system the practice now had software that would help clinicians with chronic disease management and management plans.
- The nursing staff were responsible for all patients with long term conditions, and to ensure that they had regular monitoring of their condition where required.
- The practice did have a register for patients with certain conditions, including those requiring palliative care. However these registers were not actively used by the GPs and we were informed on the day of the inspection that there was not regular contact with the hospice and palliative care team to promote shared care.
- The practice sent text message reminders of appointments and test results on request.
- There was a system in place for the recall of patients that needed an assessment by the nursing and administrative staff.
- Patients were able to receive travel vaccines available on the NHS.

**Access to the service**

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12.00pm and 2.30pm to 4.30pm daily. Extended hours appointments had been offered on a Monday evening from 6.30pm to 7.30pm but due to staff shortages this was not offered at the time of the inspection and was there was no information available regarding when this would be offered again. The practice was also unable to offer the minor surgery for skin lesions that it was registered to provide. Patients had not been informed when these services would be available again. There was a limited number of routine appointments available. At the first inspection on 8 September there were no routine appointments available for patients to book. On the second day of inspection on 13 September there were only five bookable appointments for the 27 September and no others were offered. However urgent appointments were available on the day.

Results from the national GP patient survey in March 2017 showed that patient's satisfaction with how they could access care and treatment was comparable or below local and national averages.

- 69% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 76% of patients said they could get through easily to the practice by phone compared to the CCG average of 84% and the national average of 71%.
- 88% 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 90% and the national average of 84%.
- 85% of patients said their last appointment was convenient compared with the CCG average of 88% and the national average of 81%.
- 72% of patients described their experience of making an appointment as good compared with the CCG average of 82% and the national average of 73%.
- 46% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

The practice had a system to assess:

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

The reception staff would normally refer to a triage flowchart when patients called to make an appointment. Reception staff would therefore enquire about the patient need. The information given could result in an appointment being offered, a telephone consultation, or

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

neither. If an appointment was indicated the flow chart stated that the reception staff could use their discretion whether to provide the patient with a nurse or GP appointment.

We found that reception staff had some unease regarding using the triage flowchart although the process had been risk assessed by a clinician at the practice. There was an acknowledgement by staff that the concept of triage was good, but generally there was discomfort in asking personal questions and receiving a sometimes abusive response when a GP appointment was not given. Reception staff stated that if the patient asked for an appointment, and then complained if they did not get one, then generally they were seen as an urgent appointment if possible. All staff stated that verbal complaints had increased considerably in the last few months, and they identified the main issue as lack of GP sessions, and particularly the lack of routine appointments. NHS Choices had comments on its website that patients considered the reception triage difficult and potentially unsafe.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for an appointment or a GP home visit, the patient was told to either call NHS 111 or attend the local accident and emergency department. Permanent clinical and non-clinical staff at the practice were aware of their responsibilities when managing requests for home visits, but there were occasions where home visits were not always available.

**Listening and learning from concerns and complaints**

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Written complaints were seen to be dealt with appropriately and information added to the practice database for further learning and investigation.
- There was a designated responsible person who handled all written complaints in the practice.
- We saw that information was available to help patients understand the complaints system and the complaints leaflet gave appropriate advice on progressing the complaint if necessary.
- Feedback was given to individual staff if required or generally at a staff meeting, although these were clinical meetings only and did not include reception staff.
- The practice management discussed complaints with the complaints lead, who had retired from the partnership, but now worked as an advisor to the practice.

We looked at 15 complaints received in the last 12 months and found that 11 of these were clinical and four were non-clinical. These were all written complaints and had been dealt with in a timely fashion. However we were also informed that there were verbal complaints, mostly to the non-clinical staff regarding appointment availability, but also to clinical staff too. These were not recorded, but were generally dealt with at the time by the staff member concerned or by the practice manager. Staff stated however that they received a large number of verbal complaints, particularly in the last couple of months.

# Are services well-led?

Inadequate

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

## Our findings

**Vision and strategy**

Practice staff were unable to explain to the inspection team the vision, values or direction of the practice for the future.

- The registered manager was clear that the future of the practice involved a merger with two other IMH supported practices. Practice staff however were unsure who or what the leadership of the practice was, who it was that they actually worked for, and what the future plans were for the practice.
- Practice staff generally did not feel that there was a strategy in place regarding future staffing or delivery of care.

**Governance arrangements**

There was a shortfall in the provision of a governance framework to support the delivery of the strategy and good quality care.

- Two GP partners had left the practice in the last two years. Of the two remaining GP partners, one did not attend the practice regularly and the other had retired, but did come into the practice in a supportive role for two days a week.
- There was a shortfall in the delivery of GP clinical sessions. At the time of the inspection there was generally only one GP rostered per day and this had meant that there was a maximum of ten GP clinical sessions per week, instead of the 16 GP clinical sessions that the practice had previously been providing.
- All staff stated that there was a severe shortage of clinical staff, and there was evidence that the nursing staff and salaried GPs were working longer hours than they were contracted to in order to see urgent patients on the day and monitor some patient groups.
- There was no overall understanding of the quality markers at the practice with no routine audits and monitoring of patient data. Clinicians, when asked, did not have a comprehensive understanding of the performance of the practice.
- Practice meetings were held for some staff, but did not include reception staff. There were no regular clinical meetings for the GPs and no opportunities for regular communication or peer review between the GPs.
- The GP partner (who was also the registered manager) stated that he had the overall clinical responsibility for the practice. However, the partner was not at the practice every week and did not undertake clinical sessions with patients. Day to day clinical responsibility had not been delegated to another clinician. Most staff when asked on the day of inspection were unsure who had the overall clinical responsibility for the practice.
- Practice staff had some concerns regarding the extensive use of locums and the varying quality of the locums that were supplied. Most locums were not regularly employed and therefore this had contributed to further issues with continuity of care for patients.
- The nursing staff did not feel supported by the leadership. There were specific concerns regarding a lack of risk assessment for sole working when there was no GP immediately available. This was of particular concern to nurses who undertook vaccinations as there was a risk of a serious adverse reaction for which they might need clinical assistance.
- There had been no cover provided for some salaried staff that had been on annual leave.An example was the when the practice nurse had taken two weeks leave in August 2017. This had meant that there had been issues with continuity of care for some patients and an increase in workload for the staff on return to work.
- A health care assistant had recently started work when there had no direct clinical support for their induction. A practice nurse had been required to provide some support despite being on annual leave.

**Leadership and culture**

We spoke to the registered manager who did not show a clear knowledge of the clinical sessions and staffing levels of the practice at the current time. It was stated that there would soon be recruitment of a GP for the practice in order to reduce the reliance on locum GPs but this had not been finalised at the time of the inspections. There had been a change of computer system in the last two weeks. The registered manager stated that this had given the impression that there had been a backlog of pathology

# Are services well-led?

Inadequate

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

results, which was thought to be misleading. We were told the change of computer system had contributed to other issues such as the electronic prescriptions incident and the regular appointment availability. However no evidence was offered at the time of the inspections that showed this to be the main reason for the issues outlined.

The partner who had retired as a GP still checked pathology results, acted as lead for certain areas and gave advice where needed. However the doctor was no longer registered on the NHS Performers' List, and as such was not registered to perform further clinical duties.

The provider was aware of the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice staff felt that a culture of openness and honesty did not always exist at the practice and that the management company were not approachable or accessible.

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

The practice did not act upon feedback from staff or patients:

- There was no active patient participation group (PPG). The latest minutes recorded for the PPG were in 2013.
- Positive or negative comments about service provision made by patients via the NHS Choices website had not been acknowledged or responded to by the practice.
- The practice management had not carried out recent staff surveys and there were no recent whole practice meetings. Clinical staff considered that they were up to date with appraisals. Non-clinical staff did not consider that they had enough regular contact with management or were up to date with their appraisals.
- Staff said they did not feel engaged in the running of the practice and did not feel supported by the leadership team. They did not feel that they had been listened to by management generally and some staff felt that their work was not appreciated.
- Four members of staff stated to the inspection team that the verbal complaints were directly leading to increased stress and unhappiness at work. Two members of staff had decided to leave their employment and both stated that this was because of the stressful working environment.
- It was unclear, as there was no record, if the partners and management company were aware of the level of verbal complaints that the staff were receiving. There was no training or advice or support to help staff to deal with the stress and workload associated with managing concerns and complaints. Staff had support from the local practice management for daily issues, but there was no clear line of management responsibilities and accountability for when there was an escalation of issues.
- The leadership team did not consider that there were any shortfalls in the number of clinical sessions provided and that there were any issues with clinical governance or continuity of care for patients.
- The leadership did consider that there was an underlying issue with the number of patients leaving the practice in the last year, which was around 500 registered patients.
- There was little provision for reflective practice or team communication.

**Continuous improvement**

We found clear shortfalls in the delivery of clear and effective leadership. Staff said they were not motivated and did not feel appreciated. There was no future plan in place that provided reassurance to staff that there would be improvements. There was a shortfall in all areas of staffing, although the leadership did state that they would be employing another salaried GP in the next few weeks. This could not be confirmed at the time of the inspection. There were early plans to merge with at least one other local practice, according to the practice management, but this had not been formalised at the time of the inspections and no notification had been given to the clinical commissioning group regarding this intention.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met**<br>The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. In particular:<br>• There had been a reduction in clinical sessions and appointment availability due to an ongoing shortage of clinical staff, and the practice was unable to meet the requirements of the patient population.<br>• There were some staff training requirements that needed addressing, particularly with reference to IT systems and procedures and the provision of chaperone training.<br>This was in breach of the regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

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<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. They had failed to identify the risks associated with the lack of GP appointments, the shortfalls in the recruitment and retainment of staff and the need for clear clinical leadership.<br>There was no recorded assessment of the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. In particular:<br>• The monitoring of water quality with regard to the legionella bacterium.<br>The premises being used to care for and treat service users was not being used in a safe way. In particular:<br>• There was no health and safety policy in place, and the fire alarm testing and drills were not being regularly undertaken.<br>• There was no risk assessment in place for when there was a sole clinician on the premises. |

This section is primarily information for the provider

# Enforcement actions

This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met**<br>There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services provided. In particular:<br>• In the absence of the lead GP, who is the registered manager and one of the two practice partners, it was found that the day to day clinical responsibility had not been delegated to another clinician<br>• There was lack of support for staff with regards to leadership and acting on feedback.<br>• Patient feedback was not always taken into account.<br>• Governance arrangements did not support the delivery of good quality care. There was a shortfall in the delivery of GP clinical sessions.<br>• Systems were not in place for acting on test results.<br>• Systems were not in place for ensuring completion of training requirements for staff.<br>This was in breach of the regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |