Dr Srinivas Dharmana

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?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr Dharmana's Family and General Practice. Our inspection was a planned comprehensive inspection, which took place on 1 October 2014. Dr Dharmana delivers services under a General Medical Services contract.

The service provided by Dr Srinivas Dharmana is rated as inadequate.

All five domains for Safe, Effective, Caring, Responsive and Well Led were rated inadequate

Our key findings were as follows:

- We received positive comments from patients we spoke with during the visit. They were complimentary about the reception staff.
- Although Dr Dharmana had not been providing clinical care since November 2013 patients spoke highly of him.
- There were no systems in place to monitor the quality and safety of the service provided to patients. Evidence of analysis of significant events was not available for 2014 and nor was there evidence of recent clinical audits.
- The quality of service provided to patients by locum GPs was not monitored. Systems to ensure information was shared with locum GPs for example alerts for medicine and equipment were not in place.
- Equipment to respond to medical emergencies was not accessible and when located was not adequately resourced to respond to a medical emergency. Checks to monitor medicines and medical equipment held at the practice were not undertaken.
- Systems to monitor and respond appropriately to safeguarding concerns were not robust nor were staff pre-employment checks. .
- Health and safety risk assessment were not up to date.

Importantly, the provider must:

- The provider must take action to protect service users (patients) from the risks of inappropriate or unsafe care and treatment. There was no system in place to

Summary of findings

regularly assess and monitor the quality and safety of the service provided. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

- The provider must take action to identify, assess and manage risks or potential risks relating to the health, welfare and safety of patients and people working at the practice. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must ensure that incidents and significant events are recorded, analysed and action taken to minimise the risk of potential harm to patients. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must ensure information alerting of potential issues with medicines and equipment is shared so that where necessary changes to the treatment or care provided to patients is undertaken swiftly. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must ensure that patients' views about the service they receive are obtained and action is taken as required to improve the service provided. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must take action so that patients are protected against the risks of receiving care or treatment that is inappropriate or unsafe. Adequate measures to monitor the safety of care and treatment delivered were not in place. The provider is failing to meet Regulation 9(1) and (2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must take action to ensure that suitable arrangements are in place so that all staff respond appropriately to any safeguarding concern and to report any safeguarding concerns to the appropriate body. The provider is failing to meet Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must take action to ensure sufficient information is provided to patients in relation to their care and treatment. Patients were not informed of choices available to them regarding accessing healthcare services that were no longer being provided at the GP practice since November 2013. The provider is failing to meet Regulation 17(2)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must take action to protect patients' health, welfare and safety by ensuring suitable arrangements are in place to share information with other health care professionals so that patients receive continuity of care when they move between services. The provider is failing to meet Regulation 24(1)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
- The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008, to ensure necessary employment checks are in place for all staff. The provider is failing to meet Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the basis of this inspection and the concerns identified which have resulted in an inadequate rating for all domains I am placing the provider into special measures. This will be for a period of six months. We are currently piloting our approach to special measures, working closely with NHS England. The proposals we are piloting are that GP practices rated as inadequate for one or more of the five key questions or six population groups will be inspected no longer than six months after the initial rating is confirmed. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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 was rated as inadequate for the domain of safe and improvements are required.

There was no effective system in place for the handling of Medicines and Healthcare products Regulatory Agency alerts (MHRA alerts) in relation to medicines used regularly in the treatment of some patients. There was no access to on-line intranet resource, which locums or the practice nurse could use to research current best practice guidance and updates on the treatment of particular conditions.

There was a lack of systems in place to monitor the safe running of the practice, for example serious incident review and analysis. There were no clear lines of accountability in relation to incident recording and reporting and no measures in place to share learning from findings of those investigations.

Lead responsibility for the handling of information in relation to patients subject to a safeguarding plan had not been established. Staff were unable to locate emergency drugs and equipment quickly. When these were found, they were in an unmarked box and contained out of date drugs and equipment that was not suitable for use. Following a security incident at the practice, there had been no review of lone working of staff and there was no policy in place for staff to refer to on lone working.

Are services effective?

Inadequate

The practice was rated as inadequate for the domain of effective and improvements are required.

Patients registering with the practice did not always receive a new patient appointment, where their needs were correctly assessed.

There was no benchmarking of patients and performance of their corresponding treatments over time. Benchmarking allows a doctor to see how fast an illness is progressing, or how quickly or well a patient responds to treatment, for comparison with expected results.

Attendance of patients at the local children's accident and emergency unit was higher than that of a practice of a similar size. The provider told us that parents of children preferred to use the local children's A&E unit, rather than seek treatment from the locum GPs at the practice. There were no pro-active measures in place to address this.

Summary of findings

No plans had been put in place to recruit a person with practice management experience on a temporary basis to cover the long term absence of two key staff members. It was not clear how the practice management function was being delivered.

Screening and monitoring of patients with chronic conditions was not delivered in a consistent and systematic way.

Are services caring?

Inadequate

The practice was rated as inadequate for the domain of caring and improvements are required.

Our observations of reception staff confirmed that patients were treated with dignity and respect. Although the reception and waiting areas were in close proximity to each other, reception staff were aware of patients' right to privacy and offered the use of a more private room for any patient who required this, for example when registering with the practice.

Patients spoke highly of Dr Dharmana, and valued the continuity of care he had provided until recently. Patients felt they did not receive continuity of care from the locum GPs who had been delivering services since the end of 2013.

The provider confirmed that some of the services the GP practice was registered to deliver were not being provided by locum GPs, for example minor surgery or contraceptive implants. However information was not provided to patients, informing them of choices they could make on how and where they could go to receive those services.

Systems to canvas patients' views on the service were inadequate. The provider had contracted an outside company to collect patient views, but results from that survey were not collated. There was no action plan or other steps in place to address reasons why parents preferred to take children to the local accident and emergency unit, rather than seek primary care from locum GPs delivering services at the practice.

Are services responsive to people's needs?

Inadequate

The practice was rated as inadequate for the domain of responsive and improvements are required.

The practice did not have a patient participant group, who could channel patient feedback, complaints and concerns to the practice.

The provider was unable to show us or confirm if registers for patients who were older, or had a mental health condition or dementia were maintained and up to date.

Summary of findings

Locums did not attend any multi-disciplinary team meetings held to support and review care of patients who were terminally ill.

Access to appointments was by phone or by attending the practice to book an appointment in person. People complained that getting through to the practice by phone was very difficult, yet no facility had been put in place to allow people to book appointments or order repeat prescriptions on-line.

Are services well-led?

Inadequate

The practice was rated as inadequate for the domain of well-led and improvements are required.

There was no systems to monitor the quality of care and treatment provided and governance arrangements were inadequate.

The practice did not have a clear vision and strategy and staff were unclear on who was in charge of the day to day running of the service. The practice had experienced a full turnover of staff which had left gaps in leadership. The provider had taken on some of the duties of the absent practice manager, but lacked the experience to deliver all elements of this role. Staff spoke of the need for leadership.

There were no arrangements in place to support the locum GPs at the practice, for example, in peer review of their work.

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 service was being delivered by locums and at the time of our inspection there was no long term commitment from those locums to the practice. This meant that the initiative to give older patients the name and contact details of a GP who would be responsible for their care, could not be met. The provider was unable to show us any plans in place to address this concern.

The provider was unable to show us, or confirm that up-to-date registers were held on patients with a diagnosis of dementia.

At the time of our inspection, no systematic clinics were planned for the delivery of flu vaccines to older people who may be more susceptible to the flu virus.

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions

Inadequate

The needs of patients with long-term conditions were not consistently met. Regular disease management clinics were not being delivered by the practice. The practice had been supported by a nurse from the local clinical commissioning group over the past 12 months, to deliver some services, but the working days of that nurse varied, so planning of patient appointments at clinics was difficult. Locums did not attend any multi-disciplinary team meetings held to support and review care of patients who were terminally ill.

Systems to share information about the healthcare needs of patients with other health care providers such as Out of hours services were not in place.

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

Inadequate

Services delivered to children and younger people required improvement. Although information was available that higher numbers of children and younger people were presenting at the local children's hospital for treatment, rather than seek services from the practice, no pro-active work was in place to address this.

Summary of findings

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Working age people (including those recently retired and students)

Inadequate

The practice had no facility for patients to book appointments on-line. Access to appointments was by phone or by attending the practice to book an appointment in person. People complained that getting through to the practice by phone was very difficult. Repeat prescriptions could not be requested on- line or by phone, except if a person was elderly or housebound. The practice did not have an extended hours surgery, the latest appointment available being 6.15pm.

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

Inadequate

The provider did not hold up-to-date registers of patients who were more vulnerable, for example, those patients with a learning disability. Although the practice had a small number of people in this category, the locum GP we spoke with was unable to tell us who those patients were. No particular locum was assigned the responsibility of ensuring patients from this group were given annual health checks, to support their physical health, which can be overlooked in people with learning disabilities.

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Inadequate

The needs of people experiencing mental health problems were not fully met. For example, there were no arrangements in place to assign care of people with mental health conditions to one locum in particular, which would help with continuity of care which is particularly important for the physical and mental health of these patients. There was no locum GP with lead responsibility for patients with a diagnosis of dementia.

Summary of findings

This provider was rated as inadequate for safe effective, caring responsive and well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

Four CQC comment cards had been completed by patients. All comments were positive and referred to the friendly and helpful reception staff. We spoke with seven patients attending the practice on the day of our inspection. They told us they were looking forward to Dr Dharmana returning to practice as they had found dealing with different locum GPs stressful.

We asked patients what they thought was good about the practice. Patients expressed their appreciation for the reception and administrative staff; we were told they were always helpful, caring and dealt with any concerns or requests in a sensitive manner. Patients told us they felt confidentiality was respected and confirmed they would be offered a more private room if they needed a private conversation.

We asked patients what changes they would make to the practice if they could. Patients said they found it difficult to get through to the practice on the phone. They said this was particularly frustrating as there was no facility to book appointments on-line. Similarly, repeat prescriptions could not be ordered on-line. The majority of the patients we spoke with told us they thought Saturday morning opening for people who worked full time would be a valuable change, as there were no extended surgery opening times in the morning or evening. The practice opened at 8.30am and closed at 6.30pm. Patients said that sometimes the doctor would see them at the end of the morning or evening session if the patient's need was urgent.

Areas for improvement

Action the service MUST take to improve

- The provider must take action to protect service users (patients) from the risks of inappropriate or unsafe care and treatment. There was no system in place to regularly assess and monitor the quality and safety of the service provided. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

- The provider must take action to identify, assess and manage risks or potential risks relating to the health, welfare and safety of patients and people working at the practice. The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

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- The provider must take action to ensure that suitable arrangements are in place so that all staff respond appropriately to any safeguarding concern and to report any safeguarding concerns to the appropriate body. The provider is failing to meet Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

- The provider must take action to ensure sufficient information is provided to patients in relation to their care and treatment. Patients were not informed of choices available to them regarding accessing healthcare services that were no longer being provided at the GP practice since November 2013. The provider is failing to meet Regulation 17(2)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

- The provider must take action to protect patients' health, welfare and safety by ensuring suitable arrangements are in place to share information with other health care professionals so that patients receive continuity of care when they move between services. The provider is failing to meet Regulation 24(1)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

- The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008, to ensure necessary employment checks are in place for all staff. The provider is failing to meet Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Dr Srinivas Dharmana

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP advisor, a second CQC inspector, a practice manager and an expert by experience. An expert by experience is a person who uses primary care services on a regular basis.

Background to Dr Srinivas Dharmana

Dr Dharmana's practice is run by Dr Srinivas Dharmana, who operates as a sole GP practitioner. At the time of our inspection Dr Dharmana had not been delivering clinical care or services to patients for approximately 12 months. In this time, he had retained the services of several locum doctors to cover patient appointments and deliver services under a General Medical Services (GMS) contract.

The practice is registered with CQC to deliver five regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening services
- Maternity and midwifery services
- Surgical procedures
- Family planning

Surgical procedures were not being delivered to patients by the practice. Some family planning services were not being delivered, for example, contraceptive implants.

The practice is run from a building that was formerly a residential property. The layout of the building provides a consulting room, a treatment room, a patient waiting room and a reception area on the ground floor. The upper floor of the property is made up of office space for a practice manager, a storage room for records, a further office and a staff room. Toilet facilities are on the upper floor. There are approximately 2,400 patients registered at the practice. The number of practice sessions delivered by the locum doctors was equivalent to slightly more than one full-time GP.

Of the three locums working at the practice, one was a female GP, the other two being male GPs. A practice nurse had been supplied by the local Clinical Commissioning Group (CCG) initially for two days each week, to support the work of the GPs and deliver services to patients. Recently this nurse had been providing training to another nurse who would be taking on the role of practice nurse on a permanent basis. This nurse was delivering services for the equivalent of one day each week, but this was due to increase over time. The practice was without a practice manager although Dr Dharmana was doing some of the work associated with this role. Out-of-hours services were delivered to patients by another provider – Urgent Care 24.

Shortly before our inspection, the practice had been broken into and a safe containing prescriptions was stolen. This incident is subject to an on-going police investigation.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before.

Detailed findings

How we carried out this inspection

Before our inspection we requested data from Liverpool Clinical Commissioning Group (CCG), information from NHS England and reviewed our own intelligent monitoring data.

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

Before our inspection, we sent comment cards and posters to the surgery advising patients of our inspection and inviting them to share their views. The practice did not have a patient participant group. We conducted a full day site visit on 1 October 2014. We spoke with all staff including reception and administrative staff, the new practice nurse, Dr Dharmana and the locum GP providing services on that day. We also spoke with patients and their carers.

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

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

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

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

We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe Track Record

The provider was unable to demonstrate that the service provided at the practice had a safe track record.

All clinical care and consultations were being provided by locum GPs. The locum GP providing services on the day of our inspection had been working at the practice since April 2014, for one day each week. We asked the locum GP how incidents were reported by the three locums working at the practice. We were told there was no specific incident reporting and review form, but that any incident was recorded on paper and passed to the provider to investigate. The locum GP told us that there were no meetings held to discuss any serious incidents or to give feedback from investigation into these. We asked the provider for copies of any incident reports for the past 12 months. We were aware of one incident at the practice, which had not been reported to the Care Quality Commission (CQC) as required. The provider could not provide documentation recording this incident or any investigation into the incident. There were no records of meetings to share any learning from findings following investigation. The provider could not show that any review of systems and procedures since that incident had taken place. The provider described details of a further incident relating to patient care, but confirmed that it had not been recorded in writing or discussed with staff. Clear lines of accountability for incident recording and reporting were not in place. From records available, we saw the last clinical audit carried out was on stroke prevention in September of 2013. No clinical audit and review of patient care or treatment had been conducted since then.

Learning and improvement from safety incidents

The practice did not have an effective system in place for reporting, recording, learning from and monitoring significant events.

When we reviewed documents kept at the practice, we saw that the practice had previously had a system in place for reporting, recording and monitoring significant events. Meetings between clinicians in the community and the provider had taken place regularly, and these were used to review and discuss any learning from incidents. However, adherence to those systems had ceased in the autumn of 2013. This was when Dr Dharmana had stopped providing clinical care to patients. Since that time, there had been no systems in place to discuss safety incidents and share learning from these.

The provider had installed CCTV at the practice following a security incident in 2013. Signage to inform patients that CCTV was in operation was placed near the entrance to the practice. Administrative staff told us they were the last to leave the building in the evening and always ensured they were never left to work alone. However, when speaking with the provider, we found that a cleaner accessed the building on their own at approximately 6.00am and would work alone before other staff arrived. There was no lone working policy for staff to refer to or updated guidance since the incident in January 2013.

Reliable safety systems and processes including safeguarding

We asked the provider to describe and show us systems in place to handle MHRA alerts. The doctor told us he was unsure how locum GPs were made aware of notifications and alerts. We were told that a member of staff on long term absence used to receive these notifications, but this duty had not been picked up by another member of staff at the practice. The provider was unable to locate MHRA alerts received in the last three months, either in paper or electronic form.

The provider confirmed there was no provision of on-line intranet resource, which locums or the practice nurse could use to research current best practice guidance and updates on the treatment of particular conditions.

We asked the locum GP delivering services on the day of our inspection if he was aware of the safeguarding policy and procedures for the practice and at local level. The locum GP said he was aware of the safeguarding policy and procedures locally. We saw documents that confirmed reception and administrative staff had received safeguarding training. Staff told us they would report concerns to the provider. We noted there were no contact details for local safeguarding teams displayed for easy access for staff, and when asked, staff were not aware they could raise concerns with safeguarding teams themselves.

Inadequate

Are services safe?

The provider confirmed that he had received safeguarding training to the required level for a doctor. Safeguarding reports had been completed by a staff member who was on long term absence from the practice, and no one had been appointed to take over these duties.

Staff were appointed as chaperones, but said they had not received training in this duty, but were aware of an on-line facility for this training. The provider confirmed that staff had not received training on the Mental Capacity Act 2005.

The provider confirmed that no risk assessments had been conducted in relation to health and safety of patients and staff when in the building. A recent fire safety assessment had been conducted and the provider had started to address action points from this report.

Medicines Management

The practice must improve the way they manage medicines. When we spoke with the nurse who was working one day each week at the practice, we were told that regular stock checks on vaccinations and immunisations were not being conducted. We asked about plans in place to identify those patients who would require a flu immunisation. No formal registers of patients, who due to underlying health conditions, would be vulnerable to infection from the flu virus, were kept or available for inspection. Administrative staff were working through the patient register to identify which patients should be asked to attend for their annual flu immunisation. Plans for clinics to deliver this service to patients were not in place. Flu jabs were offered on an opportunistic basis rather than in an organised or pro-active manner, as a flu jab clinic had not been organised.

We checked the availability of emergency drugs. Although adrenaline was kept for use in an emergency drugs kit, the provider was unable to immediately locate the kit. An antihistamine drug for treatment of allergic reaction was available but on checking we found this was out of date therefore not suitable for use. There was no oxygen supply available, and the provider had not conducted a risk assessment in relation to this.

We asked if the locum GPs knew where the emergency drugs where kept. The provider told us he expected them to have their own emergency drugs, but he had not checked that they carried these and that they were in date, ready for use.

Cleanliness & Infection Control

The recently appointed practice nurse told us they had taken on the role of infection control lead for the practice. We were shown records of completed up-to-date training in this area. We were shown a partially completed audit which had recently been carried out at the practice. The nurse was able to show us where personal protective equipment was stored and that this was quickly and easily available. We were shown an infection control audit that had been completed in March 2014 by Public Health England (PHE), on the treatment room used at the practice and where any minor surgical procedures would be performed. This showed a good standard of hygiene and infection control had been followed. The audit had just one recommendation, for the removal of items stored in the room. This had been carried out.

Hand hygiene audits had not been completed for over 12 months. The nurse showed us cleaning schedules for the practice and a daily checklist to ensure all areas had been cleaned to the required standard. When we checked cleaning products stored at the practice, we found these were household cleaning products, some of which may not have been suitable for use in a clinical environment.

Contracts were in place for the removal of any clinical waste and sharps boxes were used for the safe disposal of any syringes.

Equipment

The practice was located in a former residential property. It appeared to be well maintained, clean and tidy. The treatment room was stocked with single use, disposable clinical items, such as needles, syringes, dressings and personal protective equipment. However, the provider confirmed that there was no system in place to monitor stocks of equipment. There was no identified lead person with responsibility for rotating stock so that equipment was used in date order.

Items such as blood pressure monitors and scales had recently been tested and calibrated to ensure accurate measurements.

Staffing & Recruitment

The skills set of the recently recruited practice nurse and the locum GPs were not sufficient to deliver all the services required under the General Medical Services (GMS) contract. At the time of this inspection, the practice nurse had recently received training in the performance of

cytology (smear testing) and was conducting this testing with supervision from a nurse supplied by the CCG to support the practice. Locum GPs were not performing any surgical procedures and those patients requiring services in relation to contraceptive implant devices were referred to neighbouring practices.

The provider had not reported a change in circumstances to CQC which meant patients who required a surgical procedure or a contraceptive, would not be able to receive these services at the practice. Any changes to the availability of services provided by the practice must be reported to CQC. In such cases, the provider must inform CQC of arrangements in place to allow patients access to those services elsewhere.

When we reviewed staff files, there were no copies of checks made on locums GPs supplied by an agency. The provider was unable to give any assurances as to the level of skills and experience of the locum GPs, of background checks on their suitability to work as GPs, or of their valid and up to date registration with their relevant professional body. The provider told us that these checks were conducted by the agency but that he could not locate this information to show us.

We found references had been taken up in respect of two staff members. For three other members of staff, no referencing had been conducted. There was also no risk assessment conducted in respect of a person's suitability to act as a chaperone.

Monitoring Safety & Responding to Risk

There was a lack of systems in place to monitor safety at the practice. Arrangements for a safeguarding lead within the practice, were not in place. The provider did not know how MHRA alerts were being received by locum GPs, and whether any systematic review of patient treatment took place in response to those alerts. Disease registers were not kept up to date, so responding to any risk posed to those patients with long-term conditions would be more difficult.

At the time of our inspection, there had been a complete turnover of staff. The permanent practice manager had been away from work for approximately 12 months. The position had been taken on by another staff member who had also gone on extended leave. Three further administrative support staff had been recruited within the year. Some of the duties of the practice manager were being performed by the provider with support from the new reception staff. As there was no succession planning in place to transfer or capture knowledge of staff on long term absence, some key duties were not being performed, for example, health and safety checks, organising staff training and development, fire safety tests and fire evacuation drill.

Arrangements to deal with emergencies and major incidents

We asked to see the emergency kit kept at the practice. The provider could not locate this immediately. It was found in an unmarked box on a top shelf in the GP consulting room so would not be easily accessible. The kit contained an airway which was not packaged and therefore not sterile and a medicine to treat an allergic reaction that was out of date.

Staff described how they would respond to a medical emergency. Staff were also able to evidence their learning from training on cardio-pulmonary resuscitation (CPR) and how they would place a patient in the recovery position and dial 999.

The provider was unable to produce a business continuity plan. The practice premises had recently been broken into and following this, locum GPs and support staff were still able to deliver surgery appointments on that day. However, the provider could not describe or show plans in place to deal with emergencies such as flood or other extremes of weather, IT failure or absence of key staff members. A business continuity plan would address these issues and should be reviewed with staff on an annual basis, or following incidents, such as the recent break in.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Not all patients that had registered with the practice in the past 12 months had received a new patient assessment of needs. Regular and systematic review of patients with long-term conditions had not been in place for some time. The nurse who had recently taken on the role of practice nurse was still being trained in some aspects of this work. Half hour appointments were being arranged for patients to see the nurse to have their healthcare needs reviewed. At the time of this inspection the nurse was working at the practice for just one day each week, although the requirement for nursing duties at the practice was estimated at 20 hours per week.

Because there were no multi-disciplinary team meetings being held by the practice, there was little input from the locum GPs on care for patients who were receiving treatment and support at home. For example, those receiving end of life care. There was no register of patients receiving end of life care, kept by the practice.

Management, monitoring and improving outcomes for people

There was no monitoring of patient outcomes of care and treatment by clinical audit. The last clinical audit undertaken was in September 2013. Data we obtained and considered before our inspection confirmed that several key areas in relation to the management and treatment of patients with ongoing health conditions, were not being met. Examples of these included the successful monitoring and interventions for patients with a body mass index (BMI) score of 40 or above, those with chronic kidney disease, patients with diabetes or heart disease. The provider was unable to show us any work that was underway to address this. We found that intervention was only made if patients had made an appointment to see the locum GPs. i.e. there was no pro-active work in relation to these patients. There was no evidence of benchmarking of patient outcomes; benchmarking would allow a doctor to see how quickly a patient's condition improves, deteriorates or responds to treatment over time.

Effective staffing

Three locum GPs were delivering services to patients at the time of our inspection. The working patterns of the locum doctors meant there was one doctor on duty at all times that the practice was open. Two of the locum GPs were male and one was female. The female locum was due to go on maternity leave. We were told that one of the male GP locums would pick up the sessions previously delivered by the female locum. There was no planning or provision for those patients who wished to be seen by a female GP. The skills set of the locum GPs were not sufficient to deliver all of the services under the GMS contract. This meant patients would be referred elsewhere for surgical procedures and some contraceptive services, such as contraceptive implants. No impact assessment in relation to this had been conducted, showing how many patients would have to be referred elsewhere.

We asked about the overview and induction that locums were given before delivering services at the practice. We were told that the locums received an induction pack. This contained details of referrals for x-ray and blood taking procedures and log-in details for the computer. We found that locums worked in isolation and there were no formal arrangements in place to support them with peer review of their work or clinical supervision.

Although the provider was present at the practice most days, he was not delivering any clinical care, but acting as practice manager. The provider was not aware of the full scope of duties undertaken by the previous practice managers and could not access key documents when asked to. No plans had been put in place to recruit a person with practice management experience on a temporary basis to cover the long term absence of two key staff members. It was not clear how the practice management function was being delivered.

Working with colleagues and other services

There were no records or evidence of any multi-disciplinary team meetings at the practice since June 2013. When we questioned this we were told a meeting had been held two months ago which district nurses and health visitors attended. However, we were unable to find a record of this and the locum GP on duty at the time of our inspection told us they had not attended this meeting. The locum told us they were unaware of any structured meetings of primary care teams or shared care plans for terminally ill patients. The provider confirmed that he used to contribute to multi-disciplinary team meetings for delivery of end-of-life care to patients, to a recognised national standard. (The Gold Standards Framework - GSF). These meetings were not being attended by locum GPs.

Inadequate

Are services effective?

(for example, treatment is effective)

Reception staff told us they were unaware of any communications sent to out of hours services, regarding terminally ill patients who may pass away overnight.

We could see that there was a system in place for receipt of information from out of hours services and that reception staff understood this would need to be referred to the locum GP immediately for any follow-up action to be taken.

From data we considered before our inspection, we found there was a higher than normal number of patients who were children, presenting at Alder Hey hospital, for treatment that should be available through the practice. We could see no proactive work by the practice to address the problems that this can cause secondary care services, or to understand why parents of children did not seek primary care at the practice.

In the waiting area of the practice, leaflets were displayed of other partner organisations that people could contact for support, for example, smoking cessation services. However, several of these were out of date and gave patients the wrong contact details. A patient who talked to us about services available at the practice, expressed their frustration about not being referred to a counselling service.

Information Sharing

Referral systems for patients who needed to access services such as surgical procedures, which were not being delivered by the practice at the time of our inspection, were not clear. We were unable to check if patients had consented to having their details passed to another GP who would perform this service.

Information sharing was limited by the absence of multi-disciplinary team meetings held by the practice. Where these did take place, locum GPs did not attend.

The lead responsibility for safeguarding children and vulnerable adults had not been delegated by the provider to another member of staff. The staff member who responded to requests for safeguarding reports was on long term absence and this duty had also not been delegated to another staff member. When we spoke with staff they were unaware that they could raise any safeguarding concerns themselves, rather than just reporting them to a safeguarding lead at the practice.

Consent to care and treatment

The nurse who had recently taken on the post of practice nurse understood the issues around gaining consent to treatment, as well as consent to sharing information, for example, with a patient's carer or next of kin. Administrative staff showed us how they identified a patients carer or named next of kin on computer systems and what level of information they were allowed to share with a carer. The practice nurse told us about training they were considering, on the assessment of competency in line with patient consent.

Health Promotion & Prevention

We spoke with the person who had taken on the role of practice nurse. This person was inexperienced in the role of a practice nurse, having previously worked in a nursing home. The nurse was still receiving training in several areas, such as cytology screening and inputting information onto the patient database. They had recently completed training on immunisation and vaccines. Because up-to-date disease registers were not available, reception staff checked individual patient records to see if patients had a long-term condition listed on their file. If so they would contact patients and offer an appointment with the nurse. These appointments were for 30 minutes per patient. Patients would also be offered advice on other health matters such as alcohol consumption and smoking cessation, within the appointment time.

As the nurse was only working one day per week at the practice, it was not possible to offer structured, specific clinics.

Inadequate

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Our observations of patients being helped with their enquiries in the reception area, showed staff to be caring and respectful towards patients. The reception area where patients spoke with staff when making enquiries, offered little privacy. Staff were aware of this and confirmed that they would offer patients the option of talking to them in a more private room.

Care planning and involvement in decisions about care and treatment

Services delivered to children and younger people required improvement. Although information was available that higher numbers of children and younger people were presenting at the local children's hospital for treatment, rather than seek services from the practice, no pro-active work was in place to address this.

The nurse who had recently taken on the role of practice nurse understood the importance of consent and involvement of patients in their treatment options. When we asked patients if they felt suitably informed about their care, five out of seven patients said they were informed and understood options available to them. Two people commented that they thought locum GPs did not fully involve them in their care and treatment options.

There were a lack of formal disease management clinics to support people with long term conditions. The newly recruited practice nurse was inviting patients in for 30 minute health check appointments and reviewing peoples health conditions. However, as disease registers were not up to date, these appointments could not be targeted to those patients most in need of a health review.

Locum GPs were not attending multi-disciplinary team meetings to discuss support for patients who required end of life care. The practice had no up-to-date cancer register and names and details of those patients who may be expected to pass away overnight or at the weekend , and details of their carer or next of kin were not shared with out of hours services.

The nurse at the practice gave an example of when interpreter services were used to translate for a patient who did not speak English. In doing this the nurse was able to fully explain a range of treatment options to the patient, confirm their understanding of the options and gain informed consent to treatment.

Patient/carer support to cope emotionally with care and treatment

Reception and administrative staff had worked through patient records to identify those patients that had a carer, or particular member of the family that information about a patients care and treatment could be shared with. This was recorded on patient records and gave the opportunity for carers or close family to ask questions about medicines or treatments a patient was receiving, for example, in cases of palliative or end of life care. However, there were no multi-disciplinary team meetings being held at the practice that involved the locums who were delivering patient services. This could limit the information shared with the locums about a patient's condition whilst being treated at home.

There were leaflets available in the reception area, which gave information that would be useful to carers of people with progressive illnesses and conditions, for example, dementia. However, there was limited information on support groups within the community for those who cared for people with chronic and terminal illnesses.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of patients with long-term conditions were not consistently met. Regular disease management clinics were not being delivered by the practice. The practice had been supported by a nurse from the local clinical commissioning group over the past 12 months, to deliver some services, but the working days of that nurse varied, so planning of patient appointments at clinics was difficult. Locums did not attend any multi-disciplinary team meetings held to support and review care of people who were terminally ill. Lists of terminally ill patients expected to pass away overnight were not systematically shared with providers of out-of-hours services.

The practice did not have a patient participant group. We asked administrative staff if any feedback had been sought from patients. They were able to show us two copies of patient responses in 2013, to a survey conducted by an outside organisation. Staff were unsure of the numbers of patients included in the survey (sample size) or the response rate. They told us the responses to the survey had not been collated. We saw no evidence that the results of this survey had been used to inform improvements to patient care, experience or service.

Patients we spoke to on the day of our inspection told us services were being provided by three different locum GPs so it was difficult to get continuity of care from the same doctor. This was also something that patients commented on, on comment cards left by CQC to encourage patient feedback.

The practice had no facility for patients to book appointments on-line. Access to appointments was by phone or by attending the practice to book an appointment in person. People complained that getting through to the practice by phone was very difficult. Repeat prescriptions could not be requested on- line or by phone, except if a person was elderly or housebound. The practice did not have an extended hours surgery, the latest appointment available being 6.15pm.

Of the five regulated activities the provider is registered to deliver, only three were being delivered to patients registered at the practice. There was no evidence of communication with patients to advise who could deliver the other two regulated activities and where patients could chose to go to receive them, for example, surgical procedures or family planning services (contraceptive implants).

Tackling inequity and promoting equality

The provider was aware of the patients on his register who had a learning disability, and a register of those patients with mental health conditions was also kept. When asked, the provider was unable to say if responsibility for care of those patients with learning disabilities or mental health conditions, had been delegated to one locum GP in particular, which would have given vulnerable patients some continuity of care and support.

Although the practice was located in what was formerly a domestic property, the GP consulting room was on the ground floor of the practice. We saw that doorways were wide enough to allow wheelchair access. The service did not have a hearing loop device in place for those patients who may be deaf. Staff were aware of interpreting services available through language line although they told us they had not had cause to utilize these.

Access to the service

We asked patients how easy it was to get an appointment with a GP. On analysis of patient responses, most patients said they were able to get an appointment to see the doctor either on the day or within three days. We noted that any children that needed to see a doctor on the day, would be offered an appointment at the end of the planned surgery times.

The choice for patients to be seen by a female doctor was limited due to the female locum GP working only one day each week at the practice. There were no formal arrangements in place between the practice and a neighbouring GP surgery, for those patients wishing to be seen by a female GP. Patients did have the option of visiting the walk in centre to see if a female GP was available there.

Listening and learning from concerns & complaints

The practice had a range of policies and procedures. The provider was unable to show us the practice complaint policy, but supplied us with a policy following our inspection. Reception staff confirmed that verbal complaints were sometimes made, but they were dealt with immediately were possible. We saw an old complaints book where complaints had been logged, but this had not

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

been used for over 12 months. Regular practice meetings were not taking place, therefore learning from incidents or any verbal complaints could not be shared and discussed. There was no information displayed in the waiting area on how to make a formal complaint and who complaints could be addressed to. We were unable to confirm that the provider was listening and responding to patients complaints.

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

There was no clear vision and strategy for the practice. The locum doctor we spoke with had been providing services to patients at the practice regularly, for one or two days each week. He told us that the objective of the practice was to "keep things going for now". No steps had been put in place to support the locum GPs, for example in review of their work or discussion on best practice treatments. Locums had received no clear guidance from the provider on how they could feed information to clinicians in the community, for example on the welfare of patients when discharged from hospital. No multi-disciplinary team meetings were being held by the practice, which locums could attend and contribute to.

Administrative support staff acknowledged that the practice had been through a turbulent time, but felt that things were beginning to stabilize, particularly with the presence of a nurse who would be taking on the role of practice nurse permanently. Staff stated that they were unsure who was in charge at the practice, as the permanent practice manager had been on long term absence. The deputy practice manager had also been absent from work for an extended period.

Governance Arrangements

Governance arrangements at the practice were poor. From records held we found that no monitoring of the service, to maintain quality of care and treatment had been conducted since late 2013. There was a lack of evidence that information available to the practice was used to improve the quality, effectiveness and safety of the care and treatment provided to patients. There were no arrangements in place to ensure that key information and messages were disseminated to staff or other healthcare professionals.

Leadership, openness and transparency

The practice lacked leadership. The locum GPs delivering services told us that if they had any problems they would refer them to the provider. Management arrangements were unclear; the provider had not taken steps to ensure adequate management support was put in place to support the practice through a period of significant change.

Administrative staff acknowledged that leadership was needed and were confused by the lack of information on how all aspects of the service would be delivered, and how they could answer patient queries regarding services.

Records relating to the running of the practice were available up to the end of 2013. When we asked to see records from November 2013 onwards, the provider was unable to produce these.

The provider had not communicated to patients how services would be delivered in his absence, and how any services not delivered by locums could be accessed at another practice.

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

There was no active patient participant group for the practice. We asked to see any feedback or complaints from patients, received in the past 12 months. We were told that no formal complaints had been made but verbal ones had been and these were dealt with immediately. There was no record kept on the nature of any verbal complaints. The practice had commissioned a patient feedback exercise in 2013. However, staff were only able to show us two returned questionnaires and there were no collated findings from the results, or record of findings.

Administrative staff told us that patients had complained verbally to staff about the lack of continuity of care, as the service was being delivered by locums. The provider had not addressed this or taken steps to communicate with patients, how long it was likely to be before he returned to practice, or to explain how clinics for patients with chronic conditions would be re-established in future. Patients expressed their frustration about this on the day of our inspection.

Management lead through learning & improvement

We found there was no formal objective setting and appraisal system in place for administrative staff, or the new practice nurse who had been at the practice one day each week since June/July of 2014. There was no formal analysis and review of patient outcomes and the work of the locum GPs.

There were no succession plans in place for key staff, such as the practice manager or lead receptionist. There were no active steps in place to secure the services of a female locum GP, when the existing female locum finished work to

Are services well-led?

Inadequate

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

go on maternity leave. Plans had not been made with the input of the new practice nurse, to phase in the re-introduction of disease management clinics. The practice nurse told us it had not yet been confirmed how many hours a week she would be working at the practice, so specific clinics could not be planned.

There was no leadership development in place.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider is failing to meet Regulation 9(1) and (2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action so that patients are protected against the risks of receiving care or treatment that is inappropriate or unsafe. Adequate measures to monitor the safety of care and treatment delivered were not in place.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider is failing to meet Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action to protect service users (patients) from the risks of inappropriate or unsafe care and treatment. There was no system in place to regularly assess and monitor the quality and safety of the service provided. The provider must take action to identify, assess and manage risks or potential risks relating to the health, welfare and safety of patients and people working at the practice. The provider must ensure that incidents and significant events are recorded, analysed and action taken to minimise the risk of potential harm to patients. The provider must ensure that patients' views about the service they receive are obtained and action is taken as required to improve the service provided.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider is failing to meet Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action to ensure that suitable arrangements are in place so that all staff respond appropriately to any safeguarding concern and to report any safeguarding concerns to the appropriate body.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The provider is failing to meet Regulation 17(2)(b) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action to ensure sufficient information is provided to patients in relation to their care and treatment. Patients were not informed of choices available to them regarding accessing healthcare services that were no longer being provided at the GP practice since November 2013.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider is failing to meet Regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008, to ensure necessary employment checks are in place for all staff.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers

This section is primarily information for the provider

Enforcement actions

Surgical procedures

Treatment of disease, disorder or injury

The provider is failing to meet Regulation 24(1)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider must take action to protect patients' health, welfare and safety by ensuring suitable arrangements are in place to share information with other health care professionals so that patients receive continuity of care when they move between services.

This provider is in breach of the Health and Social Care Act 2008 and the(Regulated Activities))Regulations 2010.

On the basis of this inspection and the ratings given to this practice, this provider has been placed into special measures.

This will be for a period of six months when we will inspect the provider again.

Special measures is designed to ensure a timely and coordinated response to practices found to be providing inadequate care.