The Mandeville Practice

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?	Good
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 practice is rated as Inadequate overall.

We carried out a comprehensive inspection of The Mandeville Practice in April 2017, the practice had an overall rating of Inadequate. Specifically, the practice was rated as requires improvement for safe, caring and responsive services and inadequate for effective and well led services. We undertook a focused inspection in August 2017 to follow up on warning notices that had been issued following the April 2017 inspection.

Following the January 2018 inspection the key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Inadequate

Are services well-led? - Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Inadequate

People with long-term conditions – Inadequate

Families, children and young people – Inadequate

Working age people (including those retired and students – Inadequate

People whose circumstances may make them vulnerable – Inadequate

People experiencing poor mental health (including people with dementia) – Inadequate

We carried out an announced comprehensive inspection at The Mandeville Practice on 10 January 2018. We carried out this inspection 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 Mandeville Practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- The practice did not have clear systems to identify and manage risk. For example, known high risk actions from a fire risk assessment had not been acted upon and other risk assessments had not been considered or documented. In addition, staff recruitment processes had not considered the risks associated with staff commencing employment before their background checks had been received.
- There were duplicate safeguarding policies available, which may be confusing to staff and we found gaps in staff safeguarding training.

Summary of findings

- Patient outcomes data collected via the quality and outcomes framework demonstrated improvements in care for some patient groups although many remained below local and national averages.
- The practice had not considered or responded to the needs of its elderly patients in a local care home.
- Staff treated patients with dignity and respect.
- The practice had recently changed the telephone system and all calls were now handled at the practice. It was too soon to gauge the impact this had on patients.
- Governance processes and systems were not effective and had failed to identify a lack of staff training, risk assessments and patient care relating to dementia.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.

The areas where the provider **should** make improvements are:

- Review complaints response documentation to include details of the health ombudsman as in line with your provider policy.

This service was placed in special measures in June 2017. Although this report identifies where improvements and changes to practice have been made, insufficient improvements have been made overall. The practice is rated as inadequate for providing safe, effective, responsive and well-led services and good for caring services. As a result, I am keeping the practice in special measures and we have taken action in line with our enforcement procedures. At the time of this inspection we were aware of a planned change in provider contract in April 2018. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months.

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

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
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

People with long term conditions
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

Families, children and young people
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

Working age people (including those recently retired and students)
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

People whose circumstances may make them vulnerable
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

People experiencing poor mental health (including people with dementia)
This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. The full description of this population group can be found in the effective and responsive domains of the report.

Inadequate

The Mandeville Practice

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 specialist adviser, a practice nurse specialist adviser and a second practice nurse specialist advisor in a shadowing role.

Background to The Mandeville Practice

The Mandeville Practice is managed by Practice U Surgeries Limited who are an organisation commissioned to deliver a range of services nationally. They took over the contract of The Mandeville Practice in April 2016 when the previous GP partnership dissolved. The practice is part of the Aylesbury Vale Clinical Commissioning Group (CCG).

According to data from the office for national statistics, the practice population has a relatively low ethnic mix with approximately 22% from black and minority ethnic backgrounds. The practice boundary serves a larger than average working age population with fewer older patients. The average life expectancy for males and females is in line with national averages. There is a medium level of deprivation in the area with pockets of high deprivation locally.

The practice provides regulated activity from:

The Mandeville Practice, Hannon Road, Aylesbury, Buckinghamshire, HP21 8TR

The practice offers online services from its website: www.mandevillesurgery.co.uk

The practice did not have a registered manager; this was highlighted at the previous inspections in April 2017 and August 2017. Despite requesting submission of an application, at the time of this inspection in January 2018, CQC had not received any documentation or correspondence to commence the registration process.

The Health and Social Care Act 2008 states that registered providers must have a registered manager, set out in the regulations. The intention of this regulation is to ensure that people who use services have their needs met because the regulated activity is managed by an appropriate person. Following our inspections we were not assured the current arrangements ensured patients at The Mandeville Practice had their needs met or these arrangements met the requirements of the Health and Social Care Act 2008.

The practice had been inspected in April 2017 when it was found to be inadequate overall and was placed in special measures. We followed up on a warning notice in August 2017 when we found the practice remained in breach of the regulations.

The provider contract with the CCG is due to terminate on 31 March 2018 with a new provider taking over the contract on 1 April 2018.

Inadequate

Are services safe?

Our findings

At our previous inspection in April 2017 we rated the practice as requires improvement for providing safe services. We found concerns relating to emergency medicines, recruitment checks and significant events not being effectively communicated with staff.

During this inspection we found there had been improvements in the emergency medicines and significant events. However, risk assessments were not well managed and there were concerns over recruitment files and safeguarding arrangements.

We have rated the practice as inadequate for providing safe services at this inspection.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse. However, we saw duplication of supporting correspondence which could create confusion.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. We saw two policies each for safeguarding adults and safeguarding children. One was a generic policy from the provider the other was the practice adopted policy. Only the local policy offered a flowchart of action and contact details for local stakeholders. This could be confusing to staff if they viewed the provider policy for this information. Policies were regularly reviewed and were accessible to all staff.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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, we found there was no risk assessment in place to determine the risk for staff newly employed who were waiting for their DBS check to be issued. For example, a new member of clinical staff commenced employment at the practice in December 2017 but the DBS check did not come through for a further 12 days. In addition, two new members of non-clinical staff commenced employment in November 2017 and December 2017 and were still waiting for their DBS check to come through at the time of the inspection. We were told these staff were supervised although we were not shown any evidence to support this and the induction record for the clinical member of staff was not in their staff file.
- We found some recruitment file paperwork was missing. For example, staff health status checks through an external occupational health service, confidentiality agreements and induction programme documentation. The practice was able to locate some of these documents during the inspection day. There was an ineffective system for following up on missing paperwork despite the provider Human Resource department having oversight of these. The provider told us after the inspection the confidentiality agreements were contained within staff contracts of employment and described their Human Resources procedures for recruitment and personnel documentation. This was in contrast to the process demonstrated on the day of the inspection and did not reflect the provider description.
- We reviewed the practice training matrix and found not all staff had received safeguarding training or updates appropriate to their role. For example, there were nine clinical staff who had no recorded safeguarding adults training in the log and 11 clinical staff with no recorded child safeguarding training or update. In addition, five non clinical staff had no documented safeguarding adults training and five non clinical staff had no recorded safeguarding children training. Staff we spoke with on the day or received written feedback from were able to demonstrate safeguarding knowledge and were aware of who their lead for safeguarding was. They knew practice policies were available and where to locate them.
- We were unable to determine if all staff who acted as chaperones were trained for the role and had received a DBS check. We asked to see a list of staff that had been offered the opportunity to train as a chaperone but were not shown one during the inspection. We requested the documents again following the inspection; however

neither the provider nor the practice supplied the requested information to us. The provider sent us a list of chaperone trained staff seven weeks after the inspection as part of a factual accuracy challenge of the draft report. However, the evidence supplied did not assure us of the chaperone status of all staff or if the appropriate background checks had been carried out.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- We were told staff understood their responsibilities to manage emergencies, although there was no emergency protocol available to refer to. In the event of an emergency, it was unclear who would contact the emergency services or wait at the entrance to the practice to show the emergency services to the location of the incident. One member of clinical staff was unable to demonstrate knowledge of emergency procedures. The provider told us after the inspection they had emergency policies available such as basic life support, automated external defibrillator and anaphylaxis but these were not shown to the inspection team on the day or after the inspection.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Whilst many non-clinical staff were able to demonstrate knowledge of how sepsis was highlighted on the practice computer system, they had not all received training to recognise symptoms.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice did not always involve patients in reviews of their medicines. For example, some of the residents in the local care home had not been consulted on changes to their medication.

Track record on safety

The practice had undertaken some assessments of safety, although not all risks had been identified or considered. Some risk assessments had high risk outcomes that had not been actioned.

- We asked to see risk assessments relating to building safety. We were told this had been undertaken by the building landlord and the practice had no oversight. They could not be reassured of building safety or the safety of anyone entering the premises.
- An external company undertook a fire risk assessment in May 2017. The report outlined seven high risk actions that required immediate attention, such as ensuring fire drills were undertaken and regular checks of fire equipment and alarms. We requested to see the alarm and equipment testing records but were not shown

these on the day of or after the inspection. A fire drill with a full evacuation of staff had also not been undertaken. The practice told us they had planned a fire drill for February 2018.

- We requested to see health and safety risk assessments but these were not shown to us.
- We were told other risk assessments had been considered, such as work flow, read coding and clinical correspondence, but not written down due to a lack of staffing resource and time to do this.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. However, there was unclear overall responsibility and oversight of significant events and incidents. The practice used an online form which was submitted to the provider. This was then reviewed by an unknown person at the provider head office. If the incident required further investigation, a request was sent to the practice to review the incident and speak with staff or check records. The request was sent to the lead for that area, for example the practice manager was informed of non-clinical issues. The provider told us after the inspection all significant events were reviewed by their Quality Assurance Team, however, this was not known by the practice staff we interviewed.
- There were systems for reviewing and investigating when things went wrong. Staff received feedback if they had been involved in the event and the practice shared lessons with staff at whole team meetings. We saw evidence of incidents being discussed at clinical meetings, although there were delays noted between the date of the reported incident and the clinical meeting discussion. For example, they were unable to identify themes and trends for the whole practice as there was no single person within the practice with oversight of these.
- We were shown a log of 14 significant events which had been reported since 16 June 2017. We saw evidence that these were discussed at clinical meetings although we noted that an incident reported in August 2017 was not discussed until January 2018, although the log notes record learning was shared at a clinical meeting in August 2017.
- We were shown examples where action was taken to improve safety in the practice. For example, the system for recording and disseminating abnormal blood test results was reviewed following an incident where a patient was not informed or offered a follow up appointment. A clinical meeting review in September 2017 identified who would action the response and the incident was discussed fully in October 2017. GPs were advised to offer more information to patients in explaining blood tests.
- There was an effective system for receiving and acting on safety alerts.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in April 2017 we rated the practice as inadequate for providing effective services. We found concerns regarding staff training, a lack of clinical audits and limited systems in place monitor patient outcomes.

Although some improvements had been made, the improvements are not sufficient. We have rated the practice as inadequate for providing effective services overall and across all population groups.

There were risks posed to patients receiving dementia care and support which had not been identified and managed. Reviews and management of patients with long term conditions had increased but remained below quality outcomes framework targets. Staff training remained fragmented and there was no training offered to staff undertaking specific lead roles for dementia.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were assessed to include their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.69. This was comparable to the clinical commissioning group (CCG) average (0.61) and better than the national average (0.90). (Hypnotics are a class of medicine that induce sedation or sleep).
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.24. This was above the CCG average (1.02) and national average (0.98). The practice had not considered the implications of high prescribing of antibacterials. However, they had undertaken some prescribing audits and had access to local guidelines.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

This population group was rated inadequate because:

- The majority of residents from a local care home were registered with the practice. We spoke the care home who told us the practice did not offer a positive service to their residents. There were no weekly ward rounds or regular GP visits. We were told some GPs would review repeat medication without consulting or involving the patients directly. There had been instances when a change in prescription did not get communicated to the pharmacy in a timely way and there were reported delays in checking repeat prescriptions as the practice pharmacist only worked on certain days of the week.
- The care home also told us the practice did not communicate with them regularly and they often had to remind the practice when a review or treatment was due.
- The practice had only recently started considering offering patients aged over 75 a health check. The CCG had provided funding for the practice to recruit a nurse to lead on over 75s. The nurse had been in post for four months and was still defining the role.
- The practice followed up on older patients discharged from hospital.

People with long-term conditions:

This population group was rated inadequate because:

- We identified a number of long term conditions that were significantly below the local and national averages for QOF achievement in 2016/17. For example, asthma, Chronic Obstructive Pulmonary Disease (a lung condition) and diabetes. However, the practice showed us their current year (2017/18) QOF which demonstrated a number of improvements in the data, although many were still projected to fall below local and national averages.
- We were told the residents at the local care home were not offered a routine long term condition review. The care home told us they often had to remind the practice this was due and did not always receive a visit to accommodate this. They also informed us care plans were not regularly reviewed or updated.
- The practice told us patients with long-term conditions were called for their annual review check during their

month of birth. The GP specialist advisor with the inspection team reviewed a sample of patient long term condition reviews and found they had been completed appropriately.
- Staff who were responsible for reviews of patients with COPD and diabetes had received specific training.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Families, children and young people:

This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. However, there were some areas of good practice:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- The practice referred female patients to a local sexual health clinic for family planning procedures such as intrauterine devices and implant insertion.
- The practice had no formal arrangements to identify and review the treatment of newly pregnant women on long-term medicines. The practice told us they had reviewed a medicines alert regarding female patients of child bearing age and a contraindication to a specific medicine. The provider told us after the inspection they had a shared care agreement with the midwifery service for newly pregnant patients to be reviewed and referred, if necessary. This was in contrast with the information supplied to the inspection team on the day of the inspection.

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

This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. However, there were some areas of good practice:

- The practice's uptake for cervical screening was 83%, which was in line with the 80% coverage target for the national screening programme. We noted the exception reporting for this indicator was 17% which was higher than the CCG average of 4% and national average of 7%. The practice told us they excepted patients who had not attended for screening after three written reminders. There was disparity amongst the nurses over how exception reporting was used and this may have contributed to patients being exception reported inaccurately.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated inadequate because:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The over 75s nurse had been designated to lead on vulnerable patients but had no oversight of the registers and the role had yet to be been defined.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

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

This population group was rated inadequate because:

- The practice had designated the over 75s nurse as the lead for dementia care planning and reviews. The nurse had been in post for four months at the time of the inspection. The dementia lead was a new role and was in the process of being developed. The practice had planned a practice learning event around Dementia in February 2018.
- One of the local care homes had a high number of residents who had a diagnosis of dementia. We were told these patients did not receive regular reviews of their condition, updated care plans or medication reviews.
- 37% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was significantly below the clinical commissioning group (CCG) average of 82% and national average of 84%. The practice showed us their current QOF data for 2017/18. At the time of the inspection, dementia care reviews were at 3%. The practice told us they carried out the dementia care plan reviews in January to March each year and had a projected forecast of 61% by the end of the QOF data

collection period. However, there were no plans to hold a review clinic at the local care home where approximately 45 of the residents had a diagnosis of dementia.

- 66% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was lower than the CCG average of 88% and national average of 90%. The current 2017/18 QOF data showed a drop in completed care plans to 42% with a projected figure of just 48%. The practice told us this group of patients was difficult to engage with.
- The practice considered the physical health needs of patients with poor mental health and those living with dementia, although improvements could be made. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 79%; CCG average 88%; national average 91%); and the percentage of patients experiencing poor mental health who had received a blood pressure check (practice 85%; CCG average 89%; national average 91%).

Monitoring care and treatment

The practice had undertaken a programme of clinical audits since the last inspection. We were shown 12 audits that had been undertaken in 2017/18, of which five were completed cycles where learning had been shared and action taken to improve the effectiveness and appropriateness of the care provided. For example, an audit of a medicine typically used to treat rheumatoid arthritis included a review of how the patient record was flagged to alert the clinician to its use and if regular blood tests had been taken. Over the two cycle audit an improvement of 100% in patient flags and alerts on the system was noted. Patient recall and blood testing within the recommended two to three month period also increased by between 7% and 11%. Actions to be taken included patient and family education, continuing the established recall of patients for regular blood tests and to limit repeat prescriptions of the medicine to three.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, an alert from NHS England regarding prescribing of a liquid opiate medicine (a controlled drug that requires strict monitoring and restrictions in use) was received in December 2017. The alert highlighted a coroner's recommendation that the medicine should have a single dosage included on the prescribing label and a maximum dosage per day. The practice undertook a search of patients and reviewed the prescribing information. The search demonstrated 83% of the prescriptions had a dosage specified. The remaining 17% were amended at the time of the audit to ensure the label would contain the information at the next issue. The audit also searched the number of patients who had received a medication review in the past 12 months. The result was 83%. Recommended actions included recall of patients for a medicine review, developing local protocols to improve quality and develop better patient communication and information. The audit was due to be repeated in February 2018.

The most recent published Quality Outcome Framework (QOF) results were 78% of the total number of points available compared with the CCG average of 96% and national average of 96%. The overall exception reporting rate was 9% compared with the CCG average of 8% and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

We noted overall QOF achievement in 2016/17 for several conditions were significantly below the CCG and national averages:

- Asthma indicators achievement was 57% compared to the CCG average of 95% and national average of 97%.
- Chronic Obstructive Pulmonary Disease achievement was 73% compared to the CCG average of 97% and national average of 96%.
- Diabetes Mellitus achievement was 73% compared to the CCG average of 92% and national average of 91%.
- Overall Dementia achievement was 19% which was significantly below the CCG average of 94% and national average of 97%.
- Mental Health indicators totalled 82% compared to the CCG average of 97% and national average of 94%.
- Exception reporting for the majority of conditions was in line with local and national averages, with the exception of Coronary Heart Disease at 15% (CCG average 8%, national average 9%) and cervical smear testing 17% (CCG average 4%, national average 7%).

Inadequate

Are services effective?

(for example, treatment is effective)

The practice were able to provide their most up to date QOF figures for the period 1 April 2017 to 10 January 2018 which demonstrated some improvements to the preceding years figures, although they would all remain below national and local averages.

- Asthma indicators achievement was approximately 64% which had improved by 7%. Their projected figures were estimated at 77% (a potential increase of 20% on the 2016/17 achievement)
- Chronic Obstructive Pulmonary Disease achievement was approximately 74% which was 1% more than the previous year's total achievement. Their projected figures estimate an achievement of 83%. This would be slightly below the QOF target of 86% overall.
- Diabetes Mellitus achievement was approximately 75% with projected estimates of 84%. This was above the 2016/17 achievement and would bring the practice close to the QOF target of 87%.
- Overall Dementia achievement was approximately 22% which was 3% higher than the previous year. Projected figures estimated 71%, an increase of 52% from the total achievement in 2016/17.
- Mental Health indicators totalled approximately 57% (a decrease of 25% on 2016/17) with projected forecast for 31 March 2018 estimated at 74% (an overall decrease of 8%).
- Exception reporting data for 2017/18 was unavailable as the exceptions were not due to be recorded until towards the end of March 2018. This enabled staff to encourage patients to attend for reviews as close to the end of the data collection period as possible.

We discussed exception reporting with members of the clinical team and found there had been disparity in the way some staff were recording these. Not all clinical staff were aware of how to use the exception reporting aspect of QOF and this may have made the figures read differently from the actual exceptions.

The practice used information about care and treatment to make improvements. For example, an audit of patients taking a medicine to treat and prevent some irregular heart rhythms showed that they were not all receiving regular blood testing or an annual electrocardiograph (ECG) test as recommended. Following the audit in August 2017, the practice made arrangements to contact the patients overdue their tests to request they attend for an appointment and to implement local protocols. The second cycle of audit (December 2017) showed an improvement to 71% for regular thyroid blood testing (previously at 0%) and 71% for regular liver function blood tests (previously 66%). ECG annual testing remained at 50% for both audit cycles. The practice were continuing with the recommendations from the first audit cycle and had planned a third cycle of audit in January 2018.

Effective staffing

The practice was unable to demonstrate all staff had the skills, knowledge and experience to carry out their roles.

- The practice offered online learning modules to staff. The practice were able to pull the updated learning activity from the online learning system onto a training matrix. At the time of the inspection we noted considerable gaps in training and learning updates. Specifically, we found nine clinical staff had no documented adult safeguarding training or update and 11 clinical staff had no record of child safeguarding training being undertaken. In addition, the matrix highlighted gaps in fire safety, infection control and mental capacity act training across all staff groups.
- The practice was unable to demonstrate how they identified the learning needs of staff. The training matrix was available to the practice manager who had oversight, but did not follow up with staff to ensure they remained up to date. We asked to see appraisal records on the inspection day and after the inspection but the practice did not provide them. The provider supplied a list of staff appraisals seven weeks after the inspection took place. However, the information supplied did not assure the CQC of appraisal processes in the practice.
- We saw evidence of an induction process although some of the induction records were missing from staff files.
- We saw evidence of staff being managed when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver care and treatment. However, the practice had not considered the needs of their older patients in residential care.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- Care and treatment of older patients at a local care home was not routinely organised or co-ordinated. There was no designated lead responsible for the patients and they were not offered continuity of care. Care and treatment was provided on an ad hoc basis and the care home told us they were often directed to contact NHS 111 for medical advice.

Helping patients to live healthier lives

Staff encouraged patients to live healthier lives although screening uptake rates and cancer urgent referrals were below local and national averages.

- The practice had started to identify patients who may be in need of extra support and direct them to relevant services. The over 75s nurse had been designated to undertake this role. The role had commenced but it was too early to gauge the impact this had.
- The percentage of new cancer cases that were referred using the urgent two week wait referral pathway was 35% (CCG average 48%, national average 50%).
- Cancer screening uptake was slightly below the national average. For example, 46% of patients aged between 60 and 69 had been screened for bowel cancer in the preceding 30 months compared to the national average of 55% and 67% of female patients aged between 50 and 70 had been screened for breast cancer in the preceding 36 months compared to the national average of 70%.
- The practice was aware of national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice did not undertake any procedures that required formal written consent, such as minor surgery, insertion of intrauterine devices or contraceptive implants.

Good

Are services caring?

Our findings

At our previous inspection in April 2017 we rated the practice as requires improvement for providing caring services. We found concerns regarding patient satisfaction scores and a lack of action taken to address them.

Improvements had been made and we have rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were aware of patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Of the 13 patient Care Quality Commission comment cards we received, 11 were positive about the service experienced. Patients said they felt listened to and were treated compassionately. The two negative comments related to staff attitude and a lack of response to a request for a GP appointment.
- We were shown the results of the practice NHS Friends and Family Test. In the three months from August 2017 to October 2017 the practice received 617 responses. Of these, 490 patients (79%) were likely or extremely likely to recommend the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. There were 301 surveys sent out and 106 were returned. This represented below 1% of the practice population. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 84% of patients who responded said the GP gave them enough time; CCG average - 88%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG average - 97%; national average - 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG average – 86%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; CCG average - 92%; national average - 91%.
- 91% of patients who responded said the nurse gave them enough time; CCG average - 92%; national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG average - 98%; national average - 97%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG average - 92%; national average - 91%.
- 77% of patients who responded said they found the receptionists at the practice helpful; CCG average - 85%; national average - 87%.

These results had improved since the previous results published in July 2016 when the satisfaction scores were considerably below local and national averages.

Involvement in decisions about care and treatment

Staff assisted patients in the practice and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- 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. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. There were 714 patients (5% practice population) registered as having a hearing impairment in the practice. The practice had a variety of ways to communicate with this group of patients including through sign language and via email.
- The practice helped patients find further information and access community and advocacy services. There were posters and information available in the waiting room.

The practice identified patients who were carers through the registration process and notices in the reception area.

Good

Are services caring?

They also displayed carers information in the waiting room. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 282 patients as carers (2% of the practice list).

- There was no designated lead for carers. The practice told us they were due to commence expression of interest with staff members to identify a number of carers champions. The practice had recently facilitated a local carers support organisation to attend a learning afternoon to talk about carers.
- Staff told us that if families had experienced bereavement, their usual GP or nurse contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with local and national averages:

- 87% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG average - 85%; national average - 82%.
- 83% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG average - 90%; national average - 90%.
- 83% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 86%; national average - 85%.

The satisfaction scores had improved by between 5% and 18% and brought most results in line with local and national averages.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our last inspection in April 2017 we rated the practice as requires improvement for providing responsive services as we found the results from the July 2016 patient satisfaction survey were below local and national averages. The practice had not taken any action to improve.

Although some changes had been made we have now rated the practice as inadequate for providing responsive services overall and across all population groups.

Patients still demonstrated some difficulty to make appointments by telephone and waiting times remained a concern. In addition, the practice had not fully reviewed the needs of their older and vulnerable practice population which required improving.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice had some understanding of the needs of its population and tailored services in response to those needs. For example, the practice had commenced extended opening hours, commuter clinics and offered telephone consultations for working patients who could not access the practice during core opening hours.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. There were plans to extend the practice premises to add further treatment and consultation rooms.
- The practice made reasonable adjustments when patients found it hard to access services. For example, a hearing loop was available for patients with a hearing impairment, although not all staff were aware this was available for use.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

This population group was rated inadequate because:

- We spoke with the local care home and were told if a resident required a home visit this was inconsistently managed. Often the home was told there were no GPs available and to call the NHS 111 telephone service. The home had been given access to an online consultation service provided by the local council and they could access a nurse assessment if required. The home told us this was their default option if they required a GP as the nurse could arrange a home visit easier than if they called the practice directly.
- The care home also told us of an instance when a patient was requested to attend the practice for an appointment, which required a member of staff and a taxi to accommodate. Once there, the elderly patient was asked to climb onto the examination couch, which they were unable to manage and the consultation was cut short as they could not be examined appropriately.
- The practice told us they had a system for reviewing requests for home visits and these were discussed during a morning team "huddle". At this meeting GPs discussed who would attend the home visit and attempted to assign the patients to their own named GP.
- Practice nurses attended patients in their own home (including the local care home) to offer annual flu vaccination.

People with long-term conditions:

This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. However, there were some areas of good practice:

- The practice had improved the recall of patients with a long-term condition to receive an annual review to check their health and medicines needs were being appropriately met. However, patients and stakeholders told us they sometimes needed to remind the practice when a review was due.
- The practice received a visit from the Chief Executive Officer of the local hospital to commend them on their work with diabetes.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. However, there were some areas of good practice:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment or telephone triage appointment when necessary.

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

This population group was rated inadequate. We identified concerns with safe, effective, responsive and well led services that include patients in this population group. However, there were some areas of good practice:

- The needs of this population group had been reviewed and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended opening hours, early morning commuter clinics and telephone consultations to patients who could not attend during core opening hours.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

This population group was rated inadequate because:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. However, the nurse assigned to have oversight of these registers was new to the post and was still defining their role.

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

This population group was rated inadequate because:

- The practice was unable to demonstrate positive examples of how they supported patients with mental health needs and those patients living with dementia.
- We were told patients from a local care home who were registered with the practice, were not responded to proactively for their dementia care needs. These patients did not receive regular GP visits or continuity of care from their named GP.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages, although many survey question had seen improvements of up to 15%. This was supported by observations on the day of inspection and completed comment cards. There were 301surveys sent out and 106 were returned. This represented below 1% of the practice population.

- 66% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%. This had increased by 3% since the previous published results.
- 64% of patients who responded said they could get through easily to the practice by phone; CCG average – 74%; national average - 71%. This had increased by 15% since July 2016.
- 79% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG average - 86%; national average - 84%. This represented an increase of 10% since the last published results.
- 74% of patients who responded said their last appointment was convenient; CCG average - 84%; national average - 81%. This had decreased by 11% since July 2016.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 68% of patients who responded described their experience of making an appointment as good; CCG average - 74%; national average - 73%. This had improved by 13%.
- 44% of patients who responded said they don't normally have to wait too long to be seen; CCG - 54%; national average - 58%. These results had remained the same since the previous published results.

The practice had recently changed the telephone system from a designated call centre to being managed at the practice. We were told the call centre had not been received well by patients and this was reflected in the satisfaction scores for appointment access. Since 2 January 2018 the telephone calls were handled locally by the practice and it was too early to gauge how this had impacted on patient opinion.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We were shown a log of 10 complaints received between June 2017 and December 2017. We reviewed three complaints and found that they were satisfactorily handled in a timely way. However, we noted complaint response letters did not offer the health ombudsman details so patients could escalate their complaint further if they were dissatisfied with how the practice had handled their complaint. This was not in line with the providers complaint policy.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. The practice reviewed national guidance for administering the flu vaccination to asthmatic patients following a complaint that a patient was not included in the recall programme.

Are services well-led?

Inadequate

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

Our findings

At our previous inspections in April and August 2017 we had significant concerns about the leadership and governance arrangements at The Mandeville Practice. The practice was rated as inadequate for providing well led services. There were not adequate systems for driving quality improvement. Risks to patients' health and welfare were not always identified, assessed and mitigated.

Although some improvements have been made these are not sufficient and we have rated the practice as inadequate for providing a well-led service.

Leadership capacity and capability

Leadership at the practice was disjointed between the provider and practice staff. On the day of the inspection we were told the practice prioritised safe, high quality and compassionate care. However, we found the evidence on the day of inspection did not reflect this.

- There was a leadership structure at the practice. Several GPs and nurses had lead roles and there was a senior member of staff for each staff group. However, there was differing information supplied to the inspection team on the day from the practice and Provider. For example, the management and monitoring of staff recruitment files was described differently by the Practice Manager, a Senior Human Resources Advisor and the Provider. In addition, neither the practice nor the Provider had submitted documentation to register a registered manager and it was unclear who was taking responsibility for this.
- The Provider told us they attended the practice weekly and held regular meetings with staff. However, staff told us leaders were not always visible and approachable. Communication between staff groups was limited to senior staff and not all staff felt involved or communicated with. The practice had recently introduced a daily 'huddle' to improve communication with staff although it was too early to see what impact this was having on staff communication.
- Knowledge about issues and priorities relating to the quality and future of services was inconsistent. The practice understood some challenges, such as local housing schemes, but had not addressed some aspects of patient care provision, for example, dementia.
- The provider had not undertaken all required actions to identify, assess and mitigate risks on concerns previously identified to the provider by external organisations. For example, following the inspection in April 2017, we highlighted a lack of monitoring of staff training and could not identify training requirements. During this inspection, we found similar concerns.
- The systems for providing long term condition reviews and long term medicine reviews were not fully identifying and prioritising the needs of patients.

Vision and strategy

The practice did not have a clear vision or strategy to deliver high quality care and promote good outcomes for patients.

- Staff were unaware of the practice vision or values. The practice was going through a period of unsettled organisational change which was affecting their priorities. There was a mission statement available although few staff were aware of this.
- The practice had not planned services to meet the needs of its population. For example, the lead for older and vulnerable patients had not had their role defined and did not have the oversight required to deliver this service.

Culture

On the day of the inspection, the practice did not demonstrate an open and transparent culture.

- Prior to, during and after the inspection the practice was requested to provide documentation to the inspection team. Many documents were not shown to us to enable us to make a sufficient judgment of certain areas of the service. For example, we were unable to determine the processes for providing all staff with the development they need. We were not shown appraisal documentation and could not verify if all staff had received an annual appraisal in the last year.
- Most staff told us they felt supported and were proud to work in the practice. We received some negative feedback from staff who did not feel valued or listened to.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. However, not all staff said they felt confident that these would be addressed.

Are services well-led?

Inadequate

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

- Staff were supported to meet the requirements of professional revalidation where necessary.
- The provider was aware of the requirements of the duty of candour.

Governance arrangements

The practice had a governance framework which did not always support the delivery of the strategy and good quality care. This outlined the structures and procedures, although there were areas where the governance arrangements needed to improve.

- Staff recruitment files were not overseen at practice level with the provider head office keeping the records centrally. The practice manager did not have direct access to the files to ensure ongoing checks were being completed. On the day of the inspection we found some documents missing from recruitment files such as confidentiality agreements, induction records and staff health checks through an external occupational health provider.
- Staff training had not been monitored to ensure staff development needs were met or were sufficient for their role. There were gaps in the staff training matrix for several training modules including safeguarding, basic life support, infection control and fire safety. The practice had not provided training for all non-clinical staff in the recognition of sepsis.
- The practice had policies and procedures in place to support the delivery of services. However, these were a mixture of local and provider policies and some had not been adopted for specific practice use or updated to reflect current staffing structure. We also noted there was no clinical emergency policy to offer guidance to staff on their roles and responsibilities.

Managing risks, issues and performance

There were unclear and inconsistent processes for managing risks, issues and performance.

- The practice had not considered or assessed the risks associated with staff commencing employment before their disclosure and barring service check had been received.
- Risk assessments had not been prioritised and the practice had not identified or acted on known risks. For example, the fire safety risk assessment had not been fully acted upon. The practice did not supply evidence to support that other fire risk assessment actions were being carried out.
- The practice had inconsistent processes to manage current and future performance. Whilst many aspects of QOF had improved, patient care for dementia and vulnerable patients had not been prioritised. Exception reporting for cervical smears had not been effectively managed and not all staff were aware of the guidance on exception reporting.
- Clinical audits demonstrated improvements in quality of care and outcomes for patients.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to review performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used information technology systems to monitor and improve the quality of care.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice encouraged and received feedback from patients, staff and external partners.

- The practice had established a new patient participation group (PPG) in 2017. On the day of the inspection we spoke with four members of the PPG. They told us they had held two meetings with the practice since September 2017 and had yet to offer any suggestions for improvements. We saw information on the PPG in the waiting room to encourage new members.
- Results from the friends and family test and national GP patient survey were reviewed by the practice. We noted that comments left on the NHS choices website, about the service, had been inconsistently responded to. For example, seven comments on the website from

Are services well-led?

Inadequate

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

September 2017 to January 2018 had received a response from the practice in January 2018. There were four comments dating from June 2017 to January 2018 that had not received a response.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

- The practice had established a programme of quality audits and had undertaken a variety of single and two cycle audits. Recommendations to improve care had been made and there were demonstrable improvements to the quality of care for some patient groups. There were plans to continue with the audit programme.
- The practice had been approved by the National Institute for Health Research as a research site. They were planning to train a number of clinical staff in good clinical practice (a clinical research module).
- The practice had engaged with a local school to promote healthy lifestyles and were looking to facilitate training for pupils in basic life support and first aid techniques. The first session was due to take place in March 2018.
- At the time of the inspection the practice was facing a change in provider organisation which was due to commence in April 2018. The staff told us their focus for the immediate future was ensuring a positive transition and to maintain and improve on the quality of care they had attained in the past year.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 17: Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk: • The provider was unable to provide evidence that all staff have undertaken mandatory training or updates relevant to their role, including safeguarding, infection control, fire safety, information governance and health and safety. • The provider had failed to assess, monitor and mitigate risks in relation to significantly low patient health outcomes for patients with dementia. • The provider had failed to identify or act on known risks. For example, high risk actions from a fire risk assessment had not been carried out. Other risk assessments had not been undertaken which could place patients, staff and visitors to the service at risk. • The provider had failed to update and maintain appropriate staff records. There were missing documents from staff files, including a suitable health assessment to determine if any reasonable adjustments were required for employees. • The provider had not considered the risks associated with a lack of confirmed DBS check prior to commencement of employment.

This section is primarily information for the provider

Enforcement actions

- The provider had failed to review, update or localise practice policies. In addition, governance processes had failed to ensure an emergency policy was available to staff.

This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment of service users must be appropriate, meet their needs and reflect their preferences **How the regulation was not being met:** Care and treatment was not being designed with a view to achieving service user preferences or ensuring their needs were met. In particular: • The provider had not considered the ongoing needs of the residents of a local care home, offered continuity of care or responded in a timely way to requests for care and treatment. • Patients were not always involved in decisions about their care or treatment. • The needs of the practice population were not being met. Older patients and patients with long term conditions were not managed appropriately to reduce risk. Patients with mental health conditions were not supported or reviewed sufficiently to meet their needs. This was in breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.