Circuit Lane Surgery

Quality Report

Circuit Lane Surgery
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice remains rated as Inadequate from the previous inspection in October 2017.

We carried out an unannounced focused inspection at Circuit Lane Surgery on 23 January 2018. We returned to the practice two days later on 25 January 2018 to gather further evidence and to review and corroborate evidence collected during our first visit. The January 2018 inspection was the fifth inspection of the practice since December 2016. The outcome of the previous four inspections is as follows:

- December 2016 inspection in response to concerns raised. No rating applied. However, conditions applied to the registration.
- January 2017 comprehensive inspection. Practice rated inadequate and placed in special measures. Six conditions upon registration in place.

Summary of findings

- June 2017 inspection to review compliance with conditions. Three conditions were lifted the remaining three were kept in place.
- October 2017 comprehensive inspection to re-rate and review special measures. The practice remained in special measures and was rated inadequate overall. Further enforcement action proposed.

This fifth inspection was undertaken to follow up on breaches of regulations and ongoing concerns identified at the four previous inspections. We also sought to assess whether the practice had made any progress since the last inspection carried out in October 2017 when the practice was rated: Safe – Requires Improvement, Effective – Inadequate, Caring – Inadequate, Responsive – Inadequate and Well–led – Inadequate. We have not updated the ratings due to this being a focused inspection. Following the October 2017 inspection we proposed to commence enforcement action.

At this inspection we found:

- The practice had responded to an assessment of the registered population and increased the number of GPs on duty each day. Access to book appointments with GPs in advance had improved.
- Staff involved patients in decisions about their care and treated them with compassion, kindness, dignity and respect.
- Changes in the way incoming telephone calls were monitored and answered had reduced the time people waited to be answered when they made telephone call to the practice.
- The practice did not routinely review the effectiveness and appropriateness of the care it provided. Care and treatment was not always delivered according to evidence-based guidelines. For example, patients with long term medical conditions were not always receiving appropriate follow up and review.
- Data showed 41% of patients with repeat prescriptions for four or more medicines had not received a medicines review in the last year. These patients may require a change in their dosage or alteration to their medicines.
- Clinical staff other than GPs were not receiving clinical supervision.
- Incoming clinical correspondence and test results were not always dealt with in a timely manner. This created a potential risk in delayed reviews of care and risk assessments, care plans, medical records and investigation and test results.
- There was a risk of recurrence of adverse events because the practice did not operate a consistent process of investigating, discussing, recording and learning from such events

This service was placed in special measures in January 2017. Insufficient improvements have been made such that there remains a rating of inadequate for provision of effective, caring, responsive and well-led services. Therefore we are taking action in line with our enforcement procedures. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

Circuit Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector on both days of the inspection**.** On 23 January 2018 the team included a GP specialist adviser throughout the day and a practice nurse specialist adviser for part of the day. On 25 January 2018 the lead inspector was accompanied by a second CQC Inspector and member of the CQC medicines optimisation team.

Background to Circuit Lane Surgery

Circuit Lane Surgery is located in the Southcote area of Reading. One Medicare Ltd took over the contract in September 2016 following a procurement exercise led by the local clinical commissioning group (CCG). When the contract was taken on by One Medicare Ltd the practice was rated good overall with provision of caring services rated as requires improvement.

Since September 2016 there have been five inspections undertaken at the practice.

At the time of the inspection the services was staffed by two salaried GPs, supported by locum GPs. The salaried and GP locums equated to 3.5 GPs. There are three nurses, supported by agency nurses. In addition there are administration staff, receptionists and a business manager. There were male and female GPs available. The practice has an Alternative Provider Medical Services (APMS) contract.

The premises were purpose built as a medical centre and cover two storeys. All consulting and treatment rooms are on the ground floor. There are approximately 8,800 patients registered with the practice.

The age profile of the registered population is similar to the national average with slightly more patients aged between 55 and 69 than average. Nationally reported data shows a higher than average incidence of income deprivation amongst the local population. The ethnic mix of the population is varied. This includes, similar to other areas of Reading, a number of people originating from Nepal.

All services are provided from: Circuit Lane Surgery, 53 Circuit Lane, Southcote, Reading, Berkshire, RG30 3AN. Information about the practice can be accessed from their website at www. circuitlanesurgery.co.uk

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours are offered on both Monday and Thursday until 8pm. They are also offered on alternate Saturday mornings from 8.30am to 11am.

When the practice is closed, out-of-hours (OOH) GP cover is provided by the Westcall OOH service.

Why we carried out this inspection

We undertook a comprehensive inspection of Circuit Lane Surgery on 12 October 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and enforcement action was proposed. The full comprehensive report following the inspection in October 2017 can be found by selecting the 'all reports' link for Circuit Lane Surgery on our website at www.cqc.org.uk.

Detailed findings

We undertook a focused inspection of Circuit Lane Surgery on 23 and 25 January 2018. This inspection was carried out to follow up the proposed enforcement action and review any changes in the way the practice delivered services since the October 2017 inspection.

Are services safe?

Our findings

At our last inspection we rated the practice as requires improvement for providing safe services. During this focused inspection we continued to find issues of serious concern that placed patients at risk and breached regulations.

Safety systems and processes

The practice had systems to keep patients safeguarded from abuse.

- At previous inspections we had reviewed the processes used by the provider to carry out staff checks for employed staff. The checks had been carried out appropriately. During this inspection we reviewed the recruitment checks the provider undertook for locum staff. These were also carried out appropriately.

Risks to patients

Following the comprehensive inspection carried out in October 2017 the provider had continued to provide activity data returns to the local clinical commissioning group (CCG). These data returns were made available to CQC and showed that the practice was not always dealing with receipt of clinical correspondence and pathology results in a timely manner. For example, on 4 January 2018 there were 79 abnormal pathology results that had not been reviewed within 24 hours and on 5 January 2018 there were 86 abnormal results not reviewed within 24 hours. During our inspection in January 2018, we therefore reviewed in detail how the practice was dealing with pathology results and clinical letters.

On both 23 and 25 January 2018 we found abnormal pathology results that had not been reviewed by GPs within 24 hours of receipt.

- On 23 January 2018, the first day of inspection, the oldest abnormal result awaiting review was from Thursday 18 January 2018 which was four working days. We found one of these abnormal results had been allocated to a GP on Thursday 18. January 2018 when the GP rota showed this GP would not be on duty until Monday 22 January 2018. The result had not been reallocated to another GP to ensure it could be reviewed earlier. The GP timetable also showed that this GP had been on duty on Monday 22 January 2018 but had not reviewed the abnormal pathology result allocated to them. We discussed this with the practice Lead GP who took immediate action to review the result and ensure a repeat blood test was arranged for Thursday 25 January 2018.
- On Thursday 25 January 2018 there were 46 abnormal test results awaiting GP review, the oldest of these were from Monday 22 January 2018 which was again four working days. On both days of the inspection we looked at a sample of four abnormal results. The eight we reviewed were not significantly out of target range and posed minimal risk to patient care and treatment.

The failure to review abnormal pathology results and take appropriate action based on the results placed patients at potential risk if the result required urgent follow up action by the GPs, referral to another service or consideration of admission to hospital. The practice could not assure themselves that if a significantly abnormal pathology result had not been alerted to them by the laboratory it would be addressed in a timely manner.

There was a system in place for GPs to review records and correspondence about patients received from other services. However, the system was not operated effectively because there was a backlog of correspondence that was not reviewed by GPs in a timely manner. The data supplied by the provider showed that on 3 January 2018 there were 454 records not reviewed by a GP within five days of receipt. On 5 January 2018 there were 453 records not reviewed by GPs within five days of receipt.

On 23 and 25 January we found the number of correspondence items that had not been reviewed had reduced. However, on both days of the inspection there remained over 100 records that had been received five days earlier and not been reviewed by GPs. The failure of the practice to deal with incoming clinical correspondence in a timely manner placed patients at potential risk. Incoming correspondence could contain information that required urgent action by GPs or clinicians such as requests to undertake further tests, change patients medicines or see the patient for an early review of their care and treatment. The practice could not be assured that urgent action identified in clinical correspondence was acted upon in a timely manner.

Are services safe?

Safe and appropriate use of medicines

There was an effective system in place to monitor the use of high risk medicines. We reviewed the process in place for monitoring high risk medicines because we noted that pathology test results were not always dealt with in a timely manner.

- Our review of two disease modifying medicines showed that patients taking these medicines received appropriate tests and prescribing for them was undertaken based on the test results. There was evidence of appropriate use of a reporting system between hospital clinics and GPs to ensure medicines appropriate dosages of medicines were maintained.
- Our review of patients taking a medicine for severe and enduring mental health problems also found that the patients completed appropriate blood tests at set intervals to ensure the medicine could continue to be prescribed safely.
- We also reviewed the records of patients that were taking medicines to thin the blood. These records also showed that dose levels were based upon the results of regular blood tests.

The practice did not operate an effective system for carrying out medicine reviews. There were 1,077 patients registered who were prescribed four or more medicines. Patients prescribed repeat medicines should receive regular medicine reviews. However, practice data showed that 442 of the patients prescribed four or more medicines had not received a medicine review in the last year. These patients were at potential risk because a review may have identified that they needed to change the dose of their medicines, cease taking a medicine or require an alternative.

We were told, following the inspection, that the provider had a plan to undertake 95 medication reviews each month

Lessons learned and improvements made

The practice had a system in place for reporting and learning from significant events. However, the system was not operated consistently. When we carried out an inspection in October 2017 we found that the number of reported events had increased from six in August to 14 in September. This had coincided with a reduction in the number of GPs on duty each day. We also noted that a number of the reported events were related to staff not reporting for duty and staff reporting they were under pressure from workload and staff shortages. Therefore we reviewed the reporting of significant events at this focused inspection. We found:

- An event of a patient being administered their flu immunisation twice within the space of 17 days was included in the provider significant event log. The minutes of clinical meetings held since the event took place did not include a record of a review of the incident or dissemination of learning from the incident. The event log also did not contain a reference to the outcome or any learning gained from the incident. There was no record of the practice learning from the incident to prevent a similar occurrence in the future. However, we noted that the incident did not lead to the patient experiencing any harm as the immunisation was not a live vaccine.
- The minutes of the clinical meeting of 12 December 2017 recorded discussion of three incidents of failure to complete referrals for patients. These minutes also recorded that a GP was charged with responsibility to record the events in the significant event log. Our review of the significant event log showed that these incidents had not been recorded when we concluded our inspection on 25 January 2018. We discussed this with the practice during the inspection and received assurance within two working days of the inspection that the incidents had been registered in the incident log.

On the first day of inspection, 23 January 2018, a member of staff told us about an incident where a patient had been prescribed the wrong medicine during their consultation on 22 January 2018 (an anti-psychotic medicine was prescribed instead if an anti-spasmodic). The patient did not come to harm because they had not taken their prescription to be dispensed. The risk was only avoided by the patient seeking a second opinion. The incorrect prescription would not otherwise have been identified. The error was corrected on 23 January 2018. The member of staff told us they would enter the incident onto the incident log. The entry into the event log had not been completed by the time we carried out our second day of inspection on 25 January 2018. The patient concerned had submitted a complaint on 24 January 2018 regarding their care they had received on 22 January 2018.

Are services effective?

(for example, treatment is effective)

Our findings

We previously rated the practice as inadequate during our last inspection in October 2017. At this inspection we found no evidence of improvement.

Monitoring care and treatment

The practice had a system in place to offer care reviews to patients with long term conditions but this system was not operated effectively. We found:

- There were 68 patients diagnosed with diabetes who had not had a blood test to assess overall blood sugar levels in the last year. A random sample of 10 of these patients showed that three patients (30%) had not had this test for over two years. Control of blood sugar levels for diabetics is important and the results of the test influence the treatment regime.
- There were also 68 patients diagnosed with severe long term mental health problems who either did not have a care plan or their care plan that had not been reviewed in the last year. A random sample of 10 of these patients showed that all 10 (100%) had not had a review for more than two years. Care plans for this group of patients enable clinicians to make treatment decisions and co-ordinate care with other professionals where this is appropriate.
- A total of 38 patients diagnosed with long term mental health problems had not had a blood pressure check in the last year. The sample of 10 of these patients we reviewed showed that three (30%) had not had their blood pressure checked for over two years with one of this group not checked for five years. Health checks for patients with long term mental health problems are important as poor mental health is often linked to poor physical health.
- A sample of 10 patients diagnosed with depression showed that six (60%) had not had their diagnosis updated to record that they were no longer suffering with depression.
- The practice had not undertaken an assessment of the breathlessness of 72 patients diagnosed with a severe long term lung condition (COPD) in the last year. The sample of 10 of these patients we reviewed showed that three (30%) had not had this assessment for over two years. Assessing breathlessness for this group of patients identifies whether their condition is stable, improved or worsened. It may indicate more active treatment is required.

Our inspection in October identified concerns in the treatment of patients diagnosed with asthma. The practice commenced a programme of asthma reviews. A weekly report sent to CQC via the CCG showed that these reviews were progressing and that up to date clinical guidelines were being used at the reviews.

Effective staffing

When we undertook a comprehensive inspection in October 2017 two members of clinical staff told us they were not receiving clinical supervision. We spoke to a further member of clinical staff during this inspection and they also told us they did not receive clinical supervision. We were also told there was no system in place for supervising, or auditing, the work of locum advanced nurse practitioners and emergency care practitioners. Patients were at risk because the work of clinical staff, other than GPs, was not reviewed or supervised.

We reviewed data from five clinics undertaken by different locum staff. Our review showed that these staff were consulting appropriately within their scope of responsibility and sought advice from GPs when patients presented with complex conditions.

Are services caring?

Our findings

When we carried out an inspection in October 2017 we rated the practice as inadequate for providing caring services.

Kindness, respect and compassion

We observed that staff treated patients with kindness, respect and compassion.

- There was an additional GP on duty each day compared to our last inspection in October 2017. This resulted in offering more GP appointments for patients.
- We received 15 pieces of feedback from patients during inspection (seven comment cards and eight patients we spoke with). All 15 were positive about the GPs and nurses being helpful and caring. Two patients told us the current GPs were the best they had been to see at the practice. Of the 15 patients giving feedback there were nine that told us they had sufficient time with the clinical staff to explain their symptoms. They also said GPs listened and were compassionate. The feedback we obtained showed an improving view of the caring aspects of the service but the sample of patients was not representative of the practice list size.
- The practice provided the results of the friends and family recommendation test for July to December 2017. This showed that the highest recommendation rating achieved in the last six months was 58%. This was significantly below the national average recommendation rates published for October and November 2017 which were both 89%.
- The feedback from the national GP patient survey had not changed since our inspection in October 2017. The results were below average.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

When we carried out an inspection in October 2017 we rated the practice as inadequate for providing responsive services.

Responding to and meeting people's needs

The practice management team had reviewed the composition of the registered patient population. They requested a change in clinical staffing structure. This had been prompted from clinical staff meetings, where the minutes showed that GPs had raised concerns regarding patient access to GP appointments. A significant event setting out the concerns had been raised.

In the third week of December 2017 the provider responded to the practice by including a third GP on the daily rota. It was too early to evaluate whether this would result in consistently improved patient feedback about the responsiveness of the service.

Timely access to the service

The practice had recently implemented changes in staffing structure which had improved patient access to care and treatment.

- Review of the practice appointment system showed that access to book appointments in advance with a GP had improved from over a three week wait when we inspected in October 2017 to 10 days. This was a similar wait to other practices in the local area. The addition of a third GP on duty each day had improved the availability of appointments.
- The telephone call logging system had been installed on a computer in the administration office. This enabled staff to view the incoming call data. When staff identified an incoming call queue forming they were able to enlist help from other staff to answer calls. This had been made possible by the recruitment of an additional member of staff to the administration and reception team. On 23 January 2018 we noted that the average time taken to answer incoming calls was two and a half minutes. In the past patients reported they were waiting over half an hour for their calls to be answered.
- The timing of the walk in clinic had been moved back by two hours every morning. This meant that the patients arriving for the walk in clinic did not clash with the peak time for receipt of incoming phone calls. Staff therefore had more time to answer incoming telephone calls.
- In the past we found that the clinic rota had not been entered in a timely manner which resulted in patients having difficulty booking appointments in advance. At this inspection we were told by staff who prepared the monthly clinic timetables had received timely approval in the last two months to enable them to enter the clinics onto the practice computer system. This had resulted in appointments being set up earlier than when we last inspected and gave more opportunity for patients to book appointments in advance.

Listening and learning from concerns and complaints

We reviewed the 12 complaints the practice had received since our last inspection in October 2017.

- The complaint policy and procedures were in line with recognised guidance. The 12 complaints we reviewed were found to be satisfactorily handled in a timely way.
- We noted that eight of the 12 complaints related to access to appointments and difficulties in contacting the practice by telephone. The practice had increased the availability of GPs, recruited an additional member of administration team and changed the way incoming calls were answered in the four weeks prior to inspection. It was too early to tell whether the changes would reduce the complaints relating to access.
- The GP advisor reviewed the two complaints relating to clinical care and found that the practice had responded appropriately and resolved the concerns the patients had raised.

Are services well-led?

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

Our findings

The practice was rated inadequate for providing a well-led service when we carried out a comprehensive inspection in October 2017.

Governance arrangements

During inspection we found that:

- Clinical supervision of Advanced Nurse Practitioners (ANPs), clinical pharmacists and Emergency Care Practitioners (ECPs) was not taking place.
- There was no system in place to monitor and audit the work of locum ANPs and ECPs.
- There was an inconsistency in investigating, reporting and learning from significant events.

The practice was therefore unable to demonstrate that oversight of policies and procedures had ensured they were operated effectively in providing clinical supervision for all clinical staff, timely review of pathology results/ clinical correspondence and responding to significant events.

Managing risks, issues and performance

Processes to manage risk were not operated effectively.

- Governance systems had not ensured patients taking repeat medicines received an annual medicines review. At the time of inspection only 59% of patients taking four or more medicines had a medicines review in the last year.
- Management of recall systems for patients with long term conditions were not operated consistently. We identified large number of patients diagnosed with diabetes, mental health problems and COPD (a chronic lung condition) who were not receiving the full range of annual review of their conditions.
- There was a lack of effective leadership to ensure patients safety was not compromised. The system in place to ensure prompt review and action from pathology results and clinical correspondence was not operated in a way that prevented backlogs from forming.

However, we did find:

- System changes had led to improvement in access to appointments and to the practice by telephone. It was too early to evaluate the sustainability of these changes.
- Clinical team meetings were held regularly and the discussions recorded. This had not been the case during previous inspections.
- The skill mix of clinical staff providing appointments had been changed to reflect the demographics of the local population. However, we did not note improvement in delivering effective care and treatment to the higher than average number of patients diagnosed with long term medical conditions.