Temple Cowley Medical Group

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced focused inspection of Temple Cowley Medical Group on 28 September 2016. The inspection was carried out because we had received information of concern from a whistle-blower in relation to patients being placed at risk. These concerns referred to the poor monitoring and management of patient correspondence in a timely manner. In addition there were concerns that referrals were not processed on time and consultation notes were not always documented. We were also informed that staff time keeping and waiting time in the waiting area were not monitored effectively. We found the service was not meeting fundamental standards and had breached regulations. Specifically, we found concerns and regulatory breaches relating to the safe care and treatment, and management and leadership of the practice.

Summary of findings

The practice was not rated during this focussed inspection. Our previous announced comprehensive inspection in July 2016 found issues relating to the effective delivery of care and treatment and we asked the practice to make improvements. The practice was rated good for providing safe, caring, responsive and well-led services. This report should be read in conjunction with the full inspection report published on 21 September 2016.

Our key findings during this focussed inspection were as follows:

- Patients were placed at risk of harm because the practice had failed to act on patient correspondence in a timely manner. There was no system in place to ensure that patient correspondence across the practice managed appropriately.
- There were inconsistent arrangements in how risks were assessed and managed. For example, during the inspection we found risks relating to referral management system, failure to seek external specialist advice for complex cases and the practice did not carry out a formal written risk assessment to assess the suitability of the premises at the branch location.
- We noted inconsistent record keeping arrangements. For example, consultation notes were not always documented in patient records and the practice did not ensure to integrate dermatology photographs within the patient information management system.
- Time keeping and long waiting times in the waiting area were not monitored effectively.
- The practice had limited governance arrangements to enable assessment and monitoring of the service.
- Staff we spoke with informed us they felt supported in their role and the management was approachable and always took time to listen to all members of staff.

The areas where the provider must make improvements are:

- Further review, assess and monitor the governance arrangements in place to ensure the delivery of safe and effective services. For example, monitoring of document management system, referral management system and improve record keeping.
- Review and improve the systems in place to act on patient correspondence and referrals in a timely manner.
- Develop a more structured approach and seek specialist advice to ensure complex cases of patients experiencing poor mental health, and drug and alcohol related conditions are managed appropriately.
- Review and improve the systems in place to monitor staff time keeping effectively and waiting times for patients in relation to their allotted appointment time.
- Ensure risks related to the branch location are identified, documented and mitigated to assess suitability of the premises.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We have not rated this domain during this follow up focussed inspection.

- On the day of inspection we found although risks to patients who used services were assessed, the systems and processes to address these risks were not always implemented to ensure patients were kept safe. For example, the practice had failed to act on correspondence in a timely manner and the arrangements for monitoring patient correspondence across the practice were not effective to ensure patients were kept safe and their care, treatment and medical records was up to date.
- The practice had failed to seek external specialist advice from a consultant to ensure complex cases of patients experiencing poor mental health and drug and alcohol related conditions were managed appropriately.
- The practice had not carried out a formal written risk assessment to assess the suitability of the premises at the branch location.

Are services effective?

We have not rated this domain during this follow up focussed inspection.

- On the day of inspection we found the arrangements for managing and monitoring patient referrals were not effective. For example, we saw a number of cases where referrals were not processed in a timely manner which could have had significant impact on the future care delivery.
- The practice had failed to monitor and audit its referral management system to ensure continuity of safe healthcare and referrals were processed in a timely manner.
- We noted that the practice had not implemented effective safety netting processes to identify missed referrals and was relying on patients to chase the referrals.
- We saw two episodes where consultation notes were not documented in patient records and there was no monitoring system in place to ensure this would not happen again.

Are services well-led?

We have not rated this domain during this follow up focussed inspection.

Summary of findings

- On the day of inspection we found weak governance framework which did not support the delivery of good quality care. The number of concerns we identified during the inspection reflected this. For example, the practice had failed to monitor and audit an electronic document management and transfer system, referral management system and documentation of consultation notes.
- The practice did not have a monitoring system to ensure good record keeping. For example, we saw consultation notes were not always documented in patient records and the practice failed to identify when referrals involving dermatology photographs were not saved in patients' electronic records.
- The practice had not monitored staff time keeping and waiting times effectively.

Temple Cowley Medical Group

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 advisor.

Why we carried out this inspection

We carried out an unannounced focused inspection in response to concerns raised by whistle-blower in relation to patients being placed at risk. These concerns referred to poor monitoring of referral management system and failure to act on patient correspondence in a timely manner. In addition there were concerns that blood test results in-tray was not monitored effectively and consultation notes were not always documented.

We carried out a follow up focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service under the Care Act 2014. We did not rate the practice during this focussed inspection.

Temple Cowley Medical Group was previously inspected in July 2016 and we found issues relating to the effective delivery of service. The practice was rated good for providing safe, caring, responsive and well-led services.

This report should be read in conjunction with the full inspection report published on 21 September 2016.

How we carried out this inspection

The inspection team carried out an unannounced focused visit on 28 September 2016. During our visit we:

- Spoke with 10 staff (included two GP partners, a salaried GP, a nurse team leader, a practice nurse, a phlebotomist, a practice manager, a reception team leader and two administration staff).
- Reviewed the personal care or treatment records of patients.

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

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

Are services safe?

Our findings

Overview of safety systems and processes

Systems, processes and practices within the practice were not operated effectively to keep patients safe and the practice had failed to act on correspondence.

- On the day of inspection we found the arrangements for managing and monitoring Docman were not effective to ensure patients were kept safe. (Docman is an electronic document management and transfer system which enabled the practice to organise, workflow, track and securely send and receive healthcare documents electronically).
- The practice had failed to act on patient correspondence in a timely manner and there was no system in place to ensure that patient correspondence across the practice was managed within a 24 to 48 hours' time period.
- We checked Docman records of five GPs and found correspondence in three inboxes were not managed efficiently; there was a total of 5,000 items across three of the GP Partners inboxes.
- We saw more than 4,000 items in an inbox dated back to July 2013. The fact that the letters had not been actioned may have had a serious impact on patients safety. This was because medicines had not been reviewed to reflect changes advised by the hospital, referrals to other professional had not been actioned, appropriate coding had not been applied of new diagnosis and lack of appropriate information in patient's records.
- On the day of inspection we did not find evidence of actual harm however, the risk of harm remained.

Monitoring risks to patients

- Risks to patients were not always assessed and well managed. For example, we saw three complex cases where the practice had failed to seek external specialist advice from a consultant to ensure patients experiencing poor mental health and drug and alcohol related long term conditions were managed appropriately.
- The practice offered GP appointments at the village hall (branch location) once a month for a morning session for the local community. However, the practice had not carried out a formal written risk assessment to ensure the suitability of the premises including confidentiality and privacy requirements.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

Management and monitoring processes within the practice were not always operated effectively to ensure delivery of high quality healthcare and improved outcomes for patients.

- On the day of inspection we found the arrangements for managing and monitoring referral system and documentation of consultation notes were not always effective to ensure continuity of safe healthcare. We observed that the practice did not have an effective governance process and the safety net was relying on patient contact. We did not find evidence that GPs or the secretary were maintaining effective logs of patients' referred for further consultation to ensure a comprehensive follow up system. We saw the secretary had maintained logs of patients referred under two weeks wait rule. However, the practice did not have a comprehensive follow up system and records were not updated regularly to ensure the two weeks rule had been achieved.
- We identified two episodes where consultation notes were not documented and safe care was not provided.
- We saw number of examples where the practice had failed to write and send referrals on time and this delay may have impacted on the decision making and care and treatment planning for patients. We looked at the records related to these specific patients and saw they contacted the practice in order to progress their referrals. We noted that once the missed referrals had been identified they were referred and the patients received a satisfactory outcome. However, the risks to patients were only mitigated by the patient contacting the practice when there was a delay in their referral.
- For example, we noted a patient at risk of breast cancer was not referred for screening on time and consultation notes were not documented. However, the lack of referral was identified after the patient had contacted the practice. The referral was made immediately during follow up consultation.
- The practice did not have a protocol in place to manage referrals involving dermatology photographs. The photographs were not always saved in patients' electronic records and there was no monitoring system to ensure good record keeping. However, we saw evidence that patients were safe and received feedback from the dermatologist and good care was provided by the practice.
- We saw an example where the practice had failed to follow instructions from a hospital discharge note. The patient had undergone a heart procedure at the hospital and prescribed a medicine which reduced the risk of blood clotting. One GP in the practice had stopped this medicine inappropriately and was restarted a few weeks later after a follow up appointment with another GP.
- We saw an example where the practice had failed to undertake blood pressure reading of a patient with a persistent headache and the patient was subsequently admitted to hospital with a transient ischaemic attack secondary to extremely high blood pressure (condition also known as malignant hypertension).
- We found the practice was following up on blood test results and actions were taken as required but they did not have an effective monitoring system in place to ensure that all pathology results from the inbox were saved in the patient records in a timely manner. We found 199 items in the inbox but most of them were national screening results which were acted by the national screening team.

Are services well-led?

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

Our findings

Governance arrangements

Governance arrangements within the practice were not operated effectively or in a way to ensure risks were monitored effectively to protect the safety of patients. The practice had failed to provide effective leadership and monitoring systems.

- The practice had failed to identify and improve the systems in place to effectively monitor patient electronic document management, referral management, to contemporaneously document consultation notes and failed to seek external specialist advice to manage complicated cases efficiently for patients experiencing poor mental health and drug and alcohol related conditions.
- The practice did not have effective monitoring system to ensure good record keeping. For example, we saw consultation notes were not always documented in patient records and the practice failed to identify when referrals involving dermatology photographs were not saved in patients' electronic records.
- The practice had not monitored staff time keeping effectively. For example, we noted a clinical staff had arrived late on number of occasions in the last two months and the practice had failed to address the issue. For example, we checked electronic records of a clinical staff member and found eight days with an average late arrival of 22 minutes in the last two months.
- The practice had not monitored waiting times effectively and we saw evidence that at times patients waited long periods after their appointment time with GPs. For example, staff we spoke with on the day of inspection informed us that sometimes patients had to wait up to 45 minutes after their appointment time. We checked electronic records of two GPs and found delay time ranged from 30 minutes to 49 minutes in the last two months. We saw the practice had introduced catch up breaks between appointment slots and increased duration of consultation time from 10 minutes to 15 minutes for one GP.
- We saw the practice had increased nursing team leader contractual hours from 15 hours to 30 hours per week with a dedicated day for managerial responsibilities.
- We saw the national GP patient survey results published on 7 July 2016 was in line with our findings showed patients were dissatisfied with waiting times. For example, 34% of patients had to wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 64% and a national average of 65%.
- Clinical and non-clinical staff we spoke with informed us they felt supported in their role and the management was approachable and always took time to listen to all members of staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found the registered person did not have suitable arrangements in place for assessing and managing risks in order to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. For example: Review and improve the systems in place to act on patient correspondence and referrals in a timely manner. Develop a more structured approach and seek specialist advice to ensure complex cases of patients experiencing poor mental health, and drug and alcohol related conditions are managed appropriately. Regulation 12(1)

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 How the regulation was not being met: We found the registered person did not have effective governance, assurance and auditing processes and they were required to further review, assess and monitor the governance arrangements in place to ensure the delivery of safe and effective services. For example, monitoring of document management system, referral management system and improve record keeping. Review and improve the systems in place to monitor staff time keeping effectively and waiting times for patients in relation to their allotted appointment time.

This section is primarily information for the provider

Enforcement actions

Ensure risks related to the branch location are identified, documented and mitigated to assess suitability of the premises.

Regulation 17(1)