Dr Stephen Lawrence

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate

The key questions are rated as:

Are services safe? – **Inadequate**

Are services effective? – **Inadequate**

Are services caring? – **inadequate**

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**

On 1 Dec 2015 the Care Quality Commission (CQC) inspected St Mary's Island Surgery. The practice was rated as 'inadequate' for providing 'safe' and 'well led' services and 'requires improvement' for providing 'effective', 'caring' and 'responsive' services. The practice was rated inadequate overall. As a result in March 2016 the practice was placed in special measures.

The practice worked with NHS Medway CCG and NHS England while in special measures to significantly improve the level of care and treatment.

The CQC inspected again on 23, 26 & 29 September 2016. The practice had made improvements and was rated as 'good' for each of CQC's key questions. As a result, the surgery was removed from special measures.

We carried out an unannounced comprehensive inspection at Dr Stephen Lawrence on 23 and 25 January 2018. We carried out the inspection in response to concerns that had been raised with us.

At this inspection we found:

- Systems to safeguard children from abuse were not effective. The practice had not responded to requests for information concerning the health and welfare of looked after children.
- There were no administration/reception staff working at the practice. Temporary reception staff, who had come from other practices to help, had not had an induction.
- Correspondence was not dealt with in a timely manner, large quantities of correspondence were awaiting inputting onto patients' records.

Summary of findings

- Medicine management was unsafe. Emergency medicines were out of date. The oxygen cylinder was empty.
- Significant events had not been reported. The practice did not have an effective system for receiving and acting on safety alerts
- GPs did not have access to the proper information technology tools to help make the best decisions for their patients' treatment and care.
- Patient care was not well co-ordinated, including end of life care.
- Patients' records and the coding of patients' records were not up to date so staff were not always able to identify patients' conditions and meet their needs.
- Patients were not referred to secondary care, nor were referrals from secondary care, dealt with in a timely manner.
- The provider was unable to demonstrate they had implemented all actions detailed in their plan to improve patient satisfaction scores.
- The practice's results from the 2017 annual national GP patient survey were below the national average for its satisfaction scores on caring and responsive issues
- Although there had been an increase in the number of patients on the practice's list who had been identified as carers we were unable to speak with staff to identify how carers were currently being identified.
- There were failings in the practice's compliance with the Data Protection Act 1998.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was not always coordinated with other services.
- The needs of children were not always addressed in a timely way and vulnerable adults were not always supported.
- Patients did not always receive care and treatment from the practice within an acceptable timescale for their needs.
- The annual national GP patient survey, relating to the practice's responsiveness was below the national average.
- Some complaints from patients were not acknowledged.
- Governance arrangements were insufficient, ineffectively implemented and were compounded by the regular absence of the GP.
- Significant issues that threatened the delivery of safe care were not identified or adequately managed.
- Staff we spoke with said that they did not feel valued or supported by the practice.
- There had been no recent staff meetings.
- There was no patient participation group.
- There was no evidence of systems and processes for learning, continuous improvement and innovation within the practice.

Following our inspection our concerns were such that on the 29 January 2018 we imposed immediate conditions on The provider's registration with the Care Quality Commission. The conditions were:

Condition 1: By 8 February 2018 the registered person must clear the existing backlogs of prescription requests, medication reviews, referrals to and responses from secondary care, patients' discharge notes and any other correspondence, relating to the health and care of patients. The progress of this task must be reported to the Care Quality Commission (the Commission) weekly by midday each Thursday.

Condition 2: By 8 February 2018 the registered person must implement a sustainable system to ensure prescription requests, medication reviews, referrals to and responses from secondary care, patients' discharge notes and any other correspondence, relating to the health and care of patients are reviewed and actioned without delay. By 8 February 2018 the registered person must report to the Commission how this system has been implemented.

Condition 3: The registered provider must ensure that a suitably qualified, competent, skilled and experienced person is present at the practice to manage day to day operations to ensure a safe delivery of the service.

Summary of findings

The provider was in breach of those conditions in that on 30 and 31January a CQC inspector called at the practice and found that on nether day was there a person on the premises who accepted responsibility for managing it.

On 31 January 2018 we issued a Notice of Proposal to cancel The provider's registration with the Care Quality Commission under Section 17(1) (c) of the Health and Social Care Act 2008. This gave The provider 28 days in which to make written representations to Her Majesty's Courts & Tribunals Service as to why he did not agree with any of the reasons for the notice of proposal. No representations were received.

On 2 March 2018 we issued a Notice of Decision to cancel The provider's registration with the Care Quality Commission. This Notice gave The provider 28 days in which to make written representations to the Care Quality Commission as to why he does not agree with the Notice of Decision.

We reported our findings to Medway Clinical Commissioning Group (CCG) and NHS England. As result of our concerns the CCG attended The provider's practice and carried out a review of aspects of care. Some evidence from that review is contained within this report.

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

Good governance

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the Act.

On 20 February 2018 a new provider was registered with the Care Quality Commission to provide general practice services from the St Mary's island surgery site.

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	**Inadequate**
People with long term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Dr Stephen Lawrence

Detailed findings

Our inspection team

Our inspection team was led by:

On the 23 January the inspection team was led by a CQC lead inspector and included a GP specialist adviser, and a practice manager adviser. On the 25 January the inspection team comprised two CQC inspectors.

Background to Dr Stephen Lawrence

Dr Stephen Lawrence (also known as St Mary's Island Surgery) is situated in Chatham, Kent and has a registered patient population of approximately 3,200. There are more patients registered between the ages of 0 and 14 years as well as 35 and 49 years than the national average. The practice is not in an area of particular deprivation. The practice staff consists of the principal GP (male), a salaried GP (female), and a locum nurse and a healthcare assistant. There was no practice manager, administration or reception staff. At the time of the inspection reception and administration staff were provided on a temporary basis from local practices.

There is a reception and waiting area. All the patient areas are accessible to patients with mobility issues, as well as parents with children and babies.

The practice is not a teaching or training practice.

The practice has a general medical services contract for delivering primary care services to the local community.

The practice's opening hours are Monday to Thursday between the hours of 8.30am to 1pm and 2pm to 6pm and Friday 8.30am to 1pm. The practice's telephone lines remain open between the hours of 1pm to 2pm. Extended hours surgeries are advertised as available on Friday 6.30am to 8am. Primary medical services are available to patients registered at the provider via an appointments system.

There are arrangements with another provider (Medway On Call Care) to deliver services to patients outside of the practice's working hours.

Services are provided from St Mary's Island Surgery, Edgeway, St Mary's Island, Chatham, Kent, ME4 3EP, only.

Inadequate

Are services safe?

Our findings

At the comprehensive inspection in September 2016 we rated the practice as good for providing safe services. The practice, and all of the patient population groups, was rated as good overall.

At this inspection we rated the practice, and all of the patient population groups, as inadequate for providing safe services because:

Systems to safeguard children from abuse were not effective. The provider had not responded to requests for information concerning the health and welfare of looked after children.

- There was no practice manager, administration or reception staff permanently employed bt the provider. At the time of the inspection reception and administration staff were provided on a temporary basis from local practices. Temporary staff, who had come from other practices to help, had not had an induction.
- Correspondence was not dealt with in a timely manner, large quantities of correspondence were awaiting inputting onto patients' records.
- Medicine management was unsafe. Emergency medicines were out of date. The oxygen cylinder was empty.
- Significant events had not been reported. There was no system for receiving safety alerts.

Safety systems and processes

The practice did not have effective systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies. Most of these were due for review in August 2017. This had not happened. On the two dates that inspectors attended there was a different temporary receptionist on duty, neither of whom were employed by the practice. No other reception or administration staff were present. The temporary staff reported that they had not had any process of induction. They were therefore unfamiliar with safety practices at the practice. For example one receptionist did not know the code to access the defibrillator outside the building or the location of emergency medical oxygen.
- Systems to safeguard children and vulnerable adults from abuse were not effective. The practice did not always work with other agencies to support patients and protect them from neglect and abuse, in a timely fashion. For example we found two instances when the practice had received requests, from the statutory authorities, about the welfare of looked after children, in neither case had the practice responded.
- There were no administration staff employed by the practice with the exception of a business manager who attended the practice only occasionally and normally worked remotely. We found evidence that a prospective staff member had been employed on reception duties without the necessary recruitment processes having been followed.
- The premises appeared clean and tidy. We could not check if there was an effective system to manage infection prevention and control, as no staff were available to show us any documentation. We asked the provider for information about any staff lead with responsibility for infection prevention and control and what training they had had but we received no information.
- We were unable to check whether the practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions because there were no staff available who tell us where to find any supporting evidence

Risks to patients

Systems to assess, monitor and manage risks to patient safety were ineffective.

- The arrangements for planning and monitoring the number and mix of staff needed to manage the practice were not effective. On both inspection days we saw that the temporary receptionists were completely occupied with the immediate tasks central to reception. There were no other reception or administration staff present in the practice to answer the telephones in the back office which were ringing frequently throughout our inspection. There were no staff available in the practice to relieve the receptionist for breaks. Although the reception was closed between 1pm and 2pm, during this time the receptionist was fully occupied dealing with the backlog of tasks arising from inadequate staffing levels, as well as answering incoming telephone calls.
- Both temporary receptionists told us that they had not received any induction training from the practice. They

were both experienced receptionists but functioned by following the procedures of their own GP practices without any knowledge as to whether this was correct in the provider's practice.

- The receptionists we saw on both inspection days were trained to manage emergencies, by their own GP practices. There was an automated external defibrillator outside the front door of the premises. It was in a locked cabinet with a keypad lock. Neither of the two staff had the number of the keypad and would have to ring a telephone number, displayed by the cabinet, to gain access.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- Where we saw individual care records they were written in a way that kept patients safe. However there was a large number of either new patients' records or records of patients awaiting transfer to other practices in boxes and bags in the back office awaiting action. Staff were not able to tell us which records were awaiting transfer out which were awaiting transfer in. The practice was signed up to a system, GP2GP, which allowed practice to access a shorter medical record of patients who were in the process of transfer. However because patients' records were not kept up to date other practices, accessing this providers' patients through GP2GP, might be accessing records which were out of date and would not be aware of this.
- Referral letters not routinely completed in a timely fashion. We found several referrals, the earliest dating back to the first week in September 2017 which had not been forwarded to the relevant secondary care provider.
- There was a large amount of correspondence, approximately 450 items, awaiting action at the practice. The earliest of these items dated from the second week in November 2017. They included, but were not confined to:
- Electronic discharge (from hospital) notices (EDN). EDNs are primarily designed to improve patient care and safety through to the availability of complete, accurate and timely information and reduce the risk of missing or inappropriate critical clinical information.
- The results of clinical tests, apart from blood tests which are received electronically. These were tests ordered to help diagnose or monitor the health and safety of patients.
- Letters, addressed to the practice, following patients' having been seen by Consultants or other secondary care providers concerning matters impacting on the health and safety of patients.
- There were 1047 blood test results that were not marked on the practice electronic recording system as having been viewed or actioned. The earliest of these was 15 February 2017. Some of these were subsequently identified as posing a risk to patients' health.

Safe and appropriate use of medicines

The practice did not have adequate systems for appropriate and safe handling of medicines.

- The systems for managing medicines, and emergency medicines were not adequate. For example there were out of date medicines in the emergency medicines cupboard. The emergency oxygen cylinder was empty, on 23 January 2018 we reported this to the administration staff member. When we returned on 25 January we saw a new medical oxygen cylinder being delivered.
- On 25 January we were provided with a binder of practice policies. A medicines management policy was indexed in the binder but the policy was not in the binder. In May 2017 a GP working at the practice informed the provider that they would not sign prescriptions for Warfarin (a blood thinning medicine) because there was no process to reduce the clinical risks. The provider replied saying that a patient notice and protocol would be developed. We were not able to find any such protocol. Clearly a protocol had not been produced because on 23 January 2018 the provider wrote to a GP at the practice reminding them that they had promised to compile a protocol for Warfarin prescriptions which he said he had yet received.
- We saw that there was a new system, driven by the local Clinical Commissioning Group (CCG) coming into place at the end of January 2018. Under this arrangement each practice would receive a list of such patients who had been seen in the community during the previous week. The provider was aware of the changes and had prepared a circular for staff. However there was still no system in the sense that the provider's document did not set out the action required when the list was receive or who would do it.
- Processes to ensure safe prescribing of other medicines, which needed additional monitoring, through blood testing were ineffective. The provider told us that the

practice relied upon the warning flags that were displayed on the patients' notes when considering whether to prescribe, or further prescribe these medicines. However we found several patients prescribed methotrexate (a chemotherapy agent and immune system suppressant) and Lithium (primarily a psychiatric medication) who had not had blood tests within the time frame that best practice indicated was required to keep them safe. We asked the provider for a list of patients prescribed any one of three specific medicines that required additional monitoring, showing the dates of their last blood test. We did not receive a list. On the 25 January we asked the provider to search the practice's electronic patient records system to identify such patients. He was unable to use the electronic patient records system to carry out this search but relied upon remembering the details of individual patients prescribed any one of the three medicines we were asking about. The records showed that the practice was not always following national prescribing guidelines. We saw one patient prescribed methotrexate who had been issued a prescription on 18 January 2018 whose last blood test had been on 13 June 2017. This is significantly outside the guidelines for methotrexate monitoring.

- As result of our concerns the local clinical commissioning group (CCG) attended the provider's practice and carried out a review of aspects of care. They identified at least seven patients whose monitoring of methotrexate was inadequate.
- Data showed that antimicrobial prescribing at the practice was a concern in that it was significantly outside the parameters that would be expected at such a practice. On the 24 January we sent the provider a document illustrating our concerns and asking for any explanation. We did not receive reply. However the practice had not audited antimicrobial prescribing. There was no evidence of actions taken to support good antimicrobial stewardship.
- The practice kept prescription stationery securely and monitored its use.

Track record on safety

- We asked the temporary reception staff if they had had any induction. They said they had not. Therefore they were unfamiliar with safety practices.
- Health and safety information was out of date. For example many COSHH (control of substances hazardous to health) assessments were dated across a range from 2015 to 2009.
- There was a comprehensive fire safety policy, however some tasks, such as fire wardens, were assigned to staff who no longer worked at the practice.

Lessons learned and improvements made

There was some evidence that the practice learned and made improvements when things went wrong.

- There had been 13 significant events reported since our last inspection in September 2016. The last event had been recorded in September 2017. There was some evidence for recording and acting on significant events and incidents. For example there had been a power cut which had been recorded as a significant event. The patients' records could not be accessed and a decision made that it was unsafe to proceed with consultations in the absence of that information. The learning from the event was that no prescribing or consultations should happen without access to the records. However the significant event record showed that the vaccines refrigerator had been without power for over two hours and there was not mention of how this was risk assessed by the practice to determine what, if any, action was required.
- There was evidence that other events, such as; the failure to view and act on blood test results, failure to act on an adult safeguarding alert, possible missed referrals and medication errors, which should have been recorded as significant events were not so recorded.
- During the inspection we spoke with three members of staff, one clinical and two non-clinical. Both understood their duty to raise concerns and report incidents and near misses. There was evidence that when staff raised concerns that were not always acted upon. For example, records showed that in September 2016 a staff member raised an adult safeguarding issue, concerning a potential suicide. The staff member reported that the provider did not respond.
- The Central Alerting System (CAS) is a system for issuing patient safety alerts, and safety critical information to the NHS. The practice did not have an effective system for receiving and acting on these alerts. There was a folder marked Patient Safety Alerts. It contained a number of alerts about local patients who might try to obtain medicines improperly. It contained one alert

from the CAS dated 25 February 2017 calling for action within 48 hours. However, there were no records to demonstrate what action had been taken by the practice (or if no action was required).

- In January 2015, February 2016 and in April 2017 a medicine safety alert was issued relating to valproate (a medicine used to treat epilepsy and bipolar disorder as well as to prevent migraine headaches) and developmental disorders. The latest alert repeated the urgency of the earlier notifications and asked clinicians for 'all such patients to be reviewed and further consideration of risk minimisation measures'. The practice was not able to show that the alert had been received and acted upon. The provider told us that any such patients would be reviewed when they submitted a repeat prescription.
- Another alert (January 2018) concerned the use of medical oxygen cylinders and asked providers to determine if immediate local action was necessary. The provider was unaware of this alert. We found that the oxygen cylinder at the practice was empty. Had this alert been acted upon it is probable that, had the oxygen cylinder been empty at that time, this would have been noticed.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At the comprehensive inspection in September 2016 we rated the practice as good for providing effective services. The practice, and all of the patient population groups, was rated as good overall.

We rated the practice, and all of the patient population groups, as inadequate for providing effective services overall and across all population groups because:

- GPs did not have access to the proper information technology tools to help make the best decisions for their patients' treatment and care.
- Patient care was not well co-ordinated, including end of life care.
- Patients' records and the coding of patients' records was not up to date so staff were not always able to identify patients' conditions and meet their needs.
- Patients were not referred to or dealt with from secondary care in a timely manner

Effective needs assessment, care and treatment

The practice's systems to keep clinicians up to date with current evidence-based practice were not effective.

- The salaried GP did not have access to the necessary systems to support their work including Choose and Book (an NHS electronic booking system with a choice of place, date and time for first hospital or clinic appointments), Map of Medicine (a system used by doctors to help determine the best treatment options for their patients) or the provider's' own patients' results.
- We were not assured that patients' needs were fully assessed, including their clinical needs and their mental and physical wellbeing because patients' records were not up to date or properly coded. For example the parent of a patient of a terminally ill child repeatedly requested, and was refused, home visits. A GP eventually made a home visit to find that there was no alert or coding on the notes of the patient's specific condition, there was no alert to say the patient had been recently discharged from hospital and required review, there was no alert to say that the patient was receiving palliative care.
- On another occasion a patient had run out of warfarin (a blood thinning medicine), despite requesting it on multiple occasions. There was no coding on the patient's notes to say why warfarin was needed. It transpired that the patient needed the warfarin because they had had cardiac surgery. In this case the local NHS trust had sent an urgent email asking for GP intervention for the patient. We could not find evidence that this had been done.
- We saw no evidence of discrimination when making care and treatment decisions.

Older people:

The practice is rated as inadequate for the care of older people. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- On the 24 January 2018 we asked the provider for the numbers of patients aged over 74 who had been invited for a health check. We did not receive reply.
- It was not clear if the practice always followed up on older patients discharged from hospital. There was a large amount of correspondence awaiting action at the practice and this included electronic discharge notices (EDN) (from hospital). These often relate to this population group. EDNs are primarily designed to improve patient care and safety through to the availability of complete, accurate and timely information and reduce the risk of missing or inappropriate critical clinical information.

People with long-term conditions:

The practice is rated as inadequate for the care of people with long-term conditions. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- We looked at three nurse led reviews of patients with the long-term condition of asthma and saw that all were completed to a good standard.
- On 24 January 2018 we asked the provider for any evidence of specific training for staff who were responsible for reviews of patients with long term conditions. We did not receive a reply.

Families, children and young people:

The practice is rated as inadequate for the care of families, children and young people. The provider is rated as

Inadequate

Are services effective?

(for example, treatment is effective)

inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 48%, 12%, 64% and 64% across the four measured indicators. This was a significant variation from the target percentage of 90%. On the 24 January 2018 we sent the provider a document illustrating our concerns and asking for any explanation. We did not receive a written reply. When we spoke with the provider on 25 January he said that believed those percentages were wrong and were in fact well over 80%.

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

The practice is rated as inadequate for the care of working age people (including those recently retired and students). The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

People whose circumstances make them vulnerable:

The practice is rated as inadequate for the care of people whose circumstances make them vulnerable. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- End of life care was not always delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example patients were not always correctly clinically coded correctly. A patient had been coded as having a suspected cancer some years previously. There was no coded update since then to confirm the cancer nor that they were now receiving palliative care. They were not on the practice's palliative care register. Therefore they were not allocated home visits correctly. When the clinician did visit they were not aware of the diagnosis and its impact.

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

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group

- Fifty percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting during the current QOF year. There were three patients remaining to be seen.
- Fifty percent of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented during the current QOF year. There were eight patients remaining to be seen.

Monitoring care and treatment

The provider told us that the practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. However because of problems that occurred when the practice changed from one electronic record system to another the practice's QOF returns, for the year April 2016 – March 2017 had not been validated so were not available in the public domain. The Care Quality Commission confines its analysis of data about the practice's performance to that which is available in the public domain.

There was no current comprehensive programme of quality improvement activity. There was no routine review the effectiveness and appropriateness of the care provided.

On 24 January 2018 we asked the provider for any evidence of a programme of quality improvement activity, such as audit, preferably audit with completed cycles. We asked, given that locums and a newly qualified GP were employed whether there was any audit of their consultations, prescribing and referral decisions. We did not receive a written reply. When we spoke with the provider on 25 January he said that the only audits that had been carried out since the last inspection were those driven by the medicines optimisation team from the CCG.

Effective staffing

There were no administration staff employed by the practice with the exception of a business manager who

Inadequate

Are services effective?

(for example, treatment is effective)

attended the practice only occasionally and normally worked remotely. We could not say therefore if such staff had the skills, knowledge and experience to carry out their roles.

Coordinating care and treatment

The practice was unable to demonstrate they were working together and with other health and social care professionals to deliver effective care and treatment.

- Not all patients received coordinated and person-centred care. For example there was a large amount of correspondence, approximately 450 items, awaiting action at the practice. This included electronic discharge notices (EDN), results of tests (excluding blood tests) and replies from secondary care providers, such as consultants, about patients the practice had referred. These patients therefore were not necessarily receiving the care recommended by the consultants or which might be indicated from the results of the tests.
- The provider told us that that multidisciplinary meetings (where the practice works with other relevant agencies) had not taken place at the practice since early in 2017.
- The practice could not show 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.

Helping patients to live healthier lives

- The practice failed, in some cases, to identify patients who may be in need of extra support and direct them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- As result of our concerns the CCG attended the provider's practice and carried out a review of aspects of care. They identified at least five occasions when patients ought to have been referred as a matter of urgency (under the two week wait or rapid access referral procedures) who had not been so referred or followed up. For example a patient had been seen at a rapid access clinic in March 2017. The clinic had returned the referral to the practice as it was missing certain information. The patient was next seen in November 2017.

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.

Inadequate

Are services caring?

Our findings

At the comprehensive inspection in September 2016 we rated the practice as good for providing caring services. The practice, and all of the patient population groups, was rated as good overall.

We rated the practice, and all of the patient population groups, as requires inadequate for providing caring services because:

Following our inspection in September 2016 we found that

Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. Where national GP patient survey results were below average,

the practice had an action plan to address the findings and improve patient satisfaction.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Kindness, respect and compassion

The staff we saw on both inspection days treated patients with kindness, respect and compassion.

- 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. We saw one occasion when such an incident arose. However as there only one reception staff member on duty, at the time, there was no opportunity for that staff member to devote any time to the issue, because they would have to have left the reception area unattended.
- During the September 2016 inspection we were told that practice had developed an action plan to improve patient satisfaction.
- The plan included, the recruitment of a full time female GP This had been partially achieved in that a part time female salaried GP had been recruited.
- The plan also included advertising the practice's current extended opening hours to improve patient awareness of the availability of appointments during these times. We were not able to say if this had been achieved. However the extended opening hours had not been available to patients for several months.
- The plan also included encouraging all GPs and nursing staff to attend training to help improve their communication skills and address issues identified by the GP patient survey. We found no evidence that this training had happened.

We compared the results from the 2016 and 2017 annual national GP patient survey, relating to caring, where these where comparable. The practice was below average (compared with local and national data) for its satisfaction scores on consultations with GPs and but not nursing staff. In some areas there had been an increase in satisfaction, in others a decrease. For example:

- 71% of patients who responded said the GP was good at listening to them which was below the clinical commissioning group (CCG) average of 83% and the national average of 89%. This showed a 4% decrease on the previous year.
- 70% of patients who responded said the GP gave them enough time; CCG - 81%; national average - 86%. This was an 8% decrease on the previous year.
- 66% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 79%; national average - 86%. This showed a 9% decrease on the previous year.
- 89% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 90%; national average - 91%. This showed a 5% increase on the previous year.

Involvement in decisions about care and treatment

With the exception of the provider and the salaried GP, none of staff that we spoke with were employed by the practice so we could not say whether staff helped patients be involved in decisions about their care or 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.

The practice identified patients who were carers. At the time of the September 2016 inspection 12 patients (0.4%) on the practice list had been identified as carers. At the time of this inspection this had risen to 21 patients (1%). We were not able to speak with staff to identify how the practice supported carers. At the September 2016

Inadequate

Are services caring?

inspection we found that the practice offered a 'carers' clinic to patients who were also carers and that this was run by one of the reception staff. However there was no longer a staff member available to carry out this function.

We compared the results from the 2016 and 2017 annual national GP patient survey, relating to patients involvement in their own care, where these where comparable. The results were below local and national averages. However, there were some improvements over the last patient survey results.

- 66% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 80% and the national average of 86%. This showed a 6% decrease on the previous year.
- 62% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 75%; national average - 82%. This showed a 3% increase on the previous year.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 89%; national average - 90%. This showed a 9% increase on the previous year.
- 81% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 85%; national average - 85%. This showed a 7% increase on the previous year.

There were failings in the practices compliance with the Data Protection Act 1998. For example we found patients' personal data, such as a marriage certificate lying on a desk unattended in the back office.

It was not clear if there were proper safeguards to protect patients' records. As result of our concerns the CCG attended the provider's practice and carried out a review of aspects of care. For example they found that the on 2 February 2018 the business manager, who was not a clinician and who was not on site had accessed the clinical records of 65 patients. They were not able to identify the reason for the records being accessed.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the comprehensive inspection in September 2016 we rated the practice as good for providing responsive services. The practice, and all of the patient population groups, was rated as good overall.

We rated the practice, and all of the patient population groups, as inadequate for providing responsive services overall and across all population groups because:

- An extended hours surgery retained to meet the needs of the working population had not available for some months because of the lack of staff.
- Care and treatment for patient with multiple long-term conditions and patients approaching the end of life was not always coordinated with other services.
- The needs of children were not always addressed in a timely way and vulnerable patients were not always supported.
- Patients did not always receive care and treatment from the practice within an acceptable timescale for their needs.
- The annual national GP patient survey, relating to the practice's responsiveness was below the national average.
- Some complaints from patients were not acknowledged.
- The practice was not able to identify some patients' needs because their records were up to date or not coded properly.

Responding to and meeting people's needs

The practice was not organised so as to deliver services to meet patients' needs.

The practice had identified that there was a need for extended hours opening hours because of the larger than average numbers of patients who were working. It had had an extended hours surgery each a Friday 6.30am to 8.30am, however there had been insufficient staff (clinical and/or non-clinical) to deliver that service for some months.

- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was not always coordinated with other services. For example we found that electronic discharge notices (EDN) from hospital and the results of tests and consultants' examinations were not always dealt with in a timely way. There was information about patients, that impacted on their care that had not been actioned. Some of these had been received at the practice in the second week in November 2017.

Older people:

The practice is rated as inadequate for the care of older people. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice offered home visits and urgent appointments for those with enhanced needs. The GPs accommodated home visits for those who had difficulties getting to the practice. However because patients' records and the coding of records was not up to date. Staff were not always able to identify when patients needed these services.

People with long-term conditions:

The practice is rated as inadequate for the care of people with long-term conditions. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- We asked the provider for details of the training for staff who were responsible for reviews of patients with long-term conditions. We did not receive this information.
- The practice did not hold 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:

The practice is rated as inadequate for the care of families, children and young people. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 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 were not effective because the relevant records had not, in all cases, been scanned onto patients records and actioned. Therefore there was no record to follow up and if a patient came to the practice for a consultation the doctor or nurse might be unaware that they had been in hospital.
- The needs of children were not always addressed in a timely way. For example we found two instances when the practice had received requests, from the statutory authorities, about the welfare of looked after children, in neither case had the practice replied to the letter.

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

The practice is rated as inadequate for the care of working age people (including those recently retired and students). The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The needs of this population group had been identified and the practice had offered a surgery from 6.30am on Fridays to help ensure that appointments were accessible, flexible and offered continuity of care. However staff told us that the Friday morning surgery had not been available for some months.
- 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:

The practice is rated as inadequate for the care of people whose circumstances make them vulnerable. The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Vulnerable patients' records had not been coded properly and so had not been identified. For example we found a patient with a congenital disorder which made them vulnerable who was not coded as such. They had not been offered, nor received, the relevant annual health checks.
- Vulnerable patients were not always supported. For example in September 2016 a staff member raised an adult safeguarding issue, concerning a potential suicide. The staff member reported that the provider did not respond.

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

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider is rated as inadequate for safe, effective, caring, responsive and well-led services. The resulting overall rating applies to everyone using the practice, including this patient population group.

Timely access to the service

Patients did not always receive care and treatment from the practice within an acceptable timescale for their needs.

We looked at the available appointments. Routine appointments with GPs were not readily available. On 25 January there were appointments available with the salaried GP from 12 February. The system only showed the appointments available until 16 February. The provider had no appointments available before that date so it was not possible to say when a patient might secure an appointment to see him. There were appointments available with the nurse or healthcare assistant.

- Where patients had had an initial assessment and diagnostic tests were deemed necessary there were marked delays in processing them. For example delays with test results including blood tests. There were 1,047 blood test results that were not marked on the system as having been viewed or actioned. The earliest of these was 15 February 2017. A number of these tests would be determinants in whether or not a patient should receive, or continue to receive treatments, such as medicines and to what dosage.
- There were delays in issuing prescriptions to patients. During the inspection several patients approached the reception desk to enquire about their prescription. On several occasions there were problems over prescriptions. One patient said they had called three times in the course of a week and had not had the prescription. Another patient was told the prescription was done but was lost and on one occasion the prescription was correctly filed but had not been signed by a doctor.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- In the absence of proper scrutiny of test results and referrals it was not possible to be sure that patients with the most urgent needs had their care and treatment prioritised. However as result of our concerns the clinical commissioning group (CCG) attended the provider's practice and carried out a review of aspects of care. They found that some patients with urgent needs had not had their care and treatment prioritised.
- On Tuesdays and Wednesdays there was no GP available after 4pm and patients were directed to the local walk in centre.
- We saw evidence that, when the practice was unable to book locum cover for the provider's absence, for example on a Friday morning, staff were instructed to tell patients that the Friday morning sessions were already fully booked and that urgent calls would be taken by the on-call service after 1pm.

We compared the results from the 2016 and 2017 annual national GP patient survey, relating to the practice's responsiveness, where these where comparable. The practice was below average (compared with local and national data) for its satisfaction scores on consultations with GPs and nurses. There had been a decrease in all the areas compared. For example:

- 56% of patients who responded were satisfied with the practice's opening hours compared with the CCG average of 70% and the national average of 80%. This showed a 2% decrease on the previous year.
- 65% of patients who responded said they could get through easily to the practice by telephone; CCG – 60%; national average - 71%. This showed a 6% decrease on the previous year.
- 57% of patients who responded described their experience of making an appointment as good; CCG - 64%; national average - 73%. This showed a 1% decrease on the previous year.
- 44% of patients who responded said they usually waited 15 minutes or less after their appointment time; CCG average 60%, national average 64%. This showed an 11% decrease on the previous year.

Listening and learning from concerns and complaints

- There were no staff available with whom we could discuss how complaints were handled. We were not able to see if any complaints had been received since our last inspection.
- At this inspection we found the process for raising complaints was through the practice manager in the first instance. There had been no practice manager, in post, since June 2017.
- There was evidence that a patient had formally written to the provider with a complaint but this had not been acknowledged.

Are services well-led?

Inadequate

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

Our findings

At the comprehensive inspection in September 2016 we rated the practice as good for providing well-led services. The practice, and all of the patient population groups, was rated as good overall.

We rated the practice as inadequate, and all of the patient population groups, for providing well-led services overall because:

- Often there was no leadership at the practice, leaders were not approachable and the leadership response to staff was sometimes ineffective.
- Staff we spoke with said that they did not feel valued by the practice.
- Governance arrangements were insufficient and not always effectively implemented.
- Significant issues that threatened the delivery of safe care were not identified or adequately managed
- There had been no recent staff meetings.
- There was no patient participation group.
- There was no evidence of systems and processes for learning, continuous improvement and innovation within the practice.

Leadership capacity and capability

The leader did not have the capacity and skills to deliver high-quality, sustainable care.

The the provider was not delivering high-quality, sustainable care. The provider had teaching appointments, teaching and training of both GPs and other healthcare staff commitments namely:

- Medical School GP Tutor at Imperial College Medical School
- Medical School GP Tutor at Kings College Hospital
- Executive Committee Member Primary Care Diabetes Society at PCDS
- Principal Teaching Fellow at Warwick University Medical School for Certificate in Diabetes Care (CIDC) and MSc in Diabetes courses

Consequenlty the provider was absent as a minimum on Tuesdays and Wednesdays.

- There was a newly qualified salaried GP on the premises until 4pm on those days. That salaried GP had no authority or responsibility to manage the practice in the absence of the provider. There had been no practice manager since June 2017. There were no permanent reception staff or other administration staff (with the exception of the business manager who worked remotely).
- On Tuesday 23 January when we arrived for the unannounced inspection we asked the temporary receptionist on duty who was in change. They told us that no one was. The lead inspector contacted the provider to tell him of the inspection. The provider explained that the three permanent staff members had left for various reasons, he stated that he had been seeking help for the local Clinical Commissioning Group (CCG) and from NHS England. He did not attend the practice during the inspection. He did not advance any reason for not attending.

The provider had been made awrare of the impact of the absence of leadership.

- In August 2016 the provider was made aware of staff concerns about equipment, training, staff moral and the impact of changes to his own diary schedule. He acknowledged that his busy speaking schedule and moving to various venues made communication with staff difficult.
- As result of our concerns, on 29 January 2018 we imposed conditions on the registration of the provider. One of those conditions was that the provider must ensure that a suitably qualified, competent, skilled and experienced person was present at the practice to manage day to day operations to ensure a safe delivery of the service. The reason for this condition was to ensure that there was leadership present at the practice. On Tuesday 30 and Wednesday 31January a CQC inspector called at the practice and found that on nether day was there a person on the premises who accepted responsibility for managing it.

The leadership was not responsive in that when issues were raised they were often not addressed.

- For example more than one GP had raised the issue, with the provider, of the lack of monitoring for patients prescribed anticoagulant medicines but the issue was not addressed. Staff had raised the issue, with the provider, of the large numbers of blood tests results that had not been checked but, despite promises to check them, it was not done.
- Staff raised the timeliness of referrals, with the provider, and by June 2017 a new process for referrals had been

Are services well-led?

Inadequate

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

agreed. At the time of this inspection referrals were still not being done in a timely manner. Reminders about referrals were recorded in the provider's electronic task list together with other required actions. On 23 January there were such106 tasks that had not been actioned in the provider's electronic record system. Records showed that on the afternoon of 23 January the provider reported to a colleague that whilst the tasks might not have been be ticked off (the list) it was his belief that none were outstanding. However there were tasks, including urgent referrals, which had not been done.

The leadership response sometimes appeared ineffective.

- In August 2016 records showed that the provider was told that staff were seeking new employment. He acknowledged that this was a risk to business continuity at the surgery. There was an imminent staff meeting. He asked each staff member to clarify their intention, to him, in writing, before the meeting. He asked for an agenda of staff points for discussion but made it clear that time for such discussion would be limited as he had a presentation on patient survey data and the practice's statement of purpose and its vision. His stated goal was for the practice go forward with the same team intact. A goal that was not achieved.

We did not see evidence of effective processes to develop leadership capacity and skills, nor for planning for the future leadership or staffing of the practice.

- The provider had promoted a staff member to practice manager. There was no development plan or any practice manager training for that individual. By June 2017 that person had resigned as the practice manager and returned to duties as a receptionist in the practice. One of the duties of the practice manager had been to book required locum GPs and nurses. Following the resignation of the practice manager, the business manager was asked who would carry out this task. They responded by stating, as far as they were aware, the former practice manager would carry on with that task as part of their administration duties. There was no acknowledgement that this was an additional responsibility or that extra time would be required to carry out the task.
- In August 2016 the provider became aware of a risk to the business continuity of the practice arising from concerns that staff had raised with him. The practice had been without a practice manager since June 2017. In neither case did there appear to be any effective planning to prevent the impact of the risks or to mitigate the risk should it arise, as it did.

Vision and strategy

The practice had a set of vision and values documents that were on display in the staff corridor. The vision included safe, timely and appropriate access for patients. The values included team working, working with external stakeholders and using evidential guidelines in helping to determine patients' treatments.

- There was no evidence that staff were aware of and understood the vision, values and strategy and their role in achieving them. However there were no directly employed administration staff working at the practice. The temporary staff we spoke with felt that coping with the current issues did not leave time to reflect on the strategic direction that the practice might be pursuing.

Culture

- Staff we spoke with said that they did not feel valued by the practice. One reception staff member who was working as temporary staff was considering not taking up an offered contract of employment with the practice because of the lack of support.
- We saw no evidence of systems to ensure compliance with the requirements of the duty of candour. However there were no staff for us to discuss this with.
- Staff we spoke with told us that they had raised concerns but the concerns had either not been responded to, or if responded to had not been addressed.
- It was not possible to say there were processes for providing all staff with the development they needed because we could not speak with any employed staff. We asked to look at staff files to adduce evidence of staff development but these were not kept on the premises. On 24 and 25 January we asked the provider for any such evidence but did not receive any material.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not clearly set out or were not effective. For example, concerns had been

Are services well-led?

Inadequate

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

raised about the monitoring of some patients on medication which required additional monitoring. One clinician made a prominent note, a flag, on the affected patient's record. However another clinical staff member could not see the flag, so the system adopted was not effective.

- Patients' blood test results were not managed effectively or safely. Blood test results had not been regularly checked by clinical staff and this had been the case for some time. For example records showed that on 6 June 2017 the provider was reminded that there were 270 blood test results outstanding. On 21 January 2018 the provider was reminded that there were over 1000 blood test results outstanding. On the 23 January there were 1047 blood tests awaiting attention. The oldest had been received at the practice 16 February 2017.
- Some referrals went un-actioned, for example on 8 September 2017 the practice scanned a letter to a patient's note asking for a referral. On 19 September the provider received a reminder that this referral still needed doing. On 23 January this was checked during the inspection and the referral had not been done.
- Responsibilities for staff were not clear. For example there was evidence that the business manager, who was not clinically trained, was checking patients' blood results. There was evidence that an individual who had come to the practice for an interview was put to work, that day, on the reception desk.
- Practice leaders had established some policies, procedures and activities to help ensure safety. However that was a lack of checking to ensure they were effective. For example, there was a process for checking the emergency medicines monthly and this was duly recorded on the appropriate form. From May to July (07/17) the form recorded that the dispersible aspirin 75mg was present with an expiry date 07/17. From August to December 2017 the form continued to record that the soluble aspirin was present and due to expire 07/17. Indeed when the inspection team looked at the soluble aspirin someone had written on the box that the medicine had expired.
- There was no systematic means of checking that urgent referrals, such as those for suspected cancer or to rapid access clinics had been properly actioned. The practice faxed these referrals to the appropriate provider and a printout from the facsimile machine retained. It was not clear how the printout was reconciled against the outgoing referrals and, in any event, there were no records after 27 November 2017. For example in December 2017 a staff member was not sure if a fax referral had been successfully sent, in the fax machine over the weekend and another member of staff ask to check (if the fax had gone) on Monday morning. There was no system to record the dispatch and then to check the receipt of urgent fax referrals.

Managing risks, issues and performance

The processes to identify, understand, monitor and address current and future risks including risks to patient safety were not effective.

- There was no effective oversight of safety alerts, incidents, and complaints. In January 2015, February 2016 and in April 2017 a medicine safety alert was sent relating to valproate and developmental disorders. The latest alert repeated the urgency of the earlier notifications and asked clinicians for 'all such patients to be reviewed and further consideration of risk minimisation measures'. The practice was not able to show that the alert had been received and acted upon. We were told that all patients would be reviewed when they submitted a repeat prescription for that medicine. The practice was unaware of a safety alert that required practices to check their oxygen cylinders. The oxygen cylinder was empty.
- At our inspection of September 2016 we saw two examples of clinical audits. Both of these were due to be repeated so as to continue to monitor and improve patient care. The provider told us that there had not been any further clinical audits other than those driven by the local medicines optimisation team, relating to the prescribing of medicines.

Appropriate and accurate information

There was no evidence that the practice acted on appropriate and accurate information.

- We asked the provider for information about any programme of quality improvement activity. We did not receive any information.
- There had been no recent staff meetings. The most recent documents we saw related to a meeting in September 2016. This had identified issues, such as equipment failure which had led to new systems being introduced.
- The provider employed a newly qualified salaried GP and locum GPs. There were no clinical governance

Are services well-led?

Inadequate

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

meetings. There were no reviews of the referral and prescribing practices of the employed GPs. The salaried GP did not have access to the necessary systems to support their work including Choose and Book (an NHS electronic booking system with a choice of place, date and time for first hospital or clinic appointments), Map of Medicine (an NHS system used by doctors to help determine the best treatment options for their patients) and the provider's' own patients' results.

- There was no evidence that practice monitored or used performance information. .
- We asked the provider about data submitted to external organisations such as evidence of supporting national campaigns for example, stop smoking, tackling obesity and chlamydia. We did not receive any information.

Engagement with patients, the public, staff and external partners

There was no patient participation group. The provider told us that he did use a local individual as a sounding board for discussion about the changes and the problems the practice had encountered.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation within the practice.