

Circuit Lane Surgery

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?

Requires improvement



Are services responsive to people's needs?

Inadequate



Are services well-led?

Inadequate



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on Thursday 24 January 2017 at Circuit Lane Surgery. We undertook this inspection following urgent action taken as a result of our unannounced inspection on 1 December 2016 to identify whether improvements had been made and review all aspects of the service. We have rated the service as inadequate and taken further urgent enforcement action (subject to appeal) as a result of our findings.

At this inspection we found:

- There was not appropriate learning from significant events and complaints to ensure improvements to safety and quality were made.
- There were insufficient numbers of skilled and experienced staff deployed to ensure patients received the care they needed.
- There was a backlog of patient record summarisation (the incorporation of new patients' medical records to the practice's record system), which dated back to March 2016. Many of these records dated back to when the previous service provider was in place.

- Patients reported significant delays in obtaining repeat prescriptions. This left patients at risk as they were unable to access their medicines in a timely way.
- Patients on repeat medicines were not receiving timely reviews to ensure their medicines were being prescribed safely.
- Patient correspondence from external providers, such as hospital specialists, out of hours and paramedics was not consistently being dealt with in a timely way. We identified patients placed at risk of significant harm as a result of delays to their care and treatment.
- Referrals were not being processed in a timely way.
- The monitoring of the appointment system was poor and there was not adequate provision of appointments to meet the needs of the patient list.
- Patient feedback from comment cards stated they were treated with compassion, dignity and respect by clinicians and they were involved in decisions about their care and treatment.
- Risks to patients were not being recognised or action taken swiftly enough.
- Staff working at the practice were dedicated to the needs of the patient population and worked additional hours or through protected administration time to provide care to patients.

Summary of findings

- There was not adequate action since 1 December 2016 to reduce the most significant risks to patients' health, safety and welfare, which we reported to the provider at that time. The governance systems in place at the practice were inadequate to recognise and make the changes required to the practice.
- Since the inspection in January 2017, North and West Reading Clinical Commissioning Group have provided significant support to Circuit Lane Surgery to ensure the highest levels of risk and concern have been addressed urgently.

The areas the provider must make improvements are:

- Ensure sufficient numbers of trained, skilled and experienced staff are available, and ensure ongoing training is maintained to protect patients from the associated risks related to their health and welfare caused by insufficient staffing.
- Ensure that patients can access the care and treatment they require in a timely way in order to reduce the risks posed to patients by not receiving adequate care or treatment.
- Implement a system to assess, mitigate and resolve risks associated with outstanding and future repeat prescription requests, referrals, medication reviews, patient correspondence, paper medical records, the low number of learning disability reviews, the storage, incomplete recruitment and staff checks and security of blank prescription forms and medicine safety alerts.
- Ensure leadership and governance systems are able to assess, monitor and improve the quality and safety of

the services where improvements are identified as required and that the culture within the practice is conducive to making improvements. Specifically ensure that significant events and complaints are fully investigated and responded to, actions and learning undertaken where necessary and changes made to improve care and treatment including communication with staff and patients.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

The practice was rated as inadequate for providing safe services. There were significant risks to patients' health and welfare:

- Concerns reported by staff and patients to the provider were not acted on to identify, assess and mitigate the associated risks.
- Medicine alerts were not consistently processed to ensure actions were fulfilled.
- There was not sufficient staffing to enable access to meet patients' needs, undertake tasks related to care and treatment or to prioritise patients on the basis of need.
- Medicines were stored safely, including emergency medicines. However, prescription pad security was inadequate.
- Safeguarding processes were in place, but not all GPs could evidence that they were trained to the appropriate level. There was a risk that children at risk may not have any outstanding correspondence acted on and we saw one example where this was the case.
- Equipment was checked and calibrated.
- There were health and safety policies in place.
- Firefighting equipment was not maintained appropriately.
- Emergency medicines were available and within expiry dates.

Inadequate



Are services effective?

The practice was rated as inadequate for providing effective services. There were significant risks to patients' health and welfare:

- Patients reported long delays in accessing repeat prescriptions, leaving patients at risk of delays and gaps in treatment. These included delays for insulin dependent diabetics.
- There was a backlog of patient records summarisation (the incorporation of new patients' medical records to the practice's record system) from March 2016. Many of these records dated back to when the previous service provider was in place. This posed a risk due to the potential for a lack of appropriate assessment of each patient registered since October 2015.
- Patient correspondence from external providers, such as hospital and paramedics, was often not being dealt with in a timely way. We saw several examples where patients were

Inadequate



Summary of findings

placed at risk of significant harm as a result of the poor system for acting on this correspondence. For example, letters from external clinicians which required actions from GPs were not always acted on in a timely way.

- A search on the record system showed that patients on four or more medicines, only 45% had an up to date review.
- Data provided to us showed that approximately one third of patients on lithium were not within appropriate ranges. This posed a risk of harm to patients. This indicated that patients were frequently accessing medicines without receiving reviews to ensure their repeat prescriptions were appropriate.
- So far in 2016/17 performance for the care of long term conditions showed variation and some significant concerns. For example, diabetes indicators showed 77% of patients were within desirable blood pressure ranges compared to the target of 93%, 60% of patients had a foot examination within the last 12 months compared to the target of 90%. Performance for chronic obstructive pulmonary disease related (COPD) indicators in 2016/17 showed that 78% of patients had received up to date spirometry tests and 67% had an annual review within the current year. Only 49% of patients had up to date asthma reviews compared to the target of 70%.
- We saw that there were 72 referrals for further care and treatment waiting to be sent, dating back to early December 2016. There was a risk that patients would not access external services in a timely way due to the backlog of referrals.
- There was limited clinical audit and no indication this was driving improvements.
- Some programmes for encouraging patients to lead healthy lives was taking place.
- Training was not being kept up to date for many staff in various topics, for example, safeguarding and infection control.

Are services caring?

The practice was rated as requires improvement for providing caring services.

- There was no relevant data from the national GP patient survey as the outcomes from the most recent survey were published before the provider took over the contract at the practice.
- Patient feedback from comment cards stated they were treated with compassion, dignity and respect by clinicians and they were involved in decisions about their care and treatment.
- There was difficulty in providing continuity of care to patients due to the staffing levels.

Requires improvement



Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice was rated as inadequate for providing responsive services.

- We found the systems in place did not identify and ensure improvements in services to patients.
- The availability of appointments was insufficient to meet patients' needs. Patients reported not being able to see GPs or nurses without significant waits.
- The open access clinic provided daily required patients to wait until a slot became available and many chose to queue before the practice opened in order to try and book an appointment.
- Patients reported four to eight week waits for routine appointments. Female and male GP appointments could be booked.
- There was a 'you said we did board' in the waiting room which listed changes based on some patient feedback and actions resulting from these. For example, when an open access clinic was introduced patients found waiting times unpredictable. Therefore the practice was implementing a numbering scheme for patients see where they were in the queue.
- GPs visited care homes regularly. We spoke with staff at local care homes who said that although waiting times on the phone caused a barrier when trying to book appointments, when they could request GPs they usually visited the same or next day depending on need.
- Complaints were not investigated appropriately and often not responded to.

Inadequate



Are services well-led?

The practice is rated inadequate for being well-led. The practice did not have adequate governance frameworks. For example:

- There was a lack of strategy to support the business model implemented since the provider took on the practice in September 2016.
- The governance framework was inadequate as it did not support the delivery of safe, effective and responsive care. We found significant risks identified in December 2016 were not assessed appropriately to determine the high level of impact to patient safety and had not been appropriately acted on.

Inadequate



Summary of findings

- The inherent risks associated with the backlog of patient correspondence, lack of appropriately trained staff and medical record summarising were not being mitigated with a robust action plan. We saw actions listed as completed on the provider action plan from December's inspection were not completed.
- Effective systems to assess, monitor and improve the quality and safety of the services provided had also not been implemented. We found examples of poor care resulting from a lack of appropriate systems to monitor and address the backlog of clinical and administrative tasks.
- There was no clear and embedded leadership structure at the practice. We found that the leadership team and processes that were in place did not enable development to manage and implement the significant change.
- Staff told us there was not an open culture within the practice and although they had the opportunity to raise any issues they did not feel confident and supported in doing so.
- The practice had recently employed a clinical lead to work 0.5 whole time equivalent at the practice to support changes within the governance systems. However, their role had not been clearly defined to ensure changes were made to the governance structures within the 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

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There was no system to prioritise older patients for appointments. This risk was exacerbated by insufficient staffing leading to a shortage of appointments.
- GPs visited care homes regularly. We spoke with staff at local care homes who said that although waiting times on the phone caused a barrier when trying to book appointments, when they could request GPs they usually visited the same or next day depending on need. However, delays on the phone lines could cause problems in accessing home visits and lead to out of hours services being required.
- Patients reported long delays in issuing repeat prescriptions, leaving patients at risk if they were unable to access their medicines.
- We saw hospital admissions, letters from specialists and paramedic correspondence was not acted on promptly and we saw examples where this led to risks for patients. This was a particularly significant risk for this population group.
- The practice provided care plans for patients to support multi-disciplinary team (MDT) care, including palliative care for patients approaching the end of life.
- The facilities were based on the ground floor where patients could access clinical treatment rooms via wide corridors.

Inadequate



People with long term conditions

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Patients reported long delays in issuing repeat prescriptions, leaving patients at risk if they were unable to access their medicines. These included delays for insulin dependent diabetics.
- Patient correspondence from external providers, such as hospital and paramedics, was often not being dealt with in a timely way. We saw several examples where patients with chronic conditions were placed at risk of significant harm as a result of the poor system for acting on this correspondence.

Inadequate



Summary of findings

- A search on the record system showed for patients on four or more medicines, only 45% had an up to date review. This posed a risk of harm to patients. This indicated that patients were frequently accessing medicines without receiving reviews to ensure their repeat prescriptions were appropriate.
- So far in 2016/17 performance for the care of long term conditions showed variation and some significant concerns. For example, diabetes indicators showed 77% of patients were within desirable blood pressure ranges compared to the target of 93%, 60% of patients had a foot examination within the last 12 months compared to the target of 90%. Performance for chronic obstructive pulmonary disease related (COPD) indicators in 2016/17 showed that 78% of patients had received up to date spirometry tests and 67% had an annual review within the current year. Only 49% of patients had up to date asthma reviews compared to the target of 70%.
- Nursing staff had lead roles in chronic disease management and had appropriate training.

Families, children and young people

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- There were systems in place 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 A&E attendances. However, these systems were not operating effectively due to the backlog of patient correspondence.
- The backlog of patient correspondence waiting to be viewed meant that the practice may not be aware of these risks from as far back as December 2016. There was a risk children at risk may not have any outstanding correspondence acted on and we saw one example where this was the case.
- Appointments were available outside of school hours and the premises were suitable for children and babies. However, patients reported examples where they could not access appointments including for ill children.

Inadequate



Working age people (including those recently retired and students)

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Inadequate



Summary of findings

- The needs of the working age population, those recently retired and students were not being met due to the insufficient staffing levels and lack of appointments.
- An open access clinic had been implemented in December 2016, but this led to unpredictable waits for patients, which disadvantaged people in this population group specifically.
- The surgery offered extended late appointments every on alternate Mondays and Thursdays until 8pm and most Saturdays from 8.30am to 11am.
- Online services were available, but wait times for repeat prescriptions were significant and many patients had to attend the practice to chase their requests for completion.

People whose circumstances may make them vulnerable

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered longer appointments for vulnerable patients including those with a learning disability.
- The practice offered annual health checks to patients with a learning disability. There were 57 patients on the register and five had health checks since September 2016.
- Practice staff were trained to recognise signs of abuse within their vulnerable patients, although training was out of date for many staff according to the training matrix.
- GPs worked within a multi-disciplinary team to in regards to managing the needs of vulnerable patients. The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.

Inadequate



People experiencing poor mental health (including people with dementia)

The provider was rated as inadequate. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Performance for mental health related indicators so far in 2016/17 showed 33% of patients had an agreed care plan in place compared to the target of 90%.
- Of 11 patients on lithium, four had their recorded levels within correct range at the time of the inspection.

Inadequate



Summary of findings

- Poor access to appointments placed patients with mental health problems at particular risk they became unwell or needed support.
- The backlog of prescriptions posed a specific risk to these patients.
- The practice carried out advanced care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in July 2016, before the current provider took over the contract at Circuit Lane Surgery.

Patient feedback showed significant concerns about long waits on phones, difficulty in booking appointments and long waits for prescriptions. We identified this through speaking with 16 patients on the day of inspection and reviewing 24 CQC comments cards completed by patients prior to and on the day of inspection.

We spoke with one patient who had booked their appointment for 24 January 2017 in December 2016. This patient had significant health conditions which required monitoring.

Some patients reported using the open access clinic and that this caused long delays at time to see a clinician. Two patients who had attended the open access clinic before reported to us that there was no guarantee of seeing a GP when they did access the service. The open access clinic required patients to wait until a slot became available and many chose to queue before the practice opened in order to try and book an appointment.

Patients reported four to eight week waits for routine appointments. There were four positive comments alongside negative feedback regarding booking an appointment. Some also noted how supportive staff were despite being under pressure. We spoke to two members of patient participation group (PPG). They were positive about the caring nature of staff, but were concerned by the pressure the service was under due to low staffing levels.

We received patient feedback including information from very concerned patients via local Healthwatch. A local meeting was held to discuss local patients' concerns in January and the PPG who attended reported a high attendance with many patients reporting similar concerns to the feedback we received at the inspection; difficulty in accessing appointments and other services at the practice.

Preceding the inspection we received feedback from patients who were concerned about the ability to get through on the phone and to book appointments. The NHS Choices website showed

12 negative comments about the practice in January 2017, mainly around phone and appointment access.

The practice undertook the friends and family test. In December 2016 41 patients responded to the question "how likely are you to recommend Circuit Lane Surgery to friends and family?" The majority of patients said they would not recommend the practice. Patients also provided comments and the main concerns reported related to making appointments (10 comments), delays in prescriptions (8 comments), ability to get through on the telephone (14 comments), and general administration (three comments). Some positive feedback was received with three patients saying the staff were very helpful and they'd had a positive experience at the Surgery.

Circuit Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included an inspection manager, two further CQC inspectors, a GP specialist adviser and an assistant inspector.

Background to Circuit Lane Surgery

Circuit Lane Surgery is located in the Southcote area of Reading. One Medicare Ltd took over the contract following a procurement exercise led by the local clinical commissioning group (CCG) in September 2016. The previous provider was Berkshire Healthcare Foundation Trust who undertook the contract from 2014.

The practice has been through a challenging four years with three changes in provider and a number of GPs and managers leaving, which has caused instability in the practice.

At the time of the inspection the services was staffed by 2.9 whole time equivalent (WTE) salaried GPs, supported by locum GPs, and 3.1 WTE nurses, supported by agency nurses. In addition there are administration staff, receptionists and a registered 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 9,700 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. There is significant experience among the local population of income deprivation. The ethnic mix of the population is varied, with a significant proportion of people originating from Nepal.

All services are provided from: Circuit Lane Surgery, 53 Circuit Lane, Southcote, Reading, Berkshire, RG30 3AN.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours surgeries are on alternate Mondays and Thursdays until 8pm and most Saturdays 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 carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We undertook this inspection following urgent action taken as a result of our unannounced inspection on 1 December 2016 to identify whether improvements had been made and review all aspects of the service.

The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 24 January 2017.

During our visit we:

- Spoke with a range of staff, including three GPs, members of the nursing team and support staff based at the practice. We also spoke with members of the senior leadership team.
- Observed how patients were being cared for.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with patients regarding their experience.
- Spoke with members of the patient participation group.
- Observed the premises.
- Reviewed documentation related to the management of the service and patient care.
- We looked at medical records of patients where we identified significant risks to their care and welfare.

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

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

During our last inspection in December 2016 we identified concerns regarding the investigation process and resulting actions from significant events. Learning was not taking place when incidents occurred and staff did not feel their feedback was being acted on. We found that staffing levels were unsafe and did not ensure patients' health and welfare were being protected.

Safe track record and learning

- In January 2017 we reviewed the significant event process and the significant events reported. We saw 12 significant events had been logged on the central significant event log. These were mainly reported by staff onsite at Circuit Lane Surgery and related to backlogs of clinical tasks and concerns about staffing levels, among other concerns raised by staff.
- We also had access to significant event documents which had not been included in the main log. This identified that two systems for significant events were being used; one was the provider's online reporting system and the other was a paper based system where staff used significant events records to report issues. This meant that the systems used were not consistent and there was a risk that some significant events would not be reviewed by senior management.
- We saw outcomes from hand written significant events. For example, there were two significant events regarding the difficulty in completing the workload for GPs when only two were on duty, leading to an inability for the practice to complete daily tasks such as prescriptions and they reported that this resulted in the service being unsafe. However, it was not clear that this had been reported on the electronic log. There were other examples of delays in patient care which were not on the central log.
- The paper records noted significant event outcomes such as more GPs were needed to ensure the service was safe. However, on the significant event log there were no clear actions noted to reduce the risk of the incidents being repeated.
- The process for reviewing significant events showed no clear process for learning outcomes to be shared with staff. When we asked staff if they received feedback from significant event outcomes they informed us that they frequently reported concerns or passed on patient

concerns but did not receive any responses from the provider. The provider informed us that daily huddles (short meetings) were used to communicate significant events outcomes. We looked at minutes of huddles and saw that when significant events were referred to, there was no specific reference of what was discussed or learning for staff to be able to refer to these minutes if they missed huddles. Significant events were not acted on to ensure that learning was identified and acted on in order to improve the service.

The practice had two systems for receiving and reviewing medicine alerts. One system was based on the provider receiving alerts and sharing them with the practice to take action and the other was where the practice received alerts and shared them with staff to take any necessary action.

We asked clinical and non-clinical staff who received the alerts what happened when they were received. Staff informed us and showed an example where a medicine alert received in January 2017 had been shared staff. However, we asked about three other medicine alerts from December 2016 and January 2017 where the process for storing the alert onsite had not been followed. There was no evidence the alerts had been shared with staff and they were not stored in the alerts' folder. Therefore the process had not been followed within the practice to ensure that any action required had been taken. It was not clear who was the lead for acting on the alerts once shared with staff within the practice. There was a risk that information regarding medicines would not be acted on to ensure patient safety.

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse. There was a lead GP for safeguarding and they had level three child safeguarding training. However, the practice did not have all the records to demonstrate other GPs had received safeguarding training to the appropriate level. We saw nursing and support staff had received training to the correct level, but some were overdue refresher training according to the provider's own training renewal periods indicated on the training log. The refresher training was booked to take place before the 31 March 2017. There were safeguarding policies and these were accessible to all staff. There were contact details for further guidance if staff had concerns about a patient's welfare. Staff demonstrated they understood their

Are services safe?

responsibilities and all had received training on safeguarding children and vulnerable adults. We saw evidence that GPs attended multidisciplinary team meetings to discuss vulnerable patients and also provided information to case conferences where required. However, due to the backlog of patient correspondence which had not been acted on or reviewed in many cases, there was a risk that actions related to children on the at risk register were not undertaken. We saw one example where this was the case. There was no training provided on female genital mutilation (FGM) to ensure staff understood the risks and their responsibilities in reporting suspected cases and supporting victims of FGM. There was an alert on the patient record system to alert staff to any children deemed at risk of abuse or harm.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained and had Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was a supporting policy for chaperones.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed that the practice was clean and tidy. There was an audit tool used to identify any improvements in infection control and we saw the last audit was undertaken in January 2017. Cleaning checks were undertaken in clinical treatment rooms. Staff had access to training on infection control, but we saw that several staff were due their refresher training according to training renewal dates on the training log. Reception staff received guidance from the infection control lead on handling specimens handed in by patients at reception. There was an infection control protocol in place. This included a sharps injury protocol (needle stick injury) which was available to staff. Clinical waste was stored appropriately. Appropriate sharps containers were used and removed before becoming overfull. Privacy curtains were used and cleaned in line with the policy.
- Medicines were stored safely. We checked medicine fridges and found fridges were monitored to ensure temperatures were within recommended levels for storing vaccines and other medicines. However, when the lead nurse was not on site we saw gaps in the fridge

temperature monitoring records. Nursing staff received training and had access to necessary information on administering vaccines. We saw that medicines stored onsite were within expiry dates and stored properly.

- Blank prescription forms were not logged out of storage when placed into printers so they could be tracked throughout the practice. We saw doors were left open in rooms where printers stored blank prescription forms, and could potentially be removed by someone without authorisation.
- Patient Group Directions (PGD's) had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, we saw that some PGDs were out of date, meaning the authorisation for the prescribed medicines was not valid.
- We reviewed five personnel files to look at staff recruitment processes and background checks. We found appropriate recruitment checks had been undertaken in most cases. However, there was a lack of full employment history and reference for one member of staff prior to employment and no proof of their registration with the appropriate professional organisation. All clinical staff had checks through the Disclosure and Barring Service.

Monitoring risks to patients

There were insufficient procedures in place for monitoring and managing risks to patient and staff safety. Staffing levels were unsafe according to staff and patient feedback to CQC and from other sources indicated patients could not always access the care they needed.

- The premises were purpose built and well maintained. There were health and safety related policies and risk assessments available. For example, the practice had risk assessments in place to monitor safety of the premises such as control of substances hazardous to health. Only six out of 16 staff had received up to date training in health and safety and fire safety.
- There was a legionella risk assessment in place and testing undertaken on all water outlets to identify any risk of the bacteria occurring (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Regular flushing of water outlets took place.

Are services safe?

- There was a comprehensive fire risk assessment in place for the premises. However, maintenance checks on firefighting equipment were overdue as they had not been completed since 2015.
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was calibrated to ensure it was working properly.

In December 2016 we found significant concerns from patient feedback, staff and from data we gathered from the practice that patient care and treatment needs were not being met as a result of insufficient staffing levels. In January 2017 we found the following:

- Since our previous inspection the practice had implemented an open access clinic for 30 patients to see a GP or advanced nurse practitioner. This included patients who required urgent or routine appointments for ongoing care needs. We looked at appointment schedules from 9 to 20 January 2017 and saw that these slots were fully utilised on a daily basis. We also saw from significant events, staff rotas and the appointment schedule that the practice was regularly staffed with two GPs and that the number of advanced nurse practitioner (ANP) appointments varied greatly. This indicated that the open access clinics were not as a result of additional staffing levels, but a reorganisation of the same staffing levels, when compared to our findings in December 2016.
- The appointment availability for GPs and nurses did not meet patient demand. Since the previous inspection there had not been any significant increase in GP or nurse appointments. For example, over a two sample weeks where we reviewed the appointments provided in November and December 2016, the average GP appointments per day were 59 compared to the 64 identified as a maximum over a two week period in January.
- The provider informed us that their care model incorporated support from ANPs who were able to prescribe to patients for some minor illnesses and other conditions. We were informed that part of the additional support for GPs working at Circuit Lane Surgery was additional ANP appointments in December 2016. However, we identified from discussions with clinical staff that not all the ANPs deployed had received

appropriate training to enable them to prescribe, meaning patients would still need involvement from a GP in their care after seeing an ANP if they required a prescription.

- Since December 2016 the provider had employed a new clinical lead GP to support with clinical governance and leadership. They were employed as a 0.5 WTE for Circuit Lane Surgery according to discussions with members of the leadership team. We saw from rotas they were given designated time to provide clinical governance support to GPs and other staff.
- We spoke with 16 patients and the majority told us they found it extremely difficult to book GP and nurse appointments. Patients were attending the practice's open access clinic for routine check-ups and ongoing care needs. They were required to wait until a slot became available. This also required patients to queue before the practice opened from 7.30am in order to try and book an appointment.
- We received seven staff questionnaires handed out during the inspection and every one of the questionnaires cited a lack of GPs or staff overall as a risk and concern in regards to providing services. We spoke with clinical staff who reported that staffing levels were unsafe. We saw that several significant events had been reported regarding staffing levels and that as a direct outcome prescriptions and other tasks had not been completed. Patients we spoke with reported waiting up to a week for their prescriptions. For example, one patient attended the practice and asked for a prescription they had requested a week prior to our inspection and it had still not been signed.
- In December 2016 we found that there were frequently days when no duty doctor (a GP not allocated routine appointments in order to support urgent care cases, phone appointments, home visits and other tasks), was onsite. At this inspection we saw that from 9 to 20 January 2017 there were duty doctors available. However, there were days when one of the two GPs on the rota was also the duty doctor, meaning they had to perform this task in addition to seeing patients. It was also reported in significant events that GPs worked additional hours in order to try and complete care tasks such as prescriptions.

Arrangements to deal with emergencies and major incidents

Are services safe?

The practice had arrangements in place to respond to emergencies and major incidents. For example:

- The practice had an automated external defibrillator and clinical staff told us they had received training in how to use it. However, the training matrix indicated 12 staff were still due to be booked onto their training. Oxygen was stored onsite and this was checked regularly to ensure it was working.
- There were emergency medicines onsite and these were available for staff to use. These were within expiry dates.
- Staff had received basic life support training.
- The practice had a business continuity plan in place for major incidents such as relocation of services due to loss of premises.

Are services effective?

(for example, treatment is effective)

Our findings

During our inspection in December 2016 we found that clinical tasks such as reviewing patient correspondence which may require action, prescriptions, patient summarising and referrals were not being dealt with in a timely way, leading to significant backlogs and delays in patient care. There was not an adequate system to prioritise patients who had urgent prescriptions requests or action waiting to be taken regarding communication from external care providers.

Effective needs assessment

In January 2017 we saw that the practice had systems for assessing the needs of its patients in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However, due to the limited access to appointments and lack of time for staff to complete care tasks, the needs of patients with long term conditions were not always being met.

- The practice had some systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Training was provided to nursing staff to enable them to assess and plan care for patients with long term conditions
- Nurses told us they had training in managing long term conditions. However, the high use of agency staff did not ensure that all nurses could deliver the assessments patients always required.
- We saw examples where patients had required assessments such as blood tests and action had not been taken, despite significant risks being identified. For example, we identified evidence of one patient who had an abnormally raised potassium level of 6.1 millimoles per litre from results sent to practice on 26 November 2016. This was not reviewed by a GP until 17 January 2017. The GP requested a blood test but this was not acted on until 21 January 2017. This added an unnecessary delay to a patient who needed an urgent review, care and treatment. In a second example, we identified a patient who had a raised potassium level of 5.7 millimoles per litre on 3 January 2017. The practice had advised the patient of the abnormal result and

invited them to make an urgent appointment. The first appointment the patient was able to make was on the 9 January 2017 and the results were identified by a locum GP from the patients' record during their appointment. The delay in accessing an urgent appointment added an unnecessary risk to a patient who needed an urgent review, care and treatment.

- We reviewed the system used to view and action blood test results. There were 312 waiting to be viewed or allocated on system dating back to 19 January 2017. Patients were able to attend an open access clinic open every weekday morning at the practice from 8.30am. This could lead to significant waits for the patients, including queueing outside the practice waiting for it to open and then booking a slot at the clinic. We reviewed a tool used by reception staff to determine which appointment slots best suited patients. This did not include prioritisation for patients attending for urgent conditions or what action to take. For example, for any suspected symptoms of meningitis.

In December 2016 the practice had a backlog of new patient records requiring summarisation dating back to October 2015, which the provider inherited from the previous provider in September 2016. In January 2017 staff informed us that the practice had trained a member of staff to undertake summarising. We saw that the backlog was still significantly long dating back to March 2016. This placed patients at risk where there had not been a full assessment of their medical history and therefore potentially no full assessment of their medical needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent unvalidated data is a mix of performance prior to September 2016 when the provider took the contract for Circuit Lane Surgery and since September. Data from 2016/17 showed variation in performance so far within the QOF year (ending in March). For example:

- So far in 2016/17 performance for diabetes was as follows: Blood pressure indicators showed 77% of

Are services effective?

(for example, treatment is effective)

patients were within desirable blood pressure ranges compared to the target of 93%, 60% of patients had a foot examination within the last 12 months compared to the target of 90%.

- Performance for chronic obstructive pulmonary disease related (COPD) indicators in 2016/17 showed that 78% of patients had received up to date spirometry tests and 67% had an annual review within the current year.
- Performance for mental health related indicators in 2016/17 showed 33% of patients had an agreed care plan in place compared to the target of 90%. Of 11 patients on lithium, four had their recorded levels within correct range at the time of the inspection.
- Only 49% of patients had up to date asthma reviews compared to the target of 70%.

The practice was not yet able to provide an exception rate for their QOF data. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Staff told us the high use of locum staff did not ensure that all nurses could deliver the assessments patients always required to meet the needs of patients with long term conditions and complex needs.

During the inspection in December 2016, we found that 435 prescriptions were waiting to be processed with the oldest dating back to 25 October 2016. On 24 January 2017, staff informed us that the last 24 hours was the first time they had been up to date with hand written prescriptions requiring processing and readying for GP signatures since September 2016. We looked at the backlog of repeat electronic prescriptions. The oldest request on the electronic prescribing system was from 18 January 2017 and on the day of inspection, there were 452 prescriptions waiting to be signed. These included insulin dependent diabetic patients who had been waiting since the 18 January 2017 for their diabetic medicines. We spoke with patients who had waited up to a week for prescriptions. This posed a risk to patients who had health conditions which required medicines to maintain their health.

There was limited evidence of quality improvement including clinical audit.

- We looked at clinical audits undertaken since the provider took over in September 2016. The audits were prescribing/medicines incentive scheme audits, with

templates and searches provided by the clinical commissioning group (CCG) for the practice to undertake. They had not been repeated to identify or make quality improvements.

- From information provided before the inspection, we saw that patient medicine reviews were not taking place in a timely way. Of those patients on four or more medicines, only 45% had an up to date review. This posed a risk of harm to patients. We spoke with a patient who was taking medicine for a mental health problem which required regular reviews. They informed us they had not received a medicine review as required and was concerned about the impact of taking their medicine without clinical overview.
- On 24 January 2017 we identified that there were 72 referrals for care and treatment requests outstanding. The referral log indicated that the oldest request was dated 29 November 2016. We saw examples where referrals had been completed within the two weeks prior to the 24 January 2017, which dated back to October 2016 and the log indicated that a significant backlog has existed continually since December 2016. Many referrals had not been dealt with in a timely manner placing patients' health and welfare at risk. We identified a patient with a serious underlying health condition who needed referring to a specialist at the request of a specialist doctor. Circuit Lane Surgery had been sent the request letter on 26 October 2016 from the specialist and the referral was not reviewed or progressed until 18 January 2017. We spoke with staff who processed referrals and they had a system for prioritising urgent or two week wait (related to potential cancers diagnosis and treatment) created within the practice. However, there was a risk that urgent or two week wait referrals which were prompted by external correspondence were not processed as a priority and risked being left among the backlog of other correspondence.

Effective staffing

Staff deployed onsite did not always have the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Are services effective?

(for example, treatment is effective)

- Staff could access role-specific training and updates when required, but we saw that training for several topics such as fire safety, safeguarding and health and safety was overdue according to the training matrix.
- Some advanced nurse practitioners did not have the necessary skills prescribe and provide specific care to patients.
- Staff told us that some locum GPs did not have the experience or ability to request tasks such as referrals or other tasks. We saw an example where this led to a delay in a patients care when they already had a significant delay following a blood test.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff. However, they were unable to review and process this in a timely and accessible way through the practice's patient record system and their intranet system, due to the reduced staff capacity.

- Due to a lack of staffing there was limited joint working with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. However, when patients moved between services, including when they were discharged from hospital, access out of hours or other external services or when they required referrals there was often a significant delay in completing tasks leading to patients not receiving care and treatment they required.
- In January 2017 we identified 242 records such as discharge summaries, Out of Hours, walk-in centre reports and A&E discharges which had not been reviewed and dated back to early December 2016 on the patient correspondence system. We looked at the process for reviewing patient correspondence and saw that approximately 1,300 were stored within 'in-trays' waiting to be allocated to GPs.
- GPs reported to us that they often handed back their in-trays without completing any reviews or any administration work. They confirmed this was due to the high number of patients and home visits that they were expected to undertake during the course of their clinical sessions and any relevant follow up work required. We identified examples where the lack of monitoring of patient correspondence led to significant delays for

patients who required urgent assessment, investigations or treatment for high risk indicators of serious health conditions. This placed the patients at significant risk of harm.

- For example, one patient had been referred for an X-ray in December 2016 and this identified potentially serious health conditions which required further examination in line with national standards of a two week wait. On 7 December 2016 a letter was sent from the hospital X-ray team to Circuit Lane Surgery requesting a referral for a CT scan and an appointment with a relevant specialist. This request had not been reviewed or actioned until a GP processed the correspondence on the day of our inspection; 24 January 2017.
- Meetings took place with other health care professionals periodically to review the needs of patients with complex needs. There was a list of patients deemed at risk of unplanned admissions and 144 had a care plan in place.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- GPs and nurses understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA).
- We saw that 13 staff were booked for MCA training on 31 January 2017.
- GPs told us there was a form for obtaining written consent when required.
- There was an MCA policy and staff were able to access this.
- There was awareness of the Gillick competency (obtaining consent from patients under 16) and supporting guidance in consent policies.

Supporting patients to live healthier lives

The practice identified some patients who may be in need of extra support and provided some screening programmes. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- A smoking cessation service was started on the 2 January and as such no figures were yet available regarding its utilisation or success rates.

Are services effective?

(for example, treatment is effective)

- There were 49 patients on the dementia register but no eligible patients had been offered screening for dementia since the new provider took over the contract in September 2016.
- The practice offered annual health checks to patients with a learning disability. There were 57 patients on the register and five had health checks since September 2016.
- The practice was not commissioned to offer chlamydia screening to its patients.

- We were not able to obtain cervical screening data from the practice.

The latest available childhood immunisation rates for the vaccinations given to children registered with Circuit Lane Surgery were comparable to CCG averages. For example in 2015/16, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89% to 97% (CCG averages 58%-96%) and five year olds from 86% to 96% (CCG averages 91%-97%).

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 24 patient Care Quality Commission comment cards and spoke with 16 patients. Patients generally reported negative concerns about their ability to book appointments and in getting prescriptions signed by GPs. Some also noted how supportive staff were despite being under pressure. A majority reported being upset and frustrated by how they felt the situation at the practice was being handled by the provider. We spoke to two members of patient participation group (PPG). They were positive about the caring nature of staff, but were concerned by the pressure the service was under due to low staffing levels.

Results from the national GP patient survey were not relevant to services provided at Circuit Lane Surgery since September 2016 as the most recent results were published in July 2016. The practice had received feedback from the local Healthwatch which indicated that patients were very concerned about the level of service.

We received patient feedback including information from very concerned patients via the local Healthwatch. A meeting was held to discuss local patients' concerns in January and the PPG who attended reported a high attendance with many patients reporting similar concerns to the feedback we received at the inspection; difficulty in access appointments and other services at the practice.

Feedback from patients on the NHS Choices website produced the lowest rating possible for the practice. This was on the basis of a one to five rating (five being the best

rating for the service) alongside written feedback from patients. The website listed 12 negative comments about the practice in January 2017, mainly around phone and appointment access.

The practice undertook the friends and family test. In December 2016, 41 patients responded to the question "how likely are you to recommend Circuit Lane Surgery to friends and family?" The majority of patients said they would not recommend the practice. However the practice was unable to tell us how many patients this amounted too. Patients also provided comments and the main concerns reported related to making appointments (10 comments), delays in prescriptions (8 comments), ability to get through on the telephone (14 comments), and general administration (three comments). Some positive feedback was received with three patients saying the staff were very helpful and they'd had a positive experience at the Surgery.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received on CQC comment cards. They also told us they felt listened to and supported by staff. However, the difficulty in making appointments affected their continuity of care.

Results from the national GP patient survey were not relevant to services provided at Circuit Lane Surgery since September 2016 as the most recent results were published in July 2016.

Staff told us that they did not have access to phone translation services but could arrange interpreters when required.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 187 patients as carers which was 1.9% of the practice list. There was information provided to carers which was obtained from local carers' support groups. Carers were flagged on the record system to identify them to staff.

Are services caring?

The practice manager told us relatives were contacted soon after bereavements if they felt this was appropriate. Bereavement support information was also available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our previous inspection in December 2016 we identified concerns regarding access to appointments, continuity of care and a lack of planning to meet the needs of the practice population.

Responding to and meeting people's needs

In January 2017 the practice had a limited understanding of the needs of its local population and planned some of its services accordingly. For example:

- Due to the difficulty for patients to book appointments, an open access clinic was introduced on a daily basis from 8.30am for 30 patients. We saw this was well utilised by patients, but it did not provide the additional appointments needed to meet patient demand.
- There was a 'you said we did board' in the waiting room which listed changes based on some patient feedback and actions resulting from these. For example, when an open access clinic was introduced patients found waiting times unpredictable. Therefore the practice was implementing a numbering scheme, which allowed patients see where they were in the queue.
- GPs visited care homes regularly. We spoke with staff at local care homes who said that although waiting times on the phone caused a barrier when trying to book appointments, when they could request GPs they usually visited the same or next day depending on need. However, one care home also stated that delays on the phone lines caused problems in accessing home visits and led to an increased use of out of hours services.
- There was a hearing loop for patients with limited hearing
- The facilities were based on the ground floor where patients could access clinical treatment rooms via wide corridors.
- There were was space for mobility scooters and wheelchairs to access the premises.
- There were longer appointments available for vulnerable patients including those with a learning disability. However, there was no system to prioritise vulnerable patients who attended the open access clinic.

Access to the service

Circuit Lane Surgery was open between 8.00am and 6.30pm Monday to Friday. There were extended hours appointments on alternate Mondays and Thursdays until 8pm and most Saturdays from 8.30am to 11am.

Results from the national GP patient survey related to feedback prior to when the current provider took on the contract in September 2016.

Patient feedback showed significant concerns about long waits on phones, difficulty in booking appointments and long waits for prescriptions. We identified this through speaking with 16 patients on the day of inspection and 24 comments cards completed by patients prior to and on the day of inspection. We spoke with one patient who had booked their appointment for 24 January 2017 in December 2016. This patient was diabetic and had a respiratory disease. Some patients reported using the open access clinic and that this caused long delays to see a clinician. Two patients who had attended the open access clinic previously, reported to us that there was no guarantee of seeing a GP when they did access the service. The open access clinic required patients to wait until a slot became available and many chose to queue before the practice opened in order to try and book an appointment.

Patients reported four to eight week waits for routine appointments. There were approximately four positive comments alongside negative feedback regarding booking an appointment.

We received patient feedback including very concerned patients from Reading local Healthwatch (a statutory body which represents patients and acts on their concerns). A local meeting was held to discuss local patients' concerns in January and the PPG who attended reported a high attendance with many patients reporting similar concerns to the feedback we received at the inspection; difficulty in access appointments and other services at the practice. Preceding the inspection we received feedback from patients who were concerned about the ability to get through on the phone and to book appointments. The NHS Choices website showed listed 12 negative comments about the practice in January 2017, mainly around phone and appointment access.

A total of 669 (7%) patients were registered for online appointments.

The practice had a system in place to assess whether home visits were clinically necessary and the urgency of the need

Are services responsive to people's needs?

(for example, to feedback?)

for medical attention, when patients requested one. However, we spoke to local services who requested home visits for patients who used their services. They reported that home visits were organised when they could get through on the phone to the practice, but the long delays queueing to speak to reception, meant that on occasions the requests could not be made in time and the out of hours service had to be used instead. One patient informed us that a relative, who had a series of complex needs, was due to have a home visit on two occasions but no one showed up. They informed us the practice was unable to provide an explanation or apology. This posed a risk to the patient and an inconvenience to the relatives who had taken time off from work in order to facilitate the home visit. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures did not follow recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in leaflets. This did not include how to escalate complaints externally.

- The inspection team assessed the system for reviewing complaints on the day of inspection. In our subsequent analysis of the evidence provided, we found that the systems in place did not identify and ensure improvements to services for patients. The eight complaints we reviewed from November to December 2016, which were due to be completed in line with national guidance for completion within 20 working days, included none with investigation outcomes communicated to patients, only holding letters or no response at all. There were limited records of the investigations, improvements and learning from complaints. We saw limited evidence of changes as a result of complaint or significant event investigations.
- The practice received 26 complaints between 22 September 2016 and 9 January 2017. Of these, 73% were complaints about waiting times for appointments and/or prescriptions.
- Investigations from complaints were not comprehensive or discussed with relevant practice staff to ensure the sharing of lessons learnt. We reviewed the minutes of meetings held between September and November 2016, these did not include any details about complaint discussions. The practice confirmed that no further meetings had taken place after November 2016 and therefore complaints were not considered collectively to identify the trends.

Are services well-led?

Inadequate 

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

Our findings

During our inspection in December 2016, we identified concerns in relation to the well-led domain. This included concerns regarding a lack of governance systems in place to assess, monitor and mitigate risks to the health and welfare of patients. Effective systems to assess, monitor and improve the quality and safety of the services provided had also not been implemented.

At the inspection in January 2017, we found limited improvements had been made.

Vision and strategy

The provider's vision to deliver high quality care and promote good outcomes for patients was not supported by an effective leadership and governance. At the time of inspection the level of care and quality outcomes for patients was poor and patients had reported that in the previous six weeks improvements were minimal.

The practice had a mission statement. However, there was a lack of strategy and supporting business plans to reflect the vision and values and these were not regularly monitored and updated.

Governance arrangements

The practice had a governance framework but this was not effective and did not support the delivery of safe, effective and responsive care. Any actions that were planned from the December 2016 inspection to mitigate risks were ineffective and had not made improvements to the levels and quality of service to patients. For example:

- The information that was used to monitor performance or to make decisions was inaccurate, unreliable or out of date. Action plan information provided to the Care Quality Commission and North and West Clinical Commissioning Group following the December inspection was inaccurate. Many of the actions were confirmed as completed but on the day of inspection in January 2017, we identified continued concerns which evidenced most actions had not been completed as described. Furthermore, the evidence submitted from the provider to demonstrate the number of nurses and GPs was inconsistent and we were unable to ascertain the correct level of staffing at the practice.
- The provider did not have adequate mitigating actions in place to reduce the risks to patients associated with

insufficient staffing levels and the backlog of clinical tasks including repeat prescribing and referrals. CQC identified these risks in December 2016 and prompted the provider to take urgent action including use of our enforcement powers. However, the risks we identified were still not adequately addressed or reduced.

- The provider told us they were supporting the practice with remote clinical advice and a new clinical lead and a pharmacist had been employed since the previous inspection. However, the provider had not clearly defined their roles to ensure the practice had the necessary clinical leadership. There were no clear plans in place to deal with the backlog of clinical tasks and to ensure ongoing tasks were managed safely, such as medicine safety alerts.
- The provider acknowledged that staffing levels had been low and they were trying to recruit staff. However, their monitoring of real time staffing and appointments was not consistent and did not provide assurance that levels of suitably trained, skilled and experienced clinical staff were maintained during the recruitment of new GPs and ANPs.
- Staff were leaving the practice, including the practice manager, registered manager, a GP and lead nurse. This posed a further threat to the onsite governance of the practice.
- Staff who worked at the practice told us they repeatedly reported concerns about staffing levels and the backlog of patient correspondence and prescription requests to the provider. However, the provider had not responded with action plans that would mitigate the risks. Some backlogs had been reduced but this was in the days preceding the inspection, not as part of an ongoing plan since the previous inspection.
- We found examples of poor care resulting from a lack of appropriate systems to monitor and address the backlog of clinical and administrative tasks.
- We saw evidence that demonstrated the extent of patient correspondence not yet reviewed or filed onto the record system. Specifically, we saw that approximately 1,300 letters from specialists, discharge summaries, Out of Hours, walk-in centre reports and A&E discharges on the EMIS system, dating back to early December 2016. There were over 70 outstanding referrals dating back to November and the oldest request on the electronic prescribing system was from

Are services well-led?

Inadequate 

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

18 January 2017 there were 452 prescriptions waiting to be signed. In addition to this there were backlogs of blood test results and we identified significant risks to patients where they had not been acted on.

- We saw meeting minutes which showed staff attended meetings. Significant events and concerns from staff were discussed, but the provider could not provide clear investigation outcomes to significant events. Staff reported that their concerns regarding staffing and risks to patients were not being responded to in order to improve the service.
- There was an action plan submitted by the provider as a requirement of the previous inspection in December 2016. We saw that many actions were not completed despite being listed as 'closed'. For example, the action plan stated as one action that the lead GP should ensure that Clinicians completed their allocated patient correspondence on a daily basis. This was coded green and in the progress column referred to as 'closed'. However, as stated above we found significant backlogs in the patient correspondence queue including examples where patients had been left at significant risk of harm.

Leadership and culture

Leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively. Despite a local senior operations manager being on site and clinical lead being appointed there was a lack of clarity and authority to make decisions about mitigating risks or to make quality improvements. Some of the staff we spoke with on the day of inspection and individuals who contacted CQC prior to the inspection, reported that quality and safety were not the top priority for the provider leadership team and meeting financial targets was seen as more important.

There was no clear and embedded leadership structure at the practice. Staff were not clear about how to deliver their own roles and responsibilities due to the insufficient staffing levels, changes in management and a lack of guidance from the senior leadership team. We found that the leadership team and processes in place did not enable development under the model of care implemented by the provider from September 2016 to manage and implement the significant changes. There had been failures in communication between the leadership team and staff. The environment had left the practice staff demotivated,

demoralised and disillusioned with the reported lack of management support. The departure of on site management and other staff in the recent months further de-stabilised the practice team.

The provider had recently employed a clinical lead to support governance systems and process and to drive improvement. The provider did have a recruitment drive in place to try and recruit a lead nurse, a practice manager, nurses and advanced nurse practitioners.

There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged or repressed. This was evidenced by staff reporting significant events and them not being responded too, investigated thoroughly and appropriate action taken. Other staff also reported being pressurised by senior leaders of One Medicare Ltd to just get on with the work and not report any concerns to the Care Quality Commission.

There was a leadership structure in place; however staff told us that this was not a supportive relationship.

- We saw minutes from meetings did not resolve issues raised through significant events.
- Staff told us there was not an open culture within the practice and although they had the opportunity to raise any issues they did not feel confident and supported in doing so.

Seeking and acting on feedback from patients, the public and staff

The practice had not acted on feedback provided from patients, the public and staff. There was limited action to improve the concerns patients raised about the delivery of service.

- There was a local community meeting organised by councillors to allow patients to raise concerns regarding the practice. The provider's senior leadership team were invited but did not attend. We spoke with members of the patient participation group (PPG), who felt that the patient voice was not being listened to in regards the extent of concerns raised. The provider had not fully engaged with the PPG.
- Staff commented that the onsite leadership team had changed and there was a reduction in the number of managers. They stated that they did not know who would appropriately deal with any concerns raised.

Are services well-led?

Inadequate 

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

- The practice undertook the friends and family test. In December 2016, 41 patients responded to the question “how likely are you to recommend Circuit Lane Surgery to friends and family?” The majority of patients said they would not recommend the practice. Patients also provided comments and the main concerns reported related to making appointments (10 comments), delays in prescriptions (8 comments), ability to get through on the telephone (14 comments), and general administration (three comments). Some positive feedback was received with three patients saying the staff were very helpful and they’d had a positive experience at the Surgery.

Continuous improvement

There was minimal focus on continuous learning and improvement within the practice. The provider was not identifying improvements to the practice which could improve the quality and safety of the service in regards to the core issues which restricted improvements; staffing levels and governance. Some attempts to improve the service had been made:

- An open access clinic had been implemented to try and improve appointment access. However, this did not provide additional staff resourcing, but a reorganisation of the existing staffing levels.
- A ‘you said we did’ board was used to list improvements, such as providing ticket numbers at the open access clinic so patients had an indication how long they had to wait.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider was not assessing the risks to the health and safety of service users in regards to receiving the care or treatment and not doing all that is reasonably practicable to mitigate any such risks.</p> <p>The provider did not ensure that where responsibility for the care and treatment of service users was shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning took place to ensure the health, safety and welfare of the service users.</p> <p>Specifically risks associated with outstanding and future repeat prescription requests, referrals, medication reviews, patient correspondence and paper medical records.</p> <p>This was in breach of Regulation 12 Safe care and treatment (1).</p> <p>(The action taken is subject to appeal)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 HSCA (RA) Regulations 2014 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

This section is primarily information for the provider

Enforcement actions

The system of clinical governance did not ensure that the provider assessed and monitored the quality and safety of the services provided in the carrying on of the regulated activity.

They did not implement quality improvement where this was required and where specific risks were reported to the provider by CQC in December 2016.

They did not evaluate and improve their practice in respect of the processing of information regarding the performance of the service.

Specifically in regards to concerns reported by patients and staff and the inherent risks identified by a backlog of patient correspondence and other care related processes.

This was in breach of Regulation 17 Good governance (1).
(The action taken is subject to appeal)

Regulated activity

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

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the requirements of this regulation.

There were not sufficient staff to provide the care and appointments that the patient population required in a timely way. This posed a risk to the health and wellbeing of patients.

This section is primarily information for the provider

Enforcement actions

Regulation 18(1).

(The action taken is subject to appeal)