Horsefair Surgery

Quality Report

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection at Horsefair Surgery on 9 May 2017. The overall rating for the practice was inadequate, specifically in providing effective and well led services, requires improvement for providing safe services and good for caring and responsive services. We issued warning notices in relation to breaches of the regulations in safe care and treatment and good governance. We placed the practice in special measures for six months. We previously inspected the practice in August 2016 where we found concerns leading to a rating of inadequate in effective and an overall rating of requires improvement. We issued requirement notices at that time. The full comprehensive report from the inspection can be found by selecting the 'all reports' link for Horsefair Surgery on our website at www.cqc.org.uk.

Summary of findings

We undertook an unannounced focussed responsive inspection on 30 August 2017. This inspection was undertaken to determine whether improvements were made following the inspection in May 2016 and due to concerns raised with CQC regarding the safety of the service. Whilst improvements had been made in relation to the concerns highlighted at the last inspection, there were areas relating to staffing and governance which continued to place patients at significant risk. We have issued warning notices instructing the provider they must comply with regulations.

Our key findings were as follows:

- There was evidence that issues identified during our last inspection were in the process of being addressed and plans were in place to improve some areas of governance.
- However, there were still significant concerns regarding governance specifically the partners' involvement in the leadership of the practice.
- Staff told us that they believed clinical staffing levels were unsafe as tasks related to patient care, such as prescriptions and correspondence, were not always handled correctly due to the pressure caused by low staffing numbers.
- Although we found most clinical tasks were up to date there were examples where there were omissions in patients care due to processes not being followed.
- There was no clear system to assign patients requesting care or treatment to appropriate professionals. This meant that clinical staff may be treating patients without the skills and knowledge to safely do so. Patients informed us via comment cards and verbally that they found it difficult to book appointments and to get through on the practice's phone system. Some told us the continuity of care provided was poor due to the lack of consistent GPs and the inability to book appointments.
- A local care home reported concerns with the level of care received by their residents from the practice.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Review staffing levels and ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to ensure the safety and welfare of patients.
- Ensure a system is in place to enable patients to be seen by a clinician with the appropriate skills and knowledge to meet their needs.
- Improve governance systems to ensure the leadership team can assess, monitor and improve the quality and safety of the services, specifically in terms of clinical care.
- Review governance systems to ensure they are tailored to the practice's needs and that they enable the ongoing identification, assessment and monitoring of risks.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this domain as part of this inspection.

- Safeguarding policies were not practice specific to ensure referral and escalation criteria were clear to staff. We spoke with staff who did not know who the practice safeguarding lead was.
- Staffing levels led to risks in dealing with patient care tasks, including correspondence requiring action and prescriptions.
- Emergency medicines were risk assessed to ensure that all medicines and equipment potentially required were available.

Are services effective?

We did not rate this domain as part of this inspection.

- There was not an appropriate assessment criteria to enable receptionists to book patients' appointments with the appropriate clinicians. This posed a risk to patients' safety and welfare.
- Patients residing at a local care home were not able to access health reviews from GPs when required.
- There were improvements to the reviews of patients' on medicines to ensure they were receiving prescriptions safely. However, there were still low numbers of patients with up to date reviews for those on less than four medicines.
- The system for reviewing prescriptions did not always work effectively or safely.
- There were increased levels of clinical audit since May 2017 with more audits planned. However, improvement as a result of audit was limited.
- A system for monitoring training was in place.
- There was a system of appraisals in place for staff.
- We saw evidence that long term condition data was being monitored to identify the ongoing performance.

Are services responsive to people's needs?

We did not rate this domain as part of this inspection.

- Patients reported significant difficulty in booking appointments and accessing the phone system.
- Patients reported concerns about the continuity of their care and treatment.

Summary of findings

- Information about how to complain was available and evidence from the examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

We did not rate this domain as part of this inspection.

- We found that some of the governance issues identified in May 2017 had been acted on and there were plans to improve clinical governance. However, we also found a lack of clear governance and leadership structure.
- The partners did not attend the clinical governance or staff meetings held within the practice and were not aware of a high risk significant event which took place in August 2017.
- The provider did not always identify risks in order to assess and mitigate them as part of a system for governance. For example, there was no effective system to ensure that advanced nurse practitioners were only allocated patients who they had the skills and experience in order to meet their needs safely.
- Improvements to the monitoring of patients on repeat medicines was evident from searches performed on the patient record system.
- We saw evidence that the monitoring of training had improved to enable the leadership team to identify when staff required additional or supplementary training courses.
- An increased level of audit activity had been undertaken although much of the programme of audit was still in the planning stage.

Summary of findings

What people who use the service say

We spoke with 17 patients and their feedback consistently identified a lack of appointment availability, waiting times within the practice for booked appointments and phone access as a concern. From 14 patient comment cards we received eight noted concerns with the consistency of care patients received due to the high use of locum GPs, poor access to appointments and the inabilty to take calls via the telephone system.

We reviewed three patients' feedback on the NHS choices website from August and September 2017. All of them shared concerns about the inability to phone the practice, book appointments and to request prescriptions. There was feedback from the practice on patient comments other than the two most recent on NHS Choices.

Horsefair Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP and nurse specialist adviser and an expert by experience**.**

Background to Horsefair Surgery

The practice provides services from Horsefair Surgery, Banbury, Oxfordshire, OX16 9AD. We visited Horsefair Surgery as part of this inspection.

Horsefair Surgery has a modern purpose built location with good accessibility to all its consultation rooms. The practice serves 16,200 patients from the surrounding town and villages. The practice demographics show that the population closely matches the national profile for age spread, with a slightly higher proportion of older patients. According to national data there is minimal deprivation among the local population, although staff are aware of areas in Banbury where economic deprivation was a concern. There are patients from minority ethnic backgrounds, but this is a small proportion of the practice population.

The practice had been under pressure due to recruitment problems and losing partners, including a bereavement of one long term partner since our last inspection. The number of GPs overall had decreased since our last inspection. Nursing vacancies also added to the pressure to the existing clinical team.

Since our previous inspection two new partners had registered with CQC and now formed the legal entity of the partnership at Horsefair Surgery. The previous partners were no longer at the practice.

Two salaried GPs working at the practice, supplemented by locum GPs. There was a mixture of male and female GPs working at the practice. There are four practice nurses, two advanced nurse practitioners, three health care assistants and one emergency care practitioners (ECPs) as part of the clinical team. A number of administrative staff and a practice manager support the clinical team.

Horsefair Surgery is open between 8.00am and 6.30pm Monday to Friday. There are no extended hours appointments available, but patients had access to some appointments provided via a GP hub service in Banbury town by an external provider. Out of hours GP services were available when the practice was closed by phoning NHS 111 and this was advertised on the practice website.

There is currently no registered manager in post at the practice. In August 2016 we requested the practice register a new manager and again in April 2017. At the time of this inspection a new registered manager application had still not been received. We were informed that the new practice manager was planning on registering as manager has begun the process since the inspection on 30th August 2017.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Detailed findings

Why we carried out this inspection

We undertook an unannounced focussed responsive inspection on 30 August 2017 at Horsefair Surgery under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

Previously we undertook a comprehensive follow up inspection of Horsefair Surgery on 9 May 2017 and rated the provider inadequate and placed them in special measures. The full comprehensive report following the inspection can be found by selecting the 'all reports' link for Horsefair Surgery on our website at www.cqc.org.uk.

How we carried out this inspection

Before visiting we reviewed a range of information we hold about the practice. We carried out an unannounced visit on 30 August 2017. During our visit we:

- Spoke with a range of staff including five GPs, two nurses, support staff, the practice management team and spoke with patients.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

At this inspection we asked the following four key questions:

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

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

At our inspection in May 2017 we found that emergency medicines were not risk assessed to ensure that all medicines and equipment potentially required was available. A medicine which may be required was also identified as not being stocked at our last inspection. Safeguarding policies were not practice specific.

At this inspection we found that although some improvements had been made since the last inspection, there were risks resulting from the clinical staffing levels and a lack of practice specific processes and policies.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety.

- There were improved arrangements for monitoring patients on high risk medicines. Data we requested from the practice showed that 95% of patients on more than four repeat medicines had up to date reviews of their medicines to ensure they were safe (previously 58%). We were provided with the up to date levels of medicine reviews for patients on Warfarin and Methotrexate and saw that all patients either had a review, were in the process of being reviewed or were accounted for under other services. However, only 43% of those on less than four medicines had up to date reviews.
- Safeguarding policies were accessible to all staff. However, they were not practice specific and there was no lead identified in the policies. Two members of the clinical team we spoke with did not know who the safeguarding lead was. There was no clearly identified system for the reporting of safeguarding concerns for staff to follow. This posed a risk that any safeguarding concerns may not be reported in a way that was consistent for the appropriate recording and reporting of concerns and therefore any patients at risk of abuse or harm may not be reported appropriately to the right authority.

Monitoring risks to patients

The practice had been operating on low staffing numbers, which was a historical issue dating back over 18 months at the practice. The recruitment of nurses and GPs was ongoing and the practice was supplementing employed staffing levels with locum GPs and locum advanced nurse practitioners (ANPs). The practice leadership team aimed to staff the practice at four GPs on Mondays and three every other work day. The allocation of GPs was supplemented by ANPs. One full time and one part time GP were leaving the practice and three more including a clinical director were joining the practice in the coming weeks.

Four members of the clinical team and clinical support team reported to the CQC inspection team that clinical staffing levels, specifically the number of GPs were unsafe. Among their concerns was a lack of time to complete clinical tasks to ensure patients' care and treatment was being undertaken safely and in a timely way. For example, reviewing repeat prescriptions and patient correspondence safely. A GP provided an example of a patient who was placed at risk as their medication was not changed following a discharge summary on 17 August 2017 requesting a change to their medicine, which included Difflam, Donepezil tablets, Hypromellose eye drops and Nystatin suspension. The patient's records indicated Horsefair Surgery issued the medications on 25 August 2017, six working days after the request. In another example provided to the CQC inspection by a GP, a patient had had a high calcium reading of 3.25 mmol/L following their blood test results received into the practice on 23 August. Phone consultation notes from 24 August 2017 stated that the patient took themselves to hospital due to not being able to get through to the practice by phone. The abnormal blood test results had not been acted on in a timely manner by a GP.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was a risk assessment in place to determine what medicines should be available in the event of a number of medical emergencies. All the medicines listed on the risk assessment as required were in place and within date.

Are services effective?

(for example, treatment is effective)

Our findings

During our last inspection in May 2017, we found that patient outcomes were not always being met due to a lack of long term condition reviews taking place. The results for 2016/17 had significantly declined from 2015/16 with high instances of exception reporting (where patients were excluded from care performance data on the basis of not attending reviews or not being able to receive care in line with guidance). Reviews of patients' medicines were not being undertaken in line with national guidance or recorded properly to enable appropriate monitoring of repeat prescribing. Reviews of patients with learning disabilities were not routinely taking place, with a significant proportion of these patients having had no review in at least two years. There was limited evidence that clinical audit was used in response to areas where improvements were needed or that they improved services, care and treatment.

At this inspection we found some improvements to the monitoring of patient care had been made but there were significant risks identified in relation to effective patient care which had not been assessed and mitigated.

Effective needs assessment

The practice supplemented GP cover with the use of advanced nurse practitioners (ANPs). There were high numbers of locum ANPs being used as well as full time employed ANPs. There was no clear system to delegate which patients could be seen by a GP or an ANP and ensure that staff seeing patients had the skills and experience to provide safe care to patients. This posed a risk to patients who may have significant health risks and were not identified as such by reception staff. The practice could not ensure that ANPs had the necessary skill sets to treat patients with high risk symptoms due to the lack of a system to allocate patients to the appropriate staff. We identified an example where a patient attended with symptoms which may have indicated a risk of heart problems in early August 2017 and was seen by a locum ANP. A subsequent significant event analysis stated "no obs taken". No assessment of a potential heart condition which may have placed the patient at high risk was undertaken. The patient returned two weeks later with the same symptoms and a different ANP undertook an ECG (equipment which assesses the function of the heart) and found the patient needed an urgent referral to hospital. The patient tried to make their own way to hospital, despite the practice recommending an ambulance. The significant event analysis stated the patient had a cardiac arrest on their way to hospital. The practice had failed to ensure this patient was appropriately assessed to ensure risks to their health and wellbeing were identified and appropriate action taken as a result. The lack of coherent assessment tools posed a risk to patients as they may not have been seen by an appropriate professional.

The practice had promptly identified this risk and undertook a review of the processes used. The practice decided not to use the locum staff member again and audited 10 other patient consultation records where they had seen patients to identify further risks. However, by 30 August 2017 there was still no clear system to identify what types of patient concerns ANPs should and should not see. There was a document provided to the inspection team by the reception team called 'prioritisation of patients: a guide to urgency for non-clinical staff'. This provided a system to follow by which patients could be allocated to staff within the practice or go to external services. The tool was not a clear system to follow because the examples of patients' concerns did not differentiate the urgency of their needs in order to allocate them to specific staff. For example, extreme psychological distress, heart palpitations, bleeding or 'patient in danger' were listed as concerns which should prompt an appointment with a GP, ANP or practice nurse but did not state the concerns may require urgent action. Depending on the nature of these issues patients may be receiving advice from reception staff which placed them at risk if they did not seek immediate medical attention. We were also shown meeting minutes which had a draft list of what tasks ANPs could undertake. This tool did not identify what needs may be urgent or require escalation to emergency services.

Management, monitoring and improving outcomes for people

At our previous inspection in May 2017 there was minimal evidence of quality improvement including completed clinical audits. At this inspection we found a programme of planned clinical audits was in place including two repeated audits and four initial audits planned for repetition in the coming months. For example, an audit aimed at identifying undiagnosed diabetes undertaken in September 2016 identified 22 patients with an elevated HbA1c>48 (a long term measure of blood sugar levels), which is a potential

risk indicator for diabetes. The re-audit in May 2017 showed that the outstanding patients from the original audit had been reviewed by a GP and any changes to patient records were made. There was another repeated audit on the usage of a particular medicine associated with high risks if not monitored properly and four other initial audits, including one on gestational diabetes (diabetes during pregnancy). There was still limited audit driving improvements but an audit plan was now in place and being undertaken.

We saw evidence that long term condition data was being monitored to identify the ongoing performance against national guidance and the quality outcomes framework. The in year data from 2017/18 showed performance on the reviews undertaken on patients was on course for this point in the year. This data is not yet able to demonstrate the level of patients excepted from the final outcomes.

Data we requested indicated there were improved arrangements for monitoring patients on high risk medicines. Data we requested from the practice showed that 95% of patients on more than four repeat medicines had up to date reviews of their medicines to ensure they were safe (previously 58%). We were provided with the up to date levels of medicine reviews for patients on Warfarin and Methotrexate and saw that all patients either had a review, were in the process of being reviewed or were accounted for under other services. However, only 43% of those on less than four medicines had up to date reviews.

A staff member involved in dealing with clinical tasks stated that the system was not safe at times due to the lack of GPs reviewing of prescriptions in a timely manner. They stated that changes to medicines were not always annotated properly. We found an example where a patient had their medication changed in July to Felodipine from Amlodipine but the practice had not ensured the change was appropriately implemented. The patient's notes show that they were further prescribed Amlodipine on 4 August. The practice identified this issue on 7 August 2017 and amended.

Effective staffing

In May 2017 staff we spoke with were confident about their skills and knowledge to deliver effective care and treatment, but there was not an effective system for monitoring training. At this inspection we saw that a training matrix had been implemented and to support the monitoring of staff training. We saw that most staff had undertaken their mandatory training, as listed in the practice's log. Where staff were still due to take any training course this was marked as 'due'. We saw two members of the clinical team were due for their consent training for example, but that six members of staff had undertaken the training in 2017. 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. There was a system of appraisals in place for staff which had been implemented since May 2017.

Coordinating patient care and information sharing

We spoke to staff at a local care home in late August and again in September 2017 where many residents were registered at Horsefair Surgery. The care home staff informed us that they had significant difficulty in contacting the practice by phone when they needed to request prescriptions, ask questions or book appointments for their residents. They informed us that until recently their residents saw GPs as part of a routine visit every week as well as being able to request home visits from either a GP or an emergency care practitioner (ECP). However, the routine GP rounds had ceased as part of a reorganisation of the services at Horsefair Surgery. Staff at the care home stated they found it very difficult to speak with GPs or request them to visit.

On 5 September 2017 a staff member provided an example where a repeat prescription request was issued to the practice for Naproxen on Tuesday 29 August 2017 and only received on 5 September 2017 after chasing the repeat request that morning. They stated that repeat prescriptions are being requested by fax but long delays in receiving them are common. They provided another example where the home requested a controlled drug repeat prescription on Friday 1 September 2017 and were informed on 4 September 2017 that it would be ready to collect from pharmacy, but when the staff member attended the pharmacy they found the medicine was not ready as the practice had not processed the request.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

Horsefair Surgery was open between 8.00am and 6.30pm Monday to Friday. There were no extended hours appointments available but patients had access to some appointments provided via a GP hub service in Banbury town by an external provider. The practice supplemented GP cover with the use of advanced nurse practitioners (ANPs). There were high numbers of locum ANPs being used as well as full time employed ANPs.

We spoke with 17 patients and their feedback consistently identified a lack of appointment availability, waiting times within the practice for booked appointments and phone access as a concern. From 14 patient comment cards we received eight noted concerns with the consistency of care patients received due to high locum GP numbers, access to appointments and the phone system. The practice manager provided the CQC inspection team with a phone system monitoring tool which indicated how many calls were lost due to a lack of capacity to answer calls. However, there was no means at the time of inspection of accurately analysing how many calls were lost due to the capacity of the phone system compared to patients trying to call the practice. We were informed that the practice was in the process of identifying how this could be analysed.

We reviewed three patients' feedback on the NHS choices website from August and September 2017. All of them shared concerns about the inability to phone the practice, book appointments and to request prescriptions. There was feedback from the practice on patient comments other than the two most recent on NHS Choices.

Are services well-led?

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

Our findings

In May 2017 we found governance issues previously identified by CQC in August 2016 had not ensured improvement in care outcomes for patients. Some areas of practice had deteriorated. The practice did not demonstrate a focus on continuous learning and improvement in clinical care. Concerns from data monitoring or care outcomes were not identified as potential areas for improving clinical care. The leadership structure did not have clearly defined responsibilities for lead roles, which ensured clear oversight and management.

Since our previous inspection two new partners had registered with CQC and now formed the legal entity of the partnership at Horsefair Surgery. We found some improvements to governance arrangements had been made but there were still significant concerns.

Governance arrangements

The practice had a governance framework which was still not always effective in the delivery of the strategy. However, there had been improvements in specific areas identified as concerns during our previous inspection in May 2017.

- Improvements to the monitoring of patients on repeat medicines was evident from searches performed on the patient record system.
- We saw evidence that the monitoring of training had improved to enable the leadership team to identify when staff required additional or supplementary training courses.
- An increased level of audit activity had been undertaken although much of the programme of audit was still in the planning stage.

We also identified areas where governance was not adequate and posed a risk to patients:

- The inspection team requested time to speak with the two partners in place at the practice during the inspection. We were informed by members of the management team and the acting clinical lead that the two partners did not work within the practice but provided offsite support. We spoke with each of the current partners in place over the phone during the inspection. The partners confirmed they did not routinely attend the practice. We looked at the two meeting minutes available from August 2017 and saw that the partners did not attend clinical or staff meetings. This limited the understanding and involvement the partners had in the governance and running of the practice. For example, we identified a significant event from 16 August 2017, where a patient had suffered a cardiac arrest following two consultations nearly two weeks apart complaining of the same symptoms. When we specifically asked one of the partners if they knew of any significant events related to a cardiac arrest onsite they stated they had no knowledge.
- The provider did not always identify risks in order to assess and mitigate them as part of a system for governance. For example, there was no effective system to ensure that ANPs were only allocated patients who they had the skills and experience in order to meet their needs safely. The limited number of GP appointments meant appointments were routinely booked with ANPs. The significant event raised on 16 August 2017 identified to the practice leadership team that reception staff needed an assessment tool to determine what patient concerns could be seen by a GP and which by an ANP. This was discussed in a meeting on 23 August 2017 and minutes stated that ANPs would be providing a list of patient issues or symptoms that they felt they were able to see, in order to reduce the risk of such an event occurring again. At this inspection on 30 August this system had still not been implemented.
- Policies which were related to the management and other aspects of the practice were not always specific to the practice. For example, the safeguarding policies did not list who the safeguarding lead for the practice was or local referrals guidelines. Two members of the nursing team we interviewed did not know who the safeguarding lead was. One member of the nursing team told us they would report concerns to the practice manager and another said they would report safeguarding concerns to a GP on duty. There was no clearly identified system for the reporting of safeguarding concerns for staff to follow.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: There were not sufficient systems of clinical governance to ensure that the provider could assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity or assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). This included lack of systems to allocate patients to the correct staff, unclear processes and policies and a lack of leadership and oversight of clinical governance. This was in breach of Regulation 17 (1) Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: The provider was not ensuring sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to ensure the safety and welfare of patients. This led to risks associated with a lack of access to appointments, a lack of clinical supervision for nurses and not sufficient capacity to ensure clinical tasks were completed safely. This was in breach of Regulation 18 (1) Staffing