Cornwallis 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 focussed inspection at Cornwallis Surgery on 1 November 2016. The overall rating for the practice was requires improvement. The report on the November 2016 inspection can be found by selecting the 'all reports' link for Cornwallis Surgery on our website at www.cqc.org.uk.

This inspection was an unannounced focussed inspection carried out on 18 April 2017 to confirm that the practice had taken steps to meet the legal requirements in relation to the breaches in regulations that we identified on our previous inspection on 1 November 2016 and to respond to a number of concerns sent to the Care Quality Commission. This report covers our findings in relation to those requirements and the review of the concerns raised.

Overall the practice is now rated as inadequate.

Our key findings were as follows:

- We found that the practice did not have systems in place to manage medicines safely. Medicines were found to be out of date, medicines and computerised prescription forms were not always secure.
- The practice did not have a system to ensure significant events were identified, recorded and reviewed. There was no evidence that the practice learned from incidents and disseminated information to staff.
- Recruitment systems did not protect patients. For example staff were not risk assessed in relation to obtaining a DBS check and satisfactory information was not always available on the conduct of staff in previous employment.
- The practice had not assessed the risk of the low staffing levels on the delivery of safe services to patients.
- Patients told us that they had great difficulty in getting through to the practice on the telephone and struggled to get appointments. They felt they had no continuity in their care and treatment as they saw a different GP each time. Some patients felt the only way to be seen was to attend the practice and wait.
- Staff did not always receive the training and support for their role and the safe delivery of care and treatment to patients.
- Access to appointments was limited due largely to the limited availability of GP sessions.

Summary of findings

- The management of correspondence including hospital letters and results was unsafe.
- Governance arrangements were not in place to mitigate risks to patients. Meetings were not held with staff to review the delivery of services.

Areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure systems are put in place to manage medicines safely. This must include the security and storage of computerised prescription pads and medicines.
- Ensure a system is in place to identify, record and review significant events and demonstrate that the practice learns from incidents and disseminates information to staff.
- Ensure effective recruitment systems are in place to protect patients. This must include all information required by regulation.
- Ensure risks associated with low staffing levels and how they impact on the delivery of safe services to patients are reviewed and implement measures to mitigate these risks.
- Ensure staff receive the training and support for their role and the safe delivery of care and treatment to patients. This must include regular clinical supervision, meetings and appraisals.
- Ensure systems are in place to effectively manage correspondence including hospital letters and results.
- Ensure they review the governance arrangements in the practice to include a programme of meetings and reviews to assess the quality and safety of the services provided.
- Ensure the telephone and appointment system is reviewed and action is taken to improve these systems and patient access to appointments.

I am placing this service in special measures. Insufficient improvements have been made such that there is a rating of inadequate overall and for safe, effective, responsive and well-led services. Therefore we are taking action in line with our enforcement procedures. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The practice is rated as inadequate for providing safe services.

- At this inspection on 18 April 2017 we found that the practice did not have systems in place to manage medicines safely. Medicines were found to be out of date, medicines and computerised prescription forms were not always secured.
- The practice did not have a system to ensure significant events were identified, recorded and reviewed. There was no evidence that the practice learned from incidents and disseminated information to staff.
- Recruitment systems did not protect patients. For example staff were not risk assessed in relation to obtaining a DBS check and satisfactory information was not always available on the conduct of staff in previous employment.
- The practice had not assessed the risk of the low staffing levels on the delivery of safe services to patients.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Staff did not receive the training and support for their role and the safe delivery of care and treatment to patients. We found staff had been carrying out critical roles in the practice without clinical supervision and appropriate training to carry out these roles.
- Staff told us they felt unsupported and that the lack of clinical support made them feel unsafe. There were no clinical meetings or staff meetings to discuss concerns and review delivery of services. No appraisals took place and new staff were not in receipt of an induction.
- We found a backlog of correspondence awaiting scanning and actions that had an impact on patients receiving appropriate care and treatment.

Are services caring?

Requires improvement

The practice is rated as Requires Improvement for providing caring services. At the previous inspection on 1 November 2016 data from the National GP Patient Survey showed patients rated the practice lower than others for several aspects of care.

Summary of findings

At this inspection we found that the National GP Patient Survey again showed patients rated the practice lower than others for several aspects of care, however the survey data had been collected prior to the 31 March 2016 and changes had taken place in the practice since then.

Patients we spoke with did not always feel that staff were caring and helpful or treated them with respect and involved them in their care.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

At the inspection on 1 November 2016 the practice was found to be good for providing responsive services. Since that time CQC has received complaints in particular with regard to patient access to the practice and appointments via the telephone system and also continuity of care. There were similar complaints on review websites for each branch on the internet. In view of this we also focused on this aspect of service delivery during this inspection.

At our inspection on 18 April 2017 we found;

- Patients we spoke with and received feedback from told us that they had great difficulty in getting through on the phone and when they did it was not possible to get an appointment.
- Staff told us they had great difficulty in giving patients appointments due to the lack of clinicians working in the practice.
- New initiatives put in place at our last inspection were either no longer in place or ineffective in delivering responsive services to patients. For example the clinic known as the 'e-clinic' set up by the lead GP whereby patients could email in non-urgent requests such as administrative issues for the GP's attention was not operating. There was no plan in place to deal with any issues arising from this.
- The provision of urgent care practitioners introduced to support GPs had been reduced to one as two staff had left the practice.
- We observed a number of patients attending the practice to chase changes to their medicine prescriptions following secondary care appointments. We were told by patients that letters had gone missing or fit to work certificates had not been provided when requested. The Care Quality Commission had received complaints of a similar nature prior to the inspection.
- We spoke with the staff member managing the navigation service (a service to coordinate patient appointments,

Summary of findings

allocating them to the appropriate clinician in a timely manner) and they told us that it was ineffective at present as they had few clinicians to refer patients to and very few appointments to offer patients. All staff we spoke with commented on the lack of appointments and felt the current provision was unsafe.

Are services well-led?

Inadequate

At our last inspection on 1 November 2016 this practice was rated as requires improvement for providing well-led services.

- At that inspection the new clinical lead GP had accepted that they would have a very heavy workload in the short term. However there was no risk assessment as to the risk to patients, or sustainable written plan in place, to ensure the safe and effective provision of services and cover the breadth of role of the clinical lead GP and other key staff should they be unable to work.
- At this inspection on 18 April 2017 we found that this risk assessment had not been put in place and there was no written contingency plan for absences. The lead GP was away on leave at the time of our inspection and staff had not been left with a viable plan to ensure safe delivery of services.

Also at this inspection we found:

- The partners in the practice did not demonstrate they had capacity and capability to run the practice and ensure high quality care. There was no evidence to demonstrate they prioritised safe, high quality and compassionate care. Staff told us the lead GP was not approachable and staff felt that they were not listened to.
- We found that the provider had not assessed and mitigated risk. This included the use of untrained and unsupported staff to carry out roles in the delivery of care and treatment of patients. Staff were employed without an appropriate risk assessment or DBS check. The risks associated with low staffing levels and the inability to deliver sufficient appointments to patients had not been addressed.
- Staff said they felt under-valued and unsupported, particularly by the partners in the practice. There were no systems to involve staff in discussions about how to run and develop the practice.
- Concerns and complaints were recorded and responded to. However actions recommended as a result of the review of complaints were not always followed and learning from complaints was not evident.

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 had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

People with long term conditions
The provider had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

Families, children and young people
The provider had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

Working age people (including those recently retired and students)
The provider had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

People whose circumstances may make them vulnerable
The provider had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

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People experiencing poor mental health (including people with dementia)

The provider had not resolved the concerns for caring and well-led identified at our inspection on 1 November 2016. Also at this inspection we identified significant concerns in safe, effective and responsive which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Inadequate

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure systems are put in place to manage medicines safely. This must include the security and storage of computerised prescription pads and medicines.
- Ensure a system is in place to identify, record and review significant events and demonstrate that the practice learns from incidents and disseminates information to staff.
- Ensure effective recruitment systems are in place to protect patients. This must include all information required by regulation.
- Ensure risks associated with low staffing levels and how they impact on the delivery of safe services to patients are reviewed and implement measures to mitigate these risks.
- Ensure staff receive the training and support for their role and the safe delivery of care and treatment to patients. This must include regular clinical supervision, meetings and appraisals.
- Ensure systems are in place to effectively manage correspondence including hospital letters and results.
- Ensure they review the governance arrangements in the practice to include a programme of meetings and reviews to assess the quality and safety of the services provided.
- Ensure the telephone and appointment system is reviewed and action is taken to improve these systems and patient access to appointments.

Cornwallis Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included two GP specialist advisers, two additional CQC inspectors, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Cornwallis Surgery

The Cornwallis Surgery was taken over by a single GP in July 2015 when the location was in special measures. At the time the practice engaged with a consultant firm who provided some managerial support. In October 2015 the practice merged with another within the same building and the provider also took over three further surgeries in the Hastings area, Little Ridge, Shankill and Essenden Road. These are run as branch surgeries. The practice is still accepting new patients and currently has approximately 19,000 patients registered. The practice has a significantly higher level of deprivation score of 41.8 compared to the CCG average score of 25 and the national average of 21.8.

In February 2015 CQC carried out a comprehensive inspection after which the practice was rated requires improvement overall, requires improvement in the effective, caring and well-led domains

and good in the safe and responsive domains. The practice was taken out of special measures.

On 1 September 2016 the consultancy organisation assisting with back office support withdrew and a second GP joined the practice and took over the role of clinical lead GP (male). The newly recruited GP is the only permanent GP currently available. The registered provider (GP provider) is currently unavailable as he is on a sabbatical.

The clinical lead GP is supported by locum GPs and one Paramedic Practitioner (male) works as an urgent care practitioner (UCP). The practice also employs two nurse prescribers (both female), one of whom is a community nurse practitioner and triages and carries out home visits. The other is a nurse practitioner who can treat patients with minor illnesses. There are four practice nurses (female) and two health care assistants (female) who work across the four sites. There is also a practice clinician who had been trained to check blood pressures, and measure and weigh patients.

Practice opening hours are:

Monday :

Cornwallis Surgery 8 am to 6.30 pm

Essenden Road 8 am to 6.30pm, Little Ridge 8 am to 8 pm (8 pm to 9 pm telephone results

surgery)

Shankill 8 am to 5.30 pm

Tuesday:

Cornwallis Surgery 8 am to 6.30 pm

Essenden Road 1pm to 6.30 pm

Little Ridge 8 am to 1pm

Shankill 8 am to 8 pm

Wednesday:

Cornwallis Surgery 8 am to 8 pm

Essenden Road 8 am to 1pm

Detailed findings

Little Ridge 8 am to 6.30pm (8 pm to 9 pm telephone results surgery)

Shankill 8 am to 1.00pm

Thursday:

Cornwallis Surgery 8 am to 6.30 pm

Essenden Road 8 am to 8 pm

Little Ridge 8 am to 1 pm

Shankill 8 am to 1 pm

Friday:

Cornwallis Surgery 8 am to 6.30 pm

Essenden Road 8 am to 6.30 pm

Little Ridge 8 am to 6.30 pm

Shankill 8 am to 5.30 pm

Saturday and Sunday: All surgeries are closed.

When the surgeries are closed patients can access the out of hours service by phoning 111.

Services are provided at:

Cornwallis Surgery, Station Plaza Health Centre, Station Approach, Hastings East Sussex. TN34 1BA.

Essenden Road Surgery, 49 Essenden Road, St Leonards-on-Sea, East Sussex, TN38 0NN.

Little Ridge Surgery, 38 Little Ridge Avenue, St Leonards-on-Sea, East Sussex, TN37 7LS.

Shankill Surgery, 21 Fairlight Road, Hastings, East Sussex,TN35 5ED.

Why we carried out this inspection

We undertook a focussed inspection of Cornwallis Surgery on 1 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The report following the inspection in November 2016 can be found by selecting the 'all reports' link for Cornwallis Surgery on our website at www.cqc.org.uk.

We undertook a focused inspection of Cornwallis Surgery on 18 April 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements. This inspection was brought forward due to receipt of information of concern and we reviewed specific aspects of service delivery linked to these concerns as part of this inspection.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including the registered provider, chief operating officer, business manager, locum GPs, nurse practitioners, an urgent care practitioner, a practice clinician, reception and administration staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.
- Looked at recruitment and training records.
- Looked at medicine storage facilities and medicines held in the service.

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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 1 November 2016, we rated the practice as good for providing safe services. However when we conducted this focused inspection we found areas of concern.

The practice is now rated as inadequate for providing safe services.

Safe track record and learning

We reviewed safety records, incident reports and patient safety alerts. The practice did not have minutes of meetings where significant events were discussed. We found 11 significant events were on record since September 2016 with only three having a recorded learning outcome. The practice staff told us they did not have meetings to review incidents and there was no evidence to demonstrate that they carried out a thorough analysis of the significant events. During our inspection we identified a number of incidents that had taken place recently and these had not been recorded as significant events. For example, we were told that an incident had taken place in a branch surgery where a member of the public had suffered a cardiac arrest. Staff successfully resuscitated the individual and they were conveyed to hospital. This had not been recorded and there was no evidence of an analysis of the incident to see if lessons could be learnt.

At the same inspection we were told of another incident when a nurse had discovered the temperatures of medicine fridge at Little Ridge surgery had not been monitored for over 11 days and the nurse told us they had raised this as a significant event. This had not been recorded and no actions had been taken.

We saw a recent record were a patient had been given prescriptions for medicines despite the locum GP being advised that the patient had a history of trying to obtain additional medicines. This resulted in the patient being given double their usual prescription. A hand written note on the record indicated the practice was considering action but had not taken any steps apart from placing an additional alert on the patient's record. This included speaking to the clinician involved however this had not taken place as yet and the incident had taken place ten days before our inspection.

We spoke with the person who manages the records of significant events and complaints. They told us that significant events were discussed with the lead GP but this was dependent on time permitting. They told us they would not necessarily be prioritised as most of their time was taken up dealing with complaints.

Overview of safety systems and process

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not minimise risks to patient safety.

When we examined the emergency medicines at Little Ridge surgery, a branch of Cornwallis Surgery we found medicines that had expired within the box. We also found medicines past their expiry date in a medicine fridge, these included vaccines and immunisations. Some medicines had been contaminated with an unknown liquid leaking inside the fridge. These medicines were identified to the staff to ensure they were isolated from use. We were unable to review a stock record for medicines held at Little Ridge Surgery as staff were unsure of its location.

The security of medicines was unsafe. Whilst at Little Ridge surgery we found medicine foil cards loose on a shelf. The consultation room door was unlocked and ajar and these medicines were easily accessible to patients waiting in the reception area. When we looked at the storage of medicines at Cornwallis surgery we found the medicine cupboards to be locked. However the key to these cupboards was in an unlocked drawer in the same room and this room was unlocked.

Blank prescription forms were not securely stored and there were no systems to monitor their use. We found all consultation rooms at Little Ridge were open and all printers contained prescription forms. We checked two consultation rooms at Cornwallis surgery and these were open and the printers also contained prescription forms.

We reviewed eight personnel files and found that appropriate recruitment checks had not been undertaken prior to employment. For example, proof of identification was unavailable for five of the eight staff records we examined, seven records did not contain evidence of satisfactory conduct in previous employment in the form of references and appropriate checks through the Disclosure and Barring Service (DBS) had not been undertaken for non-clinical staff and there was no risk assessment to support this decision. Two staff had been employed using a

Inadequate

Are services safe?

DBS check from a previous employer and for one of these staff the employer on their DBS was not recorded on their Curriculum Vitae (CV). One of these was not a full enhanced check and this person had unsupervised access to patients. This individual had not been risk assessed in terms of access to children

The person in charge at the time of the inspection provided a detailed recruitment policy. They told us this had been replaced as the responsibility for human resources and recruitment had been transferred to another company. They reported that communication was poor between this individual and the staff and they were unsure if thorough checks were being completed on new staff. We saw correspondence to demonstrate these concerns had been sent to the lead GP.

We spoke with one of two pharmacy technicians employed by the practice. They told us their role was to add medicines to the patients' records from hospital letters and other documents. They monitored repeat prescribing, added medicines to the patient screen and then contacted a GP to issue and sign the prescription. We asked how they monitored medicine alerts and we were shown the practice file for such alerts. Only three of the 12 alerts we asked the staff member about were contained in the practice file and they were not aware of the others. In response the pharmacy technician went online and registered to receive updates and started a spreadsheet to ensure historical medicine safety updates had been acted upon.

Monitoring risks to patients

There were limited arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was no system to ensure enough staff were on duty to meet the needs of patients.

We found only two locum GPs on duty for a practice list in excess of 19000 patients. The person in charge told us that they had no permanent GPs working at that time. The only one (lead) GP was away on extended leave and the staff had been left with instructions to book up to 2.5 whole time equivalent locums to cover during their absence. The staff we spoke with told us they felt unsafe and were concerned for patient safety as they were unable to deliver appointments to patients.

We found no contingency plan for staff shortages had been put in place and patient appointments were regularly cancelled due to staff shortages. This had not been risk assessed to reduce the risks to patients.

A cervical screening programme was in place at the practice. We spoke with a member of staff who undertook these screening procedures. The practice could not demonstrate that they had safeguards in place to follow up on patients who had undergone cervical screening. For example we found the practice did not maintain a record of tests taken and had not checked that results were received from the laboratory for every sample.

Arrangements to deal with emergencies and major incidents

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. However not all medicines we checked were in date. For example the medicine hydrocortisone (a medicine used to treat inflammation) in the emergency medicine box at Little Ridge Surgery was no longer fit for use due to the fact that the date on it had expired. We also found out of date paediatric masks and a nasal oxygen giving set at the same branch.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 1 November 2016, we rated the practice as good for providing effective services. However when we conducted this focused inspection we found areas of concern.

The practice is now rated as inadequate for providing effective services.

Effective staffing

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.

- We reviewed the records of eight staff and there was no evidence of an induction programme for all newly appointed staff. We spoke with a member of staff who told us they had not undertaken any induction or significant training since they started in November 2016. They told us that apart from peer support they felt unsupported in their work.
- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, a member of staff reviewing patients' pathology reports had not received training specific to this role. We saw evidence that the individual had met with a GP at the practice to discuss this role as the staff member kept some hand written notes of the meeting. When we spoke with this member of staff they did not demonstrate a safe level of understanding of this role and there was a risk that patients may not receive timely intervention if abnormal results were returned. Another member of staff had taken on the role of running the navigation clinic. This is a service that triages all calls to the practice requesting an appointment and it is critical that patients are referred correctly. The staff member told us that they did not feel adequately trained to carry out this role. They had a meeting with one senior staff member to discuss the role and were then expected to carry out this task. We checked training records and found that no training programme had been put in place. One member of the clinical team told us that they had not received training in infection control or basic life support since they started at the practice over 18 months ago.
- The learning needs of staff were not identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to some training to meet their learning needs and to cover the scope of their work. This we found did not include ongoing support or one-to-one meetings. Staff we spoke with did not feel supported in their roles. Clinical staff told us that they had no support from the practice lead GP and felt the situation was unsafe. Another clinical staff member told us they often worked as the sole clinician in the practice. They told us they found this difficult at times as if they needed GP support their only avenue was to get this via the messaging system which often crashed.
- The practice did not have an operational appraisal system. Staff told us they had not had an appraisal, one staff member told us they had an appraisal over the phone lasting five minutes and no record was made. The senior staff member confirmed that no appraisals had taken place since the current lead GP started in September 2016.

Coordinating patient care and information sharing

We were told at this inspection that the scanning of correspondence awaiting action took place at Shankill Surgery- a branch of Cornwallis Surgery. We observed patients being told that the surgery had not received this information however we found that the scanning backlog was one month behind with electronic letters and two weeks behind with paper correspondence. In excess of 800 documents awaited coding. Further to this, the coding of non-urgent breast screening reports was four months behind. Staff told us they were concerned that this would affect patient care.

Accurate records were not always maintained to ensure the safe and effective treatment and care of patients. For example;

- We were told that patients at end of life who required a home visit had not received a prompt visit. We were told by staff that the visit requests were made for 29 March 2017 and that these visit requests had been moved to the 31 March 2017 by the lead GP. They told us they believed the lead GP had visited the patients on 31 March 2017 as the locum had refused to go and the lead GP was asked to come back from leave and attend to the home visit requests. We looked at the records of

Inadequate

Are services effective?

(for example, treatment is effective)

three patients and found that home visits had not been recorded in the patient records. This meant that any clinician reviewing the record would be unsure if appropriate care had been provided to these patients.

- We reviewed patient records and found that not all referrals contained an accurate summary of patient symptoms to assist the secondary care clinician in assessing the patient's clinical need. For example one record we saw contained a number of symptoms provided to the GP in consultation. Not all of these had been included in the referral letter and this could mislead the secondary care clinician when reviewing the referral information.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. We observed one patient who was attempting to get an appointment with a GP and they were met with a response that caused the individual some distress as they were told all they could have was a space on a waiting list with no guarantee of an appointment. When we spoke with this individual we were told that they had complex health needs and had made over 100 calls to the practice over the last week and a further 21 calls on the day of the inspection and had not got through on the phone.

At the previous inspection in November 2016 The practice was below average for its satisfaction scores on consultations with GPs and nurses. The practice had taken some steps to make improvements, but had continued to be very reliant on the use of locums. Since our inspection in November 2016 no new patient survey data was available therefore we have not been able to utilise new data to assess the impact of any changes made by the practice.

For example:

- 71% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 76% of patients said the last nurse they spoke to was good at treating them with care and concern compared to compared to the CCG average of 86% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

We spoke to 14 patients across all four surgeries. Three patients we spoke with felt the GP they saw did not meet their expectations. They described the GP as uncaring, dismissive and disinterested. 13 of the patients said that it had been very difficult to access the practice via the telephone system or to get an appointment with a GP.

Results from the same national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were lower than local and national averages. For example:

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 71% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

At the inspection in November 2016 the practice identified reasons for the low satisfaction rate in caring which included:

- A lack of continuity of care due to an over reliance on locum GPs.
- What was now one practice had been working as four separate surgeries in isolation.

As part of their response the practice told us they were employing a new GP partner, due to start in 2017 and more permanent clinical staff (urgent care practitioners) with the intention that one was based at each surgery. They were going to decrease the use of locum GPs.

At this inspection we found a continued over reliance on locum GPs to see patients and an imposed cap on their use meaning that very few appointments were available across all four sites and there was a consequent continued lack of continuity of care for patients. Two of the three urgent care practitioners had left employment and the only permanent GP was on leave for three weeks. The limited measures in place meant patients had fewer opportunities to get a GP appointment.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 1 November 2016, we rated the practice as good for providing responsive services. However the practice could not demonstrate that the changes they had recently introduced had embedded significantly to improve services and more time was required to determine impact.

These arrangements had significantly deteriorated when we undertook a follow up inspection on 18 April 2017. The practice is now rated as inadequate for providing responsive services.

Access to the service

Since the last inspection in November 2016 we had received letters of concern from patients about access to the practice via the telephone and also access to appointments. On the day of the inspection we spoke to 14 patients. The majority of patients (13) found the practice very difficult to access by telephone and had often had to ring many times to get through or turn up to the practice and wait to get an appointment. Patients also felt that there were not enough appointments available and that there was a lack of continuity of care because they saw different locums each time.

At our last inspection on 1 November 2016 we were told that the practice was introducing a system whereby any calls for appointments received after appointments had been filled were passed to a 'non clinical navigator' who was a trained member of administrative staff who allocated them to a GP, urgent care practitioner (UCP) or nurse practitioner depending on their presenting condition and working to a strict written protocol.

At this inspection we found that this had been introduced and was in operation on the day of our inspection. We spoke with the staff member managing this service and they told us that it was ineffective at present as they had few clinicians to refer patients to and very few appointments to offer patients. All staff we spoke with commented on the lack of appointments and felt the current provision was unsafe.

Also at the last inspection we were told of the introduction of an electronic clinic (e-clinic) whereby patients could email in non-urgent requests such as administrative issues for the GPs attention. Documents for collection by patients would be ready by the end of the next working day. This e-clinic as it was referred to by the practice would be overseen by the lead GP.

On 18 April 2017 we found that this 'e-clinic' was not in operation. The lead GP was on holiday and no provision had been made in advance of his leave to put an alternative in place. We saw evidence of staff chasing the lead GP for a response on the status of the 'e-clinic' while he was away. The lead GP also held two evening results clinics each week to discuss results with patients. These were not taking place during his absence.

We observed a number of patients attending the practice to chase changes to their medicine prescriptions following secondary care appointments. We were told by patients that letters had gone missing or fit to work certificates had not been provided when requested. The commission has received complaints of a similar nature prior to the inspection.

A locum GP told us that they had been booked by the practice at short notice to clear a backlog of prescriptions in the practice. Staff told us that they had to go around the branches to find a GP to sign prescriptions due to the lack of GPs.

Listening and learning from concerns and complaints

We reviewed the complaints system with the member of staff responsible for managing complaints and significant events. We noted that the practice had received 108 written complaints of which 43 were about access to the practice via the telephones, 38 about the lack of appointments and 25 about prescription issues. We were also informed of 71 verbal complaints of which 28 were about access to the practice via the telephones, 33 about lack of appointments and 11 about late or missing prescriptions. The complaints co-ordinator kept a detailed log of complaints and the actions taken. We were told that they met with the lead GP fortnightly to discuss complaints however these were not discussed with the wider team and there were no meetings to share information, identify themes or learn from outcomes. For example we saw a complaint from a patient in relation to delays in treatment and prescriptions. We saw evidence of discussion with the clinicians involved in the care of the individual, a response and an apology. We also

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

noted advice from the practice insurers to hold a review meeting to identify action and learning. This was included in the response letter to the patient, however no such meeting had taken place.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 1 November 2016, we rated the practice as requires improvement for providing well-led services as the arrangements for assessing, monitoring and mitigating risks relating to the health safety and welfare of service users needed improving.

We issued a requirement notice in respect of these issues and found the arrangements had significantly deteriorated when we undertook a follow up inspection on 18 April 2017. The practice is now rated as inadequate for providing well-led services.

Governance arrangements

At our last inspection on 1 November 2016 we found the new GP had introduced several innovations to maximise the efficient use of GP time. However this meant that the leas GP was working the hours of more than two and a half full time GPs, starting at 8am and working to 8pm or 9pm on Monday to Thursday (6.30 pm on a Friday) and the arrangements involved them driving between three or four surgeries each day holding surgeries and supporting staff at each. They told us that this was a situation that they had planned for and were going to continue for a total of six months whilst the changes became embedded and until a new GP partner arrived to share the workload.

We required the practice to send us a report on the actions they would take to ensure they had a risk assessment and sustainable written contingency plan in place to ensure the safe and effective provision of services and meet the needs of the patient population should the clinical lead GP or other key staff be unavailable to do so. We had made a number of requests for this to be sent to the commission and to date this has not been received.

At our inspection on 18 April 2017 we found that a contingency plan had not been put in place. We were informed prior to our inspection as part of a letter of concerns that the lead GP was away on leave for three weeks. Staff told us that no plan had been put in place except for an instruction to cover the practice with a maximum of two and a half whole time equivalent locum GPs.

Whilst we were told at the last inspection that the lead GP did not anticipate taking any holidays during this time we found that this current absence was the third holiday the GP had taken since our last inspection. Staff told us that this has resulted in patient appointments being cancelled and a lack of support for staff.

We found that the provider had not assessed and mitigated risk. This included the use of untrained and unsupported staff to carry out roles in the delivery of care and treatment of patients. Staff were employed without an appropriate risk assessment or DBS check The risks associated with low staffing levels and the inability to deliver sufficient appointments to patients had not been addressed.

Leadership and culture

On the day of inspection the provider did not demonstrate they had capacity and capability to run the practice and ensure high quality care. There was no evidence to demonstrate they prioritised safe, high quality and compassionate care. Staff told us the lead GP was not approachable and staff felt that they were not listened to.

There was a leadership structure and we were given a copy of the organisational flow chart. However the staff told us that this was not accurate. The lead GP had engaged the services of another company to manage human resources and finances of the practice. Staff were concerned about the lack of information and the current financial situation in the practice. They told us that bills had not been paid including locum staff fees, staff pension contributions and some of the utility bills were only paid at the last minute. Staff felt unsupported by the lead GP.

Staff told us the practice did not hold regular team meetings. We were told that the last meeting was held at the introduction of the new working arrangements in October 2016. Staff told us there was not an open culture within the practice and they did not have the opportunity to raise any issues at team meetings

Staff said they felt under-valued and unsupported, particularly by the partners in the practice. There were no systems to involve staff in discussions about how to run and develop the practice.