Horsefair Surgery

Inspection report

Horsefair Surgery
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Date of inspection visit: 5 July 2018
Date of publication: 22/08/2018

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 location	Requires improvement 
Are services safe?	
Are services well-led?	

Overall summary

This practice was previously inspected on 3 May 2018 and CQC issued a rating of requires improvement. We rated each domain as follows:

Safe: Requires improvement

Effective: Requires improvement

Caring: Good

Responsive: Requires improvement

Well-led: Inadequate

We took enforcement action against the provider.

We carried out an announced focussed follow up inspection at Horsefair Surgery on 5 July 2018. We undertook this inspection to identify whether improvements had been made in regards to the warning notice we issued in May 2018.

At this inspection we found:

Some improvements had been made to specific areas highlighted at the previous inspection. However, we identified broader concerns of inaccurate recording and monitoring of patient care which posed risks to patients.

For example:

- Coding used to identify what care patients had received and to monitor performance in national data submissions showed consistent inaccuracies in the areas of patient care we reviewed.
- We found patients on mental health registers had not received care in line with national guidance.
- Governance processes were not identifying the extent of risks to patients or omissions in care tasks.
- The system for monitoring patients on high risk medicines ensured reviews of patients on these medicines took place in. However, we found examples where medicine reviews were undertaken by staff who were not qualified to do so and where action was completed following a blood test.

We also found positive outcomes regarding patient care.

- We found examples of appropriate care and responses to vulnerable patients' needs, including those on the child at risk register and patients with learning disabilities.

The areas where the provider **must** make improvements are:

- Implement appropriate systems to assess, monitor and improve the quality and safety of the services provided and assess and mitigate risks related to the health, safety and welfare of patients.
- Ensure that accurate records of patient care are maintained.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Our inspection team

The inspection team included a lead inspector, a second inspector and a national GP CQC clinical adviser.

Background to Horsefair Surgery

The practice provides services from Horsefair Surgery, Banbury, Oxfordshire, OX16 9AD.

Horsefair Surgery has a modern purpose built location with good accessibility to all its consultation rooms. The practice serves 16,000 patients from the surrounding town and villages. Demographic data shows 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 is prevalent. There are patients from minority ethnic backgrounds, but this is a small proportion of the practice population.

There are three GP partners, based predominantly at other GP practices. The practice had recruited new GPs and nursing staff over recent months. There is a mixture of male and female GPs working at the practice. The schedule for staffing includes three to four GPs and three advanced nurse practitioners (ANPs) providing care Monday to Friday. These roles are supported by practice nurses and health care assistants. One emergency care practitioner (ECP) provides home visiting services and led on care for patients at two local care homes. 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 extended hours appointments available via a local primary care hub for acute care issues, but the practice does not provide extended hours services in-house for ongoing care needs. 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 a registered manager in post at the practice. 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.

Are services safe?

At our previous inspection in May 2018 we identified risks with the recording of patient care including palliative care planning and monitoring of high risk medicines prescribed to patients.

During this inspection we found some improvements to the record keeping regarding patient care. However, the process for updating palliative care plans was still in progress.

Safety systems and processes

Reports and learning from safeguarding incidents were available to staff. We looked at the child at risk register and saw that relevant information was recorded and updated when required. We saw these patients were reviewed by appropriate staff whenever a concern was raised. The clinical director informed us information was shared with safeguarding teams and local committees / hubs when required.

Staff had the information they needed to deliver safe care and treatment to patients.

The care records we saw showed that information needed to deliver safe care and treatment was

regularly inaccurate and did not enable effective monitoring and presentation of the care received.

- We found that patients on the dementia and mental health registers did not have reviews of their conditions to ensure their care, including medication, was effective and safe.
- There was consistent inaccurate recording of such reviews being completed when there was no evidence that they had taken place. This inhibited monitoring of which patients had received health checks related to their conditions.
- We saw from the clinical system that 100% patients listed as on the palliative care register had a care plan in place. However, there was data missing from the care plans we reviewed which potentially posed a risk that patients would not have their wishes or preferences considered in the delivery of their care.
- We reviewed the templates used to undertake health checks on patients with learning disabilities. We saw these followed local guidelines and national guidance regarding health checks for this group of patients.

The practice had reliable systems for appropriate and safe handling of medicines.

- The recording of patient reviews regarding the safe and effective use of prescribing, specifically high risk medicines, showed appropriate monitoring systems were in place.
- However, there were instances where not all tasks related to medicine reviews were undertaken.
- Reviews of palliative patients' care needs and updates to their care plans were undertaken by an emergency care practitioner (ECP). It was unclear how the practice ensured that patients on various medications received reviews of their prescribing, as the ECP was not a prescriber.

Are services well-led?

At our previous inspection in May 2018 we identified risks related to the governance and monitoring of patient care, specifically in relation to the accuracy of patient records and related data.

At this inspection we found areas where risks to patients were apparent due to a lack of appropriate governance processes and a lack of accurate data on the patient record system.

Governance arrangements

Governance processes were not adequate to enable the effective monitoring of patient care.

- The patient record system contained consistent inaccuracies in the recording of patient health checks and reviews of their medicines, related to specific conditions in two distinct areas of patient care.
- We found a lack of information was provided in many care plans we reviewed, although there had been improvements since our previous inspections to the identification of palliative care plans requiring data and the monitoring of patients on high risk medicines.
- These data concerns meant that the practice was not able to accurately monitor the quality of care provided to patients on the specific care registers we reviewed.
- The monitoring processes for patients on high risk medicines had improved since May 2018 and we found patients were receiving reviews of their medicines.

Managing risks, issues and performance

Risks related to clinical care were not always identified, assessed and mitigated.

- The quality of information and monitoring of patient care had been identified as a risk in previous CQC inspections, including December 2017 and May 2018.
- At this inspection we identified further risks in areas of clinical care related to the quality of data and the monitoring systems which would identify risks to patient care and enable action to rectify such risks. This included patients being coded as receiving care which had not taken place in all 20 cases of patient records we reviewed for those with mental health conditions including dementia.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating systems and processes effectively to assess, monitor and improve the quality and safety of the services provided. The provider did not maintain accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided. Regulation 17(1)We have proposed imposing conditions on the provider's registration as a result of our findings.