Kirkby Community Primary Care Centre

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 responsive to people's needs?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced focused inspection at Kirkby Community Primary Care Centre on 30 September 2015. The inspection was to follow up warning notices we issued after an inspection on 13 May 2015 from which overall services provided at the practice were rated inadequate and the location was placed into special measures.

We found the provider to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulations breached were:

Regulation 12: Safe care and treatment

Regulation 17: Good governance

As this was a follow up inspection we looked at the areas we identified in the warning notice which were about safe care and treatment to see if the improvements had been made. During the inspection we saw other areas of serious concern.

Our key findings were as follows:

- The provider had made improvements to the calibration and safety testing of equipment.
- Care plans for patients who were at risk of unplanned admission to hospital had been implemented.
- A new system of recording incidents, near misses and concerns had been implemented although it was too early to assess the effectiveness.
- We saw patients had not received essential medicines they needed to treat their condition.
- Children had been put at risk of unsafe care due to the provider's poor and increasingly worsening performance in administering childhood vaccinations.
- A number of patients had received medicines without any monitoring of their health or in line with their treatment plan.
- The poor governance of record management and lack of oversight for safeguarding children could put them at increased risk of harm.
- There were historic and widespread errors with the accuracy of clinically coding health records which had led to missed opportunities for health screening and safe treatment of patients.

In relation to all of the areas of concern identified, the provider (Central Nottinghamshire Clinical Services) and NHS commissioning organisations were informed to ensure any of the risks identified during our inspection were investigated. We also informed the local authority safeguarding team of our findings.

Summary of findings

Following our inspection, due to the serious concerns identified we urgently varied the conditions of provider's registration with the Care Quality Commission (CQC) and stopped the provider providing GP services at Kirkby Community Primary Care Centre on 2 October 2015.

If the provider was still able to provide GP services at Kirkby Community Primary Care Centre we would have told them they must have made the following improvements:

- The process for providing care and treatment to patients must be carried out in a safe way and to nationally recognised standards.
- Review care records and assess the risks to the health and safety of patients who use the practice.
- Ensure that any incidents that affect, or have affected, the safe care and treatment are recorded, investigated and learnt from.
- Where incidents that have caused harm are identified. Those affected must be told in line with duty of candour.
- Ensure the prescribing, and oversight, of medicines is safe and effective.
- Ensure that medicines are stored in line with manufacturer's instructions.

As part of our action we liaised with NHS England and NHS Mansfield and Ashfield Clinical Commissioning Group. This ensured that patients had continued access to GP services.

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

During our follow up inspection we saw that services at the practice had not been provided in a safe way.

The management of medicines was inadequate. We saw examples of medicines that had been prescribed with little oversight or review and a lack clinical monitoring of patients who took medicines. We could not be assured that all medicines at the premises had been stored in line with manufacturers' guidelines, as the room containing them did not have regular temperature checks performed. Records detailing historic safeguarding information about patients (including children) no longer registered at the practice were still on site. There had been a historic lack of oversight of safeguarding children and vulnerable adults, although there had been some recent improvements in this area. The provider did not produce a copy of their business continuity plan for the practice despite us asking for this.

There had been some improvements since our inspection in May 2015 and these related to the areas of;

- Significant event recording and investigation
- The testing of equipment for accuracy and safety.

Are services effective?

Inadequate

During our follow up inspection we saw that services at the practice had not been provided in an effective way.

We saw care and treatment records that reflected poor and inadequate assessment of patients. For example;

- Medicines recommended by a hospital doctor had not been fully prescribed for a patient and the reason why they had not been started was not recorded.
- An addiction substitute medicine had been prescribed for six months on a weekly basis with no review of care or treatment. This medicine had been stopped by a GP on the day of our inspection with no recorded explanation.

We reviewed seven care records and saw that in three clinical coding was inept and had directly led to missed opportunities for some patients to receive a review of their condition or health screening. Audits had commenced for patients diagnosed with diabetes, atrial fibrillation and osteoporosis, although they all hadn't been completed. The initial results from the audit of patients diagnosed with atrial fibrillation showed that 58 patients required to be

Summary of findings

reviewed by a GP to establish if they were receiving the correct medicines. This provider was aware of this concern in October 2014, although the audit to take action and correct the situation had only been started in August 2015.

Children had been put at risk of unsafe care due to the provider's poor and increasingly worsening performance in administering childhood vaccinations.

Are services responsive to people's needs?

Inadequate

At our previous inspection in May 2015 we saw the number of patients that attended a local accident and emergency department and local walk in centre was higher than the local average. We told the provider they must investigate and improve their poor performance. We reviewed the most up to date information available from the clinical commissioning group (CCG) and saw that the provider performance in these areas had deteriorated further and improvements were not sufficient. For example;

- The number of patients that attended a local walk in centre was 95% higher than the local average in February 2015. As of July 2015 it was 117% higher than the local average.
- The number of patients that attended a local A&E unit was 24% higher than the local average in February 2015. As of July 2015 it was 22.5% higher than the local average.

The provider had written plans on how to investigate the poor performance. However, these had not transposed into measurable action.

The way that complaints were handled in the practice had improved from our previous inspection. However, some improvements still needed to be made.

Kirkby Community Primary Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

two Care Quality Commission (CQC) inspectors and a GP specialist advisor.

Background to Kirkby Community Primary Care Centre

Kirkby Community Primary Care Centre (KCPCC) is situated in the premises of the Ashfield Health Village. The practice is all on a single level and occupies a converted former ward area. There are 10 consulting and treatment rooms. There are approximately 5,700 patients of all ages registered at the practice.

The practice first opened in 2008 as a new facility for patients in the area.

The practice was operated by Central Nottinghamshire Clinical Services (CNCS) under an Alternative Medical Provider Services contract with NHS England. The practice is also contracted to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site.

In our previous inspection in May 2015, the practice was rated as inadequate overall, and we told CNCS that services must improve.

On 30 September 2015 we carried out an unannounced inspection at the practice. During this inspection we saw numerous instances of poor and unsafe patient care also governance issues that placed patients at risk of harm. We took urgent and immediate enforcement action and removed KCPCC from CNCSs registration with CQC.

Why we carried out this inspection

This unannounced focused inspection was carried out under Section 60 of the Health and Social Care Act 2008 in follow up from previous comprehensive inspection at Kirkby Community Primary Care Centre (KCPCC) in May 2015. At our previous inspection we identified breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008. We took enforcement action against CNCS by issuing two warning notices to tell them that services must be improved.

This inspection was to ensure that the provider had met the requirements and timescales of two warning notices issued to them under the Health and Social Care Act 2008.

How we carried out this inspection

We carried out an unannounced inspection on 30 September 2015. During our inspection we spoke with two GPs and the interim manager, three senior members of staff and two members of administrative staff. We reviewed care

Detailed findings

and treatment records and other supporting information. We did this to establish how people were being cared for and to check that improvements had been made following our previous inspection.

Inadequate

Are services safe?

Our findings

Safe track record

In our previous inspection in May 2015, we identified that the provider was not recording, investigating and learning from significant events sufficiently. A new process was introduced in August 2015. The new significant event process involved all significant events recorded being rated for seriousness on site and investigated. The formal written policy was not yet in place, although we were told that it mirrored guidance for the National Patient Safety Agency. We saw since August 2015 three significant events had been reported. We reviewed records of investigations that had been completed and action taken to mitigate the risk. For example, the action that was taken following a problem with temperatures with refrigerated vaccines. The interim manager had followed national guidance and taken appropriate steps to ensure the vaccines affected were destroyed.

The staff we spoke with knew the process for recording significant events and one recalled a recent event they had reported. Learning from significant events was planned, although not yet implemented.

Reliable safety systems and processes including safeguarding

In our previous inspection we identified that there was no lead person for safeguarding and no evidence of oversight of safeguarding children and vulnerable adults. We told the provider this must improve. The interim manager told us they had reviewed the system in place for safeguarding at the practice and showed us the examples of improvements they made;

- All children identified at increased risk of harm had their care records reviewed. Alerts had not been placed on some parents' records linking them their own children who had been identified as being at increased risk of harm. If a parent of a child at increased risk of harm consulted a GP with symptoms, illnesses or conditions that may affect their behaviour, the GP would not have had oversight of the any link to the child. This could have put children at increased risk of avoidable harm. The interim manager had corrected this by linking family members with the safeguarding information.
- The interim manager had identified 69 records of safeguarding information about children at increased risk of harm that were no longer registered at the practice. This information had not been forwarded to their new GP practices and the practice were not aware whether there was a risk associated with holding these records. A representative from the clinical commissioning group (CCG) reviewed the records after our inspection and stated that there was no risk to patients.

Following our inspection we shared these findings with the local safeguarding team.

A GP had reviewed the records of any identified safeguarding issues and taken action as necessary. Where errors had been identified with coding, these had been corrected by the interim manager.

Medicines management

During our inspection, we checked to ensure the provider was providing care to nationally recognised standards. We saw that the overall management and oversight in the way that patients received medicines was unsafe and placed them at risk of harm.

We reviewed patient records and saw examples of inadequate and unsafe medicines management. For example,

- Medicines recommended for a patient by a hospital doctor had not been fully prescribed and any reason why they had not been started was not recorded.
- An addiction substitute medicine had been prescribed for six months on a weekly basis with no review of the patients' care or treatment. Prescribing an addiction substitute medicine in this manner is not safe, due to the lack of supervision of the patient's condition and lack of plan of reducing the dose in the longer term.
- A patient who took a medicine that required blood tests at least bi-monthly, to check the medicine was not harming them, had not had the blood tests for nine months. This was despite a GP medicines review during this period which did not spot or correct the error.
- A hospital letter had not been acted upon resulting in a patient not being assessed for suitability for take a medicine to prevent blood clots. The letter had been received within the practice three months previously.

At our previous inspection we identified that the provider had not consistently recorded the temperature of the room

Inadequate

Are services safe?

in which medicines were stored. The provider had not taken action to implement a robust system and medicines were still stored in an unsafe way, with no temperature checks taking place.

Equipment

At our last inspection we saw examples of equipment that had not been tested for electrical safety or its accuracy. We told the provider they must improve this. Since the previous inspection an inventory of equipment had been produced and equipment had been tested for electrical safety or accuracy as required. We checked items of medical equipment such as weighing scales and blood pressure monitoring devices and saw that they had been calibrated and checked for electrical safety.

Arrangements to deal with emergencies and major incidents

During our inspection and due to our concern about the services under this provider we requested a copy of their business continuity plan. This was to establish the arrangements in place for unplanned events such as urgent relocation from the building or loss of power. Despite our requests during the inspection a copy of the business continuity plan could not be located on site. A senior member of staff from the provider organisation told us they would send a copy to us the next working day, the documentation did not arrive.

At the last inspection we saw that the automated external defibrillator (AED) did not have 'in date' pads to use in an emergency. (An AED provides an electric shock to stabilise a life threatening heart rhythm). We checked and saw that the AED pads were in date. A check sheet for emergency equipment had been implemented since August 2015. Weekly records had been completed although the documents did not detail the items of equipment that should be checked and who had checked it.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

Following our previous inspection we told the provider that they must provide care and assessment to nationally recognised standards. We did this as their performance in reviewing patients was below local and national levels. During this inspection we saw there had been serious issues with the coding of clinical records which led to patients not receiving the appropriate monitoring, care and treatment they needed. We were provided with over 70 examples where clinical coding had been historically incorrectly applied to care records. The range of examples spanned from 2010 to records coded in recent months. The interim manager told us they were working to assess the impact of the coding errors. Despite the potential risks relating to this the Care Quality Commission hadn't been notified. For example;

- A blood test result had been reviewed by a GP and marked as being normal. The result was not normal and required further investigation and assessment of the significance of the result. There was no recorded action taken in response to the abnormal blood result and no follow up tests or investigation had been arranged. This result could have indicated that the patient's condition had deteriorated or been a sign of another serious condition. Not following up on this result could have had serious consequences for the patient.
- A patient with a long-term condition, who could not attend the practice in person, had not received a review of their condition for three years.
- A patient who experienced severe poor mental health had received a diagnosis in 2010, although had never been asked to attend the practice for a review of their condition. Not monitoring the symptoms and general wellbeing associated with this diagnosis could have resulted in serious harm for the patient.
- Patients diagnosed with diabetes did not have recall appointments set to receive regular blood tests to establish how their condition was controlled. This placed them at high risk of developing serious complications associated with their condition.
- At least 15 patients with a learning disability had not been included in the practice register for learning disabilities. This had resulted in some patients not receiving an annual health assessment. Errors ranged for recent diagnosis to one instance of health checks being missed since 2011. The purpose of the annual health checks is to detect emerging health problems that are more common in this patient group. For example, thyroid, visual and hearing disorders.
- Hospital letters and the results from scans in August 2015 had not been reviewed or scanned onto care records until September 2015. This could result in lack of prompt action or no action being taken when it needed to be.

The rate of performance for providing immunisations to children registered at the practice had deteriorated significantly and had placed children at increased risk of acquiring vaccine preventable illnesses. For example, the most recent published data from the CCG showed:

- In the period October-December 2014 the provider performance for providing the pneumococcal vaccine booster (PCV) to children aged two (to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis) was 78.6%. This was lower than the clinical commissioning group average of 95.5%.
- In the period April-June 2015 the provider performance for providing the PCV booster was71.9%. This was significantly lower than the clinical commissioning group average of 94.2%.
- In six childhood vaccination indicators, the provider performance was lower than the local average in all six. The range of performance was from 3.1% to 21.3% lower.

An audit of patients who were diagnosed with atrial fibrillation (irregular heart rhythm) had been undertaken. This had been in response to evidence we saw at our previous inspection that showed patients may not be receiving the best medicine for their condition. The initial results from the audit of patients diagnosed with atrial fibrillation showed that 58 patients required to be reviewed by a GP to establish if they were receiving the correct medicines. This area of concern had first been raised in October 2014 following an audit within the practice. However, the action needed to correct the situation had only been started in August 2015. At the time of inspection a GP and pharmacist were in the process of recalling and reviewing the patients involved.

Inadequate

Are services effective?

(for example, treatment is effective)

Further audits had been started to establish the effectiveness of treatment in patients diagnosed with diabetes and osteoporosis.

We saw that patients' felt their care and treatment was not effective. We saw that in 10 complaints raised in a six week period, eight were in relation to clinical areas. These included a referral to hospital not being made, two prescription errors, three patients that had not received follow up for their condition and two patients who felt their concerns were not listened to during a consultation.

At our previous inspection we identified that the provider, had not implemented care plans for patients identified at high risk of unplanned admission to hospital. The provider had received additional funding to provide this service for patients, many of which were vulnerable. We checked and saw care plans had now been implemented for patients in this group. The implementation of care plans had identified that some patients were overdue for blood tests and these had been arranged.

We did see some evidence of performance improvement. For example;

- The review of patients with a new diagnosis of cancer had improved from 25% in May 2015 to 90.4% in September 2015.
- The review of patients who experienced poor mental health had improved from 23% in May 2015 to 56.8% in September 2015.
- The review of patients with depression had increased from 2.8% in May 2015 to 86.7% in September 2015.
- Four patients with osteoporosis who had experienced a fragility fracture had been identified and included in the practice register. There had previously been no patients included on the register.

Effective staffing

The provider had continued to operate services at the practice during 2015 with inadequate clinical leadership. The practice had operated with a very high number of temporary GPs with no identified clinical leadership on site. Due to the widespread errors with coding of clinical records, temporary GPs had not had robust oversight of patients' medical conditions. At the time of our inspection in May 2015, interim arrangements had been put in place to provide clinical leadership with a regular GP to perform clinical oversight of recall and monitoring of patients. This arrangement did not last and it was not until August 2015 that an interim team had been placed within the practice by the provider on a part time basis. The long standing arrangement of clinical staffing by the provider had not been subject to oversight and had led to the provision of unsafe care.

The safe care and treatment of children had been put at risk by the lack of provision of suitably trained staff to administer vaccines and poor governance of performance in the provision of the vaccination programme. This was measured by rates of vaccinations for children being under the local and national average for one year. The exception to this was vaccinations for children at 1 year old had been in line with local averages from July 2014 to March 2015. The performance in this area had fallen to 3.1% below the local average in the period April 2015 to June 2015.

At our previous inspection we spoke with staff who told us they had not been supported or received regular appraisals. At this inspection we saw records that showed appraisals had been carried out for all staff. We spoke with two members of administrative staff who told us that they felt a much high level of support since the interim manager had been in post. They also told us that learning opportunities were planned for face to face learning; at the time of the inspection they had not been implemented.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

At our previous inspection we saw that the number of patients that attended local accident and emergency and local walk in centre was higher than the local average. We told the provider Central Nottinghamshire Clinical Services (CNCS) they must investigate and improve their poor performance.

We reviewed information provided by the clinical commissioning group (CCG) and saw that the provider's performance was worse or that there had been no significant improvement since May 2015. For example; the CCG data showed;

- The number of patients that attended a local walk in centre in February 2015 was 95% higher than the local average. As of July 2015, this performance had deteriorated to 117% higher than the local average.
- The number of patients that attended a local A&E unit in February 2015 was 24% higher than the local average. As of July 2015 it was relatively unchanged at 22.5% higher than the local average.
- The number of patients referred for a first contact outpatient appointment in February 2015 was 22% higher than local average. As of July 2015 it was 25.4% higher than the local average.

We spoke with the interim manager about this; no action had been taken since the last inspection to understand the reasons and to take action to improve this. An audit had been planned to evaluate the high level of A&E and walk in centre attendances although this had not yet been started.

Listening and learning from concerns and complaints

At our inspection we saw that complaints had not been recorded, investigated and responded to, adequately or, at all. The interim manager showed us the new system for complaints that had been in place since August 2015. The practice was now recording all complaints, including those made verbally. The staff we spoke with knew the new procedure in place. The interim manager had responded to complaints in a short timeframe, normally on the same day. Contact had been made by telephone and details of the conversation had been written. Some areas of the system were not robust;

- There was no written new policy for staff or patients to refer to.
- Written complaints had been acknowledged verbally, however they had not been responded to in writing.
- When this had been appropriate, patients had not received written confirmation on the nature of investigation and when they would receive a response to their complaint.