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?	Inadequate
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 unannounced focused inspection in response to concerns at Cornwallis Surgery on 7 September 2017, raised directly with CQC relating to patient access to and the quality of treatment, the management of prescriptions and delays in plans to transfer services to a new provider. We then conducted this inspection as a comprehensive inspection due to the findings of our focused visit and returned for a second unannounced visit on 11 September 2017.

During this inspection we identified risk of harm to patients due to insufficient staffing numbers and lack of effective governance processes and systems to identify, assess and monitor risk. This was a breach of legal requirement and the practice was rated inadequate providing safe, effective, caring, responsive and well-led services and overall. As a result of this inspection the Care Quality Commission has imposed urgent conditions on the registration of the service provider under Section 31 of the Health and Social Care Act 2008, in respect of all regulated activities for which they are registered. The urgent action was taken as we believe that a patient will or may be exposed to the risk of harm if we did not do so.

Our key findings across all the areas we inspected on 7 and 11 September 2017 were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, the practice had not carried out appropriate recruitment checks on locum GPs.
- Medicines and associated equipment were not always in date or stored securely and nursing staff tasked with monitoring did not have the time or capacity to do this. Blank prescriptions were not always stored securely.
- The practice had systems in place for collecting and collating significant events and complaints and there was a culture of reporting incidents within the practice.
- Staff reported incidents, near misses and concerns within the practice but there was no evidence of

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learning and communication with staff. Clinical incidents did not have the appropriate level of clinical input and staff were unsure about notifiable incidences and where the duty of candour applied.
- Medicines reviews were not consistently taking place and patients were at risk because of this.
- There were inconsistent reviews of high risk medicines and action to address risks were not always in line with national guidance. There was no system in place to deal with safety alerts.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was poor management of long term conditions, with patients not consistently receiving regular reviews. Performance relating to the Quality Outcomes Framework (QOF) had deteriorated since the most recent published data due to a lack of leadership and oversight.
- There were poor systems in place to keep clinical staff up to date and locum and nursing staff did not have dedicated time for clinical meetings or to complete training. GP locums had received inconsistent inductions and there was no evidence of clinical supervision.
- Patients reported there was poor continuity of care and we saw that this had a detrimental impact on the quality of patient treatment and care.
- The national GP patient survey results had further deteriorated in some areas of GP consultations since the previous inspection in April 2017.
- We observed staff to be caring and compassionate in their interactions with patients.
- Appointment systems were not working well so patients did not receive timely care when they needed it, particularly in relation to GP home visits. Patients continued to report some concerns about access to GP appointments and getting through to the practice by phone.
- Complaints were recorded and generally responded to although there was a lack of leadership, clinical oversight, investigation and learning. Action was not always taken to improve the quality of care as a result.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Risks within the practice were not effectively managed and risk assessments were either unavailable or insufficient. Staff responsible for the management of risks and health and safety were not aware of the scope of these responsibilities.
- Systems relating to the requirements of the Duty of Candour were informal. Staff responsible for recording and reporting safety incidents were unaware of the requirements.
- Policies and procedures were not always accessible, clear or up to date.
- There was a good deal of uncertainty amongst staff due to unclear changes in relation to the registered provider and a subsequent impact on the staffing structure within the practice.

As a result of these findings we sent a Letter of Intent notifying the provider (Dr David Huw Jones) of our concerns and that we were considering taking action using our urgent powers to impose conditions. Ten conditions were then imposed on the provider's registration on 18 September 2017.

The provider negotiated a termination of contract with Hastings and Rother clinical commissioning group for 31 October 2017 and is in the process of cancelling their CQC registration.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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 and improvements must be made.

- Although the practice lead for significant events carried out investigations when there were unintended or unexpected safety incidents there was limited clinical input into these. Lessons learned were not always identified or communicated so safety was not improved. There was limited evidence that patients received reasonable support or a verbal and written apology and staff were unsure about notifiable incidences and where the duty of candour applied.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe.
- There were insufficient processes to ensure the proper and safe management of medicines and prescriptions.
- Appropriate checks of GP locums were not sufficiently recorded or updated.
- There was insufficient attention to safeguarding children and vulnerable adults. Staff were unsure who the lead for safeguarding was.
- There were not enough staff to keep patients safe. The practice was reliant on locum GPs and there was limited nursing time for additional monitoring roles. Poor management and supervision of locum staff increased the risk of harm to people who used the service.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Data showed that patient outcomes were below average in some areas. The patient recall system for those with long term conditions was inadequate and not all patients had received regular reviews.
- There was no evidence of the use of clinical audit to drive improvement in patient outcomes.
- The practice did not have systems in place to keep clinical staff up to date.
- There was some formal engagement with other providers of health and social care although clinical staff we spoke with told us they did not regularly attend these meetings.

Summary of findings

- There was limited recognition of the benefit of an appraisal process for staff and little support for any extra training that might be required.
- There was no system of clinical supervision in place for nurses working in advanced roles such as prescribing or diagnosis of acute illness. Locum GPs received limited formal supervision and had not received an induction.
- The practice could not demonstrate a system for ensuring role-specific training updates, for example, for nurses reviewing patients with long term conditions.
- Although we were told that clinical meetings were taking place within the practice locum staff with responsibility for clinical care did not have dedicated time to attend and staff had limited time to proactively manage effective care and treatment.

Are services caring?

Inadequate

The practice is rated as inadequate for providing caring services and improvements must be made.

- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care. For example we saw that satisfaction with some aspects of GP consultations had deteriorated since the April 2017 inspection, specifically in relation to patient's confidence and trust in the GPs.
- We observed staff treating patients with care and compassion.
- Feedback from patients was that they didn't always feel that they were given the time they needed during consultations and that their care lacked consistency.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services and improvements must be made.

- Patients reported considerable difficulty in accessing a named GP and poor continuity of care.
- Patients continued to experience difficulty getting through to the practice by phone.
- Appointment systems were not working well so patients did not receive timely care when they needed it. In particular there were limited GP home visit appointments and this had resulted in increased risks for patients at home and those in care homes.

Summary of findings

- There was a designated person responsible for handling complaints although there was no leadership or clinical input to progress concerns and complaints from patients. Complaints were not always fully investigated or addressed and lessons were not learned and used to drive improvements.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice did not have a clear vision and strategy. Staff were not always clear about their responsibilities.
- Staff told us that governance responsibility lay with the registered provider who was not based at the practice and there was a lack of clarity around the leadership structure. Staff did not always feel supported by senior management.
- The practice had a number of policies and procedures to govern activity, but these were not always easily accessible and often contained outdated or unclear information.
- There was no effective system for identifying, capturing and managing issues and risks.
- There was a culture of reporting incidents and concerns within the practice.
- The practice did not hold regular governance meetings where issues could be discussed.
- The practice had not proactively sought feedback from staff or patients and did not have a patient participation group.
- Staff told us they had not received regular performance reviews and did not have clear objectives.
- The specific training needs of staff were not consistently addressed and there was a lack of support and mentorship for those appointed to extended roles.
- Patient records were not always stored securely.

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

Inadequate

The practice is rated as inadequate for the care of older people.

- The practice could not demonstrate that all staff had completed training in safeguarding adults.
- The safety of care for older patients was not a priority and there were limited attempts at measuring safe practice.
- The practice provided support to local care homes but there had been issues with telephone access, GP visits and prescription management.
- The care of older patients was not managed in a holistic way as locum GPs did not attend multi-disciplinary meetings where patient care was discussed.
- Home visits were available with a nurse practitioner for patients who were house bound, however GP home visit appointments were limited and not always responsive to need.
- The leadership of the practice had little understanding of the needs of older patients and were not attempting to improve the service for them**.** Services for older patients were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long-term conditions.

- Performance for diabetes related indicators at 92% was similar to the CCG (94%) and national (93%) averages. Unpublished data from the practice showed that current indicators were at 85%.
- Exception reporting (where patients with long term conditions are removed from QOF outcome calculations) was higher than average.
- Longer appointments and home visits were not always available when patients needed them.
- Patients did not have a named GP although we did see some evidence of personalised care planning for this group.
- Structured annual reviews were not always undertaken to check that patients' health and care needs were being met.
- Reviews and routine tests for patients with long term conditions were not consistently being carried out.

Summary of findings

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people.

- Staff did not know who the safeguarding lead within the practice was and policy information relating to this was confusing.
- Immunisation uptake rates were also relatively low for a number of the standard childhood immunisations. For example; all areas of childhood immunisations for under two year old were highlighted as negative variations in CQC data as the practice had failed to reach the 90% standard for achievement.
- The premises were suitable for this population group.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired and students).

- The percentage of respondents to the GP patient survey who were satisfied with the practice's opening hours was highlighted as a negative variation in CQC data. 55% of respondents said they were satisfied compared with CCG average of 77% and the national average of 76%.
- There were no early or extended opening hours for patients who worked or students.
- There was a lower than average uptake for health screening.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

- There was little evidence of the practice working with multi-disciplinary teams in the case management of vulnerable patients.
- Not all patients identified on the learning disability register had received annual reviews. Of five patient records we reviewed we identified two patients who had never received a learning disability check and two others who had not received regular annual reviews or appropriate follow up.
- Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not clear about who the safeguarding lead was or who to go to in case of concerns.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate 

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

- Published data showed the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 74%. This was below the CCG average of 86% and the national average of 89%.
- The practice had not worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.
- The practice carried out annual face to face reviews for patients with dementia, however at the time of inspection only 50% had had a review in the last year and the process for carrying out the rest was unclear.
- The practice had told patients experiencing poor mental health about support groups or voluntary organisations and a wellbeing advisor was available at Cornwallis Plaza.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2016. The results showed the practice was performing below local and national averages. Three hundred and ninety three survey forms were distributed and 143 were returned. This represented 0.8% of the practice's patient list.

- 51% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 85% and the national average of 85%.
- 32% of patients described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 73%.
- 37% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the CCG average of 79% and the national average of 77%.

We spoke with 11 patients during the inspection. Six of the 11 patients said they continued to experience difficulties accessing appointments and were not satisfied with the care they received due to poor continuity and seeing different GPs each time.

Areas for improvement

Action the service MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced clinical staff members deployed.
- Ensure systems and processes to assess, monitor, manage and mitigate risks to the health and safety of patients who use services are in place.
- Introduce effective systems and processes to investigate, act on and learn from significant events, incidents, near misses and complaints.
- Introduce systems to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure staff have the qualifications, competence, skills and experience to provide safe care and treatment, including safeguarding adults and children at the appropriate level and that staff are given time to attend relevant role specific training.
- Ensure that people employed by the service receive training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Ensure the proper and safe management of medicines and infection control.
- Ensure effective and formal governance arrangements and systems are introduced to assess, monitor and improve the management of risk, quality and safety of the services provided. Carry out clinical audits including re-audits to ensure improvements have been achieved.
- Ensure effective systems are in place so that patients receive regular and appropriate reviews relating to long term conditions, medicines, national guidance and safety alerts.
- Ensure staff are provided with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure formal systems are in place to meet the requirements of the Duty of Candour.
- Ensure systems are in place to receive and act on feedback from patients and take on-going action to improve and sustain accessibility of the service.

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 further CQC inspectors 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 which are run as branch surgeries. The practice is not currently accepting new patients and has approximately 17,500 patients registered.

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). In April 2017 CQC carried out an unannounced focused inspection 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. The practice was rated as inadequate following this inspection and placed into special measures. The clinical lead GP left the practice and since then the GP cover has been provided by locum GPs with remote input from the registered provider and support through the CCG from GPs from other local practices.

The practice also employs two nurse prescribers (female) one of whom is a community nurse practitioner who triages and carries out home visits. There is one practice nurse (female) and two regular agency practice nurses (male and female), three health care assistants (female) and one phlebotomist. The onsite management team are made up of a chief operating officer, general manager and reception supervisor based at Cornwallis Plaza and an assistant manager based at Shankhill Surgery.

Practice opening hours are:

Cornwallis Plaza Surgery 8-6.30 Monday to Friday

Shankill Surgery 8-6 Monday; 8-5.30 Tuesday; 8-1 Wednesday and Thursday; 8-5.30 Friday.

Little Ridge Surgery 8-6.30 Monday, Wednesday, Friday; 8-1 Tuesday and Thursday

Essenden Road Surgery is currently closed to patients.

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. At the time of the inspection Essenden Road Surgery was closed to patients.

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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 carried out a responsive comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out unannounced visits on 7 and 11 September 2017. During our visit we:

- Spoke with a range of staff including locum GPs, nursing staff, practice managers, administrative and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Visited all practice locations that were currently providing services.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. However, the incident recording form did not support the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff involved in the management of incidents were unsure of the practice policy relating to the duty of candour.
- Since April 2017 33 incidents had been reported and recorded. From the sample of 11 documented examples we reviewed we were told that when things went wrong with care and treatment, that patients were informed of the incident as soon as reasonably practicable and received a verbal apology. There was no evidence of written apologies or patients being involved in discussions about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records and found a lack of clinical input and oversight into the process. The incident reporting system was managed by a member of the administrative/management team of the practice and while we were told that some incidents had been reviewed by them and the practice manager these incidents were only reviewed by the GP provider remotely on an ad hoc basis. This meant that incidents were not always reviewed in a timely way. For example, an incident in August 2017 where a locum GP had conducted a telephone consultation rather than a home visit as requested by nursing staff, for a patient unable to mobilise and with evidence of a hip deformity had not been reviewed by the GP provider at the time of inspection, three weeks later. This incident resulted in the patient being at home and in pain overnight and they were later diagnosed with a fracture of their hip.
- The practice did not carry out a thorough analysis of significant events and there was no evidence of discussion or shared learning with practice staff. For example, locum GPs responsible for the provision of patient consultations were not involved in discussions about incidents or learning from them. None of the locum GPs we spoke with had an understanding of the management of significant events within the practice or could recall being involved in discussions about them.
- There was no evidence that lessons were shared and action was taken to improve safety in the practice. For example, significant events were not a standing agenda item for discussions at meetings within the practice.
- The practice did not monitor trends in significant events or evaluate any action taken.
- On 11 September 2017 we found that there was no system in place for dealing with medicine safety alerts. In April 2017 a medicine safety alert was sent relating to valproate (a medicine used to treat epilepsy and other conditions) and developmental disorders in pregnancy. The latest alert repeated the urgency of earlier notifications and asked clinicians for 'all such patients to be reviewed and further consideration of risk minimisation measures'. We checked the practice patient records and found one patient who had been prescribed the medicine via secondary care in April 2017. The most recent prescription was issued by the practice in July 2017 and the patient record showed no evidence that the prescription had been reviewed in line with the safety alert or that the patient had been informed by the practice of the associated risks or contraception advice given. The patient record showed that the patient was pregnant. Follow up by the practice following inspection showed that the patient had returned the prescription to their pharmacy and had not taken the medicine because they were aware of the safety alert from an alternative source. We checked the practice patient records and found a second patient who was prescribed valproate and of child bearing age. There was no record of a medicines review having taken place.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding did not reflect relevant legislation and local requirements. Policies were accessible to all staff, however these contained out of date information and did not always include practice specific information. For example, the child safeguarding policy was created in 2012, had not been

reviewed since this date and contained out of date information. The safeguarding adults policy was over 200 pages in length and contained information relating to the locality rather than practice specific. There was an undated document titled 'safeguarding contact details' that identified the GP provider who was not based on site as the safeguarding lead and had no contact details included. It included contact details for outside agency support but there was no date affixed to the document so it was not possible for us to ascertain whether the contact details were current. Staff did not know who was the current lead for safeguarding within the practice and were unsure who to contact for further guidance if they had concerns about a patient's welfare.

- There was evidence that staff had received training on safeguarding children and vulnerable adults through an online training system. Staff understood their responsibility in reporting concerns, although they were not always clear on who to report to. Posters on the wall gave the name of a GP who no longer worked at the practice as the lead for safeguarding. Training records for locum GPs were not available to us at the time of inspection so we were unable to verify their level of safeguarding training.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. However, on the first day of inspection we found that privacy curtains at the main surgery had not been replaced every six months in line with national guidance although when we returned on the second day of inspection this had been done. On 11 September 2017 we found a full unlocked clinical waste bin outside the front door at Little Ridge Surgery.
- Nursing staff told us there was no official infection control lead identified although the one permanent practice nurse at the time of inspection took responsibility for monitoring infection control across all sites as much as they could. However, there was no additional time or resource available for this role. There was no infection control audit or evidence of liaison with the local infection prevention teams to keep up to date with best practice.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Repeat prescriptions were signed before being dispensed to patients. We were told the practice had carried out some medicines audits, with the support of the local clinical commissioning group pharmacy teams. However, we found there was no system in place to ensure patients receiving medicines had appropriate medicines reviews prior to the reissuing of prescriptions. We reviewed records of medicines reviews and found that only 25% of patients receiving repeat medicines and only 35% of patients on four types of medicine or more had had a review in the previous 12 months. Failure to have established systems in place to monitor patients receiving medicines placed them at risk. For example, one patient receiving an acute prescription of co-codamol (a pain relief medicine containing codeine and paracetamol) for toothache since September 2014 had not had this medicine reviewed at all. Codeine taken over a long period of time can cause physical dependence along with liver toxicity and renal damage.
- We found that reviews of patients prescribed high risk medicines were not always consistent. For example, 63% of patients on warfarin (an anticoagulant medicine to stop blood clotting) were overdue a review and 42% of patients on methotrexate (a medicine that suppresses the immune system) were overdue a review. In addition we reviewed an incident where blood tests for a patient who was receiving warfarin indicated an urgent medicines review was needed. The patient was given incorrect clinical advice and following a review of the incident by the registered provider a protocol was sent to the practice that did not include relevant clinical advice or guidance for locum GPs in relation to this incident.
- On 11 September 2017 at Shankhill Surgery we found an unlocked medicines fridge containing vaccines and an unlocked medicines cabinet containing medicines in an

unlocked room. On 11 September 2017 we found expired medicines and equipment at both Cornwallis and Shankhill surgeries. For example, at Shankhill Surgery we found two meningococcal vaccines that had expired in July 2017 and at Cornwallis adrenaline had expired in June and July 2017.

- Blank prescription forms and pads were not always securely stored, for example, on 7 September we found printer prescriptions stored in an unlocked printer in an unlocked room at Cornwallis Plaza Surgery.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They did not receive mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We were unable to review employee personnel files to identify if appropriate recruitment checks had been undertaken prior to employment as these were stored in a locked cupboard and the staff member with access was not on site at the time when we requested to view the records. However, on the 11 September 2017 we reviewed records of checks of locum GPs relating to their appointment. These locum GPs were directly recruited by the practice. We found that the practice did not have sufficient, timely and appropriate checks to ensure those clinicians employed were trained and safe to perform clinical duties. For example: two out of four records for locum GPs did not include satisfactory evidence of conduct in previous employment. One locum record did not include evidence of a DBS check. One locum record did not include evidence of medical indemnity insurance. Two other records showed that medical indemnity had expired and there was no evidence of renewal held on file.

Monitoring risks to patients

There were some procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available although specific health and safety related risk assessments had not been carried out. The policy stated that overall responsibility for health and safety was held by an employee within the practice rather than the employer and the policy had been signed off by another employee rather than the employer. Neither staff members were fully aware of the scope of their roles in relation to health and safety. Neither staff member had received training in relation to carrying out risk assessments within the practice.
- The practice had a fire risk assessment and fire policy dated June 2016 which had been due for review in June 2017. The fire policy identified a nominated fire officer and two fire marshalls within the practice. The nominated fire officer was not employed by the practice. The risk assessment did not contain information about specific premises management, the use of fire alarms, system checks or fire drills. We were told that fire drills had been carried out periodically, however there was no record of this.
- Managers with responsibility for monitoring or managing risks within the practice were not always aware of their responsibilities or the relevant prevailing legislation.
- All electrical and clinical equipment that was viewed during inspection was checked and calibrated to ensure it was safe to use and was in good working order with the exception of one blood pressure monitor. The monitor was found at Cornwallis Plaza Surgery but was labelled 'Shankhill Surgery' and had been due for electrical and calibration checks in April 2017 which had not been carried out.
- We were told that other risk assessments to monitor safety of the premises such as control of substances hazardous to health,infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) were not available for us to view as they were held off site by the maintenance contractor. This meant that managers at Cornwallis were unaware of regular checks required such as water temperatures.
- There were minimal arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff we spoke with expressed concerns that staff were leaving but that arrangements to replace them were not clear. For example, both reception/administration and nursing staff expressed concerns about the safety within the practice due to staffing issues.

Arrangements to deal with emergencies and major incidents

Inadequate

Are services safe?

The practice did not have adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff had received annual basic life support training. Basic life support training was available through an online training resource and we saw that two of four administrative staff whose training records we viewed had received basic life support training in the last year. However, two members of the clinical/nursing team told us they had not been given time to attend training.
- Emergency medicines were available in the treatment room. However, we found expired emergency medicines at Cornwallis Plaza Surgery. For example adrenaline available in an emergency drug box at Cornwallis Plaza had expired in June and July 2017, hydrocortisone had expired in May 2017 and single use equipment such as syringes were also out of date.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. At Cornwallis Plaza Surgery we found that defibrillator pads and oxygen masks had expired in August 2017. At Shankhill Surgery both child and adult oxygen masks were out of date, expiring in 2015 and March 2017. We were told that arrangements for checking the emergency medicines and equipment were insufficient as nursing staff were not allocated the time to do it.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff, however the plan had last been updated in October 2016 and contained out of date information, particularly around staffing.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were not always aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice did not have a system in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and we were given examples of when individual clinical staff used this information to deliver care and treatment that met patients' needs, however this lacked a systematic approach and there was no overview of this from the provider.
- There was no evidence that the practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95%. However, staff and managers we spoke with told us that with no permanent GP that the management of QOF had been impacted and that current data showed a reduction on the published figures. For example, on the day of inspection data on the practice's electronic record system showed that clinical indicators were at 77%.

Published data showed that exception reporting was higher than average at 17%, 7% higher than the CCG and national average (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Published data showed that exception reporting for asthma was 26% compared with a CCG average of 11% and a national average of 7%. Exception reporting for chronic obstructive airways disease was 27% compared with a CCG average of 15% and a national average of 13%.

Unpublished data from the practice's electronic record system on the day of inspection showed that exception reporting was increasingly higher at 40% for patients on the diabetes and chronic obstructive airways registers. 51% of patients on the asthma register had been excepted.

Data from 2015/16 showed:

- Performance for diabetes related indicators at 92% was similar to the CCG (94%) and national (93%) averages. Unpublished data from the practice showed that current indicators were at 85%.
- Performance for mental health related indicators at 80% was lower when compared to the CCG (92%) and national (93%) averages. Unpublished data from the practice showed that current indicators were at 69%.
- Performance for depression related indicators at 74% was lower when compared to the CCG (93%) and national (91%).

We reviewed the records of four patients on the diabetes register and found that two had not received routine annual blood tests. One had last received a blood test 19 months before, the other 16 months before.

There was no evidence of quality improvement including clinical audit:

- There was no evidence of clinical audits commenced in the last two years and locum GPs told us they had not been involved in discussions about clinical audit.

There was little evidence that information about patients' outcomes was used to make improvements. Locum GPs we spoke with expressed concern that patients with long term conditions were not being reviewed as regularly as they should be and there was no practice-wide system in place to address this.

Effective staffing

Evidence reviewed showed that there were some systems in place to ensure staff had the skills and knowledge to deliver effective care and treatment, however;

- Locum GPs working regularly at the practice told us they had not always received an induction to the practice and there were no induction records available. As a result locum GPs were not always aware practice

specific policies, systems and processes. No other new staff had commenced in post since the previous inspection in April 2017 so we were unable to view recent induction records for staff.

- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, nurses reviewing patients with long-term conditions told us they would try and source their own training, however they expressed concern that there was little support for this. Nursing staff also told us they were not given protected learning time and were not always aware of updates available to them.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines told us that they did not receive support or time from the practice to stay up to date with changes to the immunisation programmes. However, the individual clinical staff told us they took responsibility to ensure they were up to date, for example by accessing on line resources.
- The learning needs of staff were not consistently identified through a system of appraisals, meetings and reviews of practice development needs. Staff did not always have access to appropriate training to meet their learning needs and to cover the scope of their work. For example, members of the nursing staff told us they did not have time to undertake training due to the pressure of work and staffing. Two members of staff told us they had been instructed to undertake the assessment part of online training first, and only review the training if they hadn't passed the assessment. There were limitations to the management and leadership support in relation to ongoing support, clinical supervision and facilitation. For example, both locum GPs and nursing staff we spoke with told us they did not receive clinical supervision or attend clinical meetings. Not all staff had received an appraisal within the last 12 months, some telling us they had received a brief telephone appraisal in 2016 from the previous lead GP but nothing since.
- Online training was available to all staff that included: safeguarding, fire safety awareness, basic life support and information governance. We saw evidence that administrative staff had completed mandatory training but records relating to nursing and GP training were unavailable to us on the day of inspection and clinical staff we spoke with told us they did not have the time or support to complete training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Staff we spoke with expressed concerns about the impact of a number of different locum GPs providing support and the subsequent impact on information sharing and continuity of care. There was no clinical oversight and communication systems were informal and dependent on individual clinicians. The practice had endeavoured to provide some continuity by using regular locum GPs, however the lack of formal communication systems and locum attendance at clinical meetings meant that clinical staff were often working in isolation.
- In April 2017 we found a scanning backlog where the practice was one month behind with electronic letters and two weeks behind with paper correspondence. During the September 2017 inspection we found that improvements had been made to the management of correspondence and results. One of the regular locum GPs had recently been allocated dedicated administration time to support the process, in particular addressing results. However, the practice had failed to properly investigate and mitigate all incidents relating to the previous backlog of results and poor continuity of care. For example, an incident had occurred where a patient was not informed of a positive pregnancy test result until a month after the result was received by the practice. Although the patient was informed of the omission, there was no evidence of investigation into the causative factors outside of the backlog of results at the time, despite there being evidence of three different locum GPs being involved and a misunderstanding that the result had been actioned by one of them which led to the delay.
- The practice had not always shared relevant information with other services in a timely way, for example when referring patients to other services. On 7 September 2017 we reviewed evidence of an incident where a failure to correctly code a palliative care patient resulted

in them not receiving a GP review for two months (although they were receiving care from the specialist palliative care team). The omission resulted in the patient's care not being reviewed as part of routine palliative care meetings.
- There was evidence that continuity of care and regular follow up was not always delivered. For example, action recommended by a GP providing support from a neighbouring practice in April 2017 to contact a patient on the learning disability register and send a bowel screening letter had not been followed through.

We saw examples of how staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. However, the systems for this were largely informal and with the exception of palliative care meetings information sharing between professionals and services were reliant on the individual clinicians involved.

Consent to care and treatment

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

- Individual staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, they were not always aware of the practice policies relating to this.
- When providing care and treatment for children and young people, staff told us they carried out assessments of capacity to consent in line with relevant guidance. However, locum GPs were not aware of formal practice policies and procedures relating to this.
- Where a patient's mental capacity to consent to care or treatment was unclear we were told the GP or practice nurse assessed the patient's capacity.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and had access to additional support.
- A wellbeing advisor was available on the premises at Cornwallis Plaza.

The practice's uptake for the cervical screening programme was 78%, which was comparable with the CCG average of 83% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. All areas of childhood immunisations for under two year old were highlighted as negative variations in CQC data as the practice had failed to reach the 90% standard for achievement. For example, the immunisation data for 2015-2016 showed the percentage of children aged two with the pneumococcal conjugate booster was 59% against the 90% standard. Rates for the vaccines given to five year olds ranged from 83% to 94% which was comparable to the CCG and national figures.

The practice was below average in comparison to other practice's in encouraging patients to attend national screening programmes for bowel or breast screening.

- The practice's uptake for females aged between 50 – 70 years, screened for breast cancer in the last 36 months was 58% compared to the CCG and national average of 73%.

- The practice's uptake for patients aged between 60-69 years, screened for bowel cancer in the last 30 months was 43% compared with the CCG average of 60% and the national average of 58%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients which staff told us were available on request and NHS health checks for patients aged 40–74.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We spoke with 11 patients. They told us they were not always satisfied with the care provided by the practice because of issues around poor continuity of care and not always being able to see the same GP.

Results from the national GP patient survey showed patients did not always feel they were treated with compassion, dignity and respect. At previous inspections in November 2016 and April 2017 we found that the practice was below average for its satisfaction scores on consultations with GPs and nurses. Results from July 2017 show that the practice is still below average in these areas and in some areas results have deteriorated further, particularly in relation to GP consultations. For example:

- 71% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 66% of patients said the GP gave them enough time compared to the previous result of 72%, the CCG average of 87% and the national average of 86%.
- 83% of patients said they had confidence and trust in the last GP they saw compared to the previous result of 93%, the CCG average of 95% and the national average of 95%
- 58% of patients said the last GP they spoke to was good at treating them with care and concern compared to the previous average of 76% and the national average of 86%.
- 84% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 92% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the previous result of 76% and the national average of 91%.
- 67% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they did not always feel involved in decision making about the care and treatment they received. They also told us they did not always feel listened to and supported by staff or had sufficient time during consultations to make an informed decision about the choice of treatment available to them. For example, patients told us they did not often see the same GP due to the high volume of locum GPs and that this meant there was poor continuity of care.

Children and young people were treated in an age-appropriate way and recognised as individuals. There was a children's play area in the practice waiting area and parents we spoke with told us they believed that children's care was prioritised when booking appointments. However, one parent we spoke with told us they felt the quality of clinical care was inconsistent and that they had concerns that health concerns were not always listened to, including in relation to their child.

Results from the national GP patient survey showed patients did not respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages. For example:

- 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the previous result of 75% and the CCG average of 86% and the national average of 86%.

Inadequate

Are services caring?

- 56% of patients said the last GP they saw was good at involving them in decisions about their care compared to the previous result of 66% and the national average of 82%.
- 80% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the previous result of 71% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in different formats.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. In addition a wellbeing service was offered at Cornwallis Plaza. Information about support groups was also available. Support for isolated or house-bound patients included signposting to relevant support and volunteer services and we were told of an example of where the advanced nurse practitioner had attended additional home visits when concerned about a vulnerable patient at home.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 295 patients as carers (1.7% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement they would be signposted to other services. There was no system within the practice to make contacted with bereaved patients or offer a patient consultation to meet the family's needs and/or by giving them advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice did not consistently respond to or meet people's needs.

- The practice did not offer extended hours.
- Home visits with the Advanced Nurse Practitioner were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. However, we found that the availability of home visits from GPs were somewhat limited and dependent on individual locums.
- The practice took some account of the needs and preferences of patients with life-limiting progressive conditions. We viewed one example of on-going conversations and input about end of life care where locum GPs had been involved in regular review of the patient, however we saw another situation where on-going input from the practice had been limited due to the patient not being correctly coded.
- The practice supported some care homes in the area. However, we viewed a complaint from one care home manager where they had experienced difficulties in getting through to the practice by phone, accessing visits from GPs and having prescription changes from secondary care actioned.
- We were told that same day appointments were available for children and those patients with medical problems that require same day consultation, however feedback from patients included that getting access to GPs was sometimes difficult.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Services at all locations were either on the ground floor or there was lift access.

Access to the service

The practice was open and appointments available between 8.00am and 6.30pm Monday to Friday. Extended hours appointments were not offered. Staff told us there were some pre-bookable appointment available although they had been told by the practice that they couldn't book appointments beyond October 2017. Urgent appointments were also available for patients that needed them. Staff told us that access to urgent appointments had improved since locum sessions had been increase following the April 2017 inspection. Of the 11 patients we spoke with eight told us they continued to have some difficulty accessing GP appointments.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment lower than local and national averages.

- 55% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 24% of patients said they could get through easily to the practice by phone compared to the national average of 71%.
- 59% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 84%.
- 55% of patients said their last appointment was convenient compared with the CCG average of 83% and the national average of 81%.
- 32% of patients described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 73%.
- 29% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

Patients we spoke to on the day had mixed views relating to access to appointments. Four of the eleven patients we spoke with told us they felt that access to appointment had improved since more locum GPs were available. However, five patients told us they continued to experience difficulties getting through to the practice by phone. In addition we viewed a complaint from a care home manager that included concerns about a lack of access to GPs. We saw that the manager had met with the practice lead for complaints, however when we spoke with the care home manager during inspection they told us they continued to have concerns and didn't feel that the situation had improved.

We reviewed complaints received by the practice and saw that there continued to be a number of complaints from patients about access, however the complaints coordinator

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

said there had been a reduction in the number and frequency of complaints since the increase in locum GP cover. For example, in April 2017 there had been 71 complaints about telephone access and 71 about access to appointments. At the September 2017 inspection we saw that since the April 2017 inspection there had been 31 complaints about the telephone access and 44 about appointment access.

A nurse practitioner was employed to undertake home visits for housebound patients. The practice system for assessing whether GP home visits were clinically necessary and the urgency of need for medical attention was dependent on individual locum GPs. We viewed one incident where a request for a GP home visit from the nurse practitioner for a patient unable to mobilise at home and with a hip deformity had been declined by the locum GP. The incident had been reported as a significant event, however it was unclear what action had been taken to prevent the situation from happening again. The incident had resulted in the patient being at home overnight, in pain and unable to mobilise. Staff within the practice did not believe they had the leadership support to properly address this situation at the time.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There were posters in the waiting areas informing patients of how to complain.

During the April 2017 inspection we found that complaints were logged and reviewed by the lead GP although action to identify themes and cascade learning was not always taken.

As part of the September 2017 inspection we looked at 99 written and 86 verbal complaints that had been received since the previous inspection in April 2017. We found that 31 related to telephone access, 44 to access to appointments, 34 regarding prescriptions, 28 regarding reception or administration contact and 18 regarding clinicians. We found that while these were identified and recorded and that staff directly involved in the management and coordination of complaints worked hard to address them, there was no clinical or leadership oversight. Lessons were not learned from individual concerns and complaints and trends were not identified. Action was not always taken to improve the quality of care. For example:

- On 7 September we reviewed a complaint from the manager of nursing home was made regarding poor access by phone, difficulty in organising GP visits and prescription changes from consultants not being carried out. A meeting was held on between the nursing home manager and the practice complaints lead with an outcome for the complaints manager to remind reception staff to ensure phones are answered and prescription changes undertaken. The manager of the nursing home remained unsatisfied with the outcome of the complaint which led to delays in treatment and access to GPs.
- Clinical complaints were sometimes only directed to the clinician involved for a review which meant that a potential bias was present in the review. We reviewed a complaint where a mother had complained that immunisations for her child had been cancelled five times and that a staff member had missed one immunisation. There was no log of action taken and the complainant was directed to address the complaint herself with the nurse at her next appointment.
- On 7 September 2017 we reviewed a complaint made regarding an allegation that a locum GP was rude and 'hurt' the patient during an examination had no clinical oversight and was only escalated to NHS England on 19 July 2017 after the had failed to respond to the practice. Complaints of this nature not being investigated in a timely way have the potential to leave both patients and clinicians at risk.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice did not have a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice did not have a clear strategy and supporting business plans.
- The practice staff reported they were working with a good deal of uncertainty about the future of the practice because of planned but unclear changes in registered provider.
- Staff informed us they had been told not to book appointments beyond October 2017 and that they could not recruit new staff despite a high volume of staff leaving the practice due to the uncertainty.

Governance arrangements

The practice did not have an overarching governance framework to support the delivery of the good quality care. There was a lack of structures and procedures to support good governance:

- The practice was not able to demonstrate a clear staffing structure or that staff were aware of their own roles and responsibilities. The practice was operating using a combination of regular and changing locum GPs and certain clinical activities such as patient reviews were not taking place due to a lack of clarity and appropriate clinical provision. There was limited leadership presence and a high volume of staff were leaving without adequate consideration for replacing them. For example, there was limited clinical or leadership oversight in relation patient safety issues and leadership of areas such as safeguarding and infection control.
- Practice specific policies were not always implemented or available to all staff. These were not always updated and reviewed regularly. For example, we viewed three different versions of a fire safety policy. Policies were not easily accessible to managers on the shared folder of the practice intranet. Some policies were generic and didn't include practice specific information.
- A comprehensive understanding of the performance of the practice was not maintained. Practice meetings were not held consistently and there was no opportunity for staff to learn about the performance of the practice. There was a lack of leadership in relation to the management of long term conditions and staff in the practice including locum GPs were not aware of who was taking responsibility for QOF for the current year.
- A programme of continuous clinical and internal audit was not in place to monitor quality and to make improvements. Locum GPs and nursing staff did not have any awareness of clinical audits being undertaken.
- Patient reviews were not being proactively undertaken in relation to high risk medicines, long term conditions or in response to safety alerts.
- The practice did not have an effective system in place to maintain the confidentiality and security of patient records. On 7 and 11 2017 September patient records were found on desks in unlocked consulting rooms.

There were not appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions;

- The practice relied solely on locum GP input with ad hoc support from the registered provider and through a local federation of GPs. Locum GPs were not always clear about where to access support.
- We were told that risk assessments were held off site through a maintenance contract so staff working at the practice were not aware of mitigating actions such as water temperature testing in relation to managing legionella risk. There was no evidence of fire drills taking place or learning from these although managers told us these did occasionally take place.
- We did not see evidence of minutes of meetings that allowed for lessons to be learned and shared following significant events and complaints. The process for the management of significant events and complaints did not include clinical oversight, this had resulted in a lack of investigation and potential delays in addressing issues. Staff, including locum GPs and nurses were not involved in discussions about significant events or complaints and there was no independent or clinical scrutiny through the process. Staff coordinating significant events and complaints made contact with the registered provider on an ad hoc basis to discuss individual concerns but there was no clear guidance around this. There was not an understanding or clear guidance on what incidents should be reported externally.

Are services well-led?

Inadequate

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

- Appropriate checks of locum GPs in relation to conduct in previous roles, disclosure and barring service (DBS) checks and medical indemnity insurance were inconsistent.
- The system for actioning safety alerts was unclear as there was no lead clinician to assign them to within the practice.

Leadership and culture

On the days of inspection there were no senior leadership staff on site at the practice. Staff informed us that the provider was available at the end of the phone to the managers within the practice and that they would attend the practice periodically. However, staff told us that many of them did not know who the provider was and we were given an example of where the provider had attended the practice to review records but had not interacted with staff. Staff told us they felt the provider was not approachable and that the managers based at the practice had limited authority to make decisions and changes required. Arrangements had been put in place for neighbouring GP practice to provide some continuity in terms of GP and clinical cover, however staff told us that this was not always consistent and other than the registered provider they did not always know who to contact.

The provider did not have systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff did not have an understanding of the duty of candour or what constituted a notifiable safety incident. We saw some evidence of patients having received a verbal apology when things went wrong but this was on an individual basis rather than through a systematic practice wide approach. The practice did not always keep written records of verbal interactions as well as written correspondence.

There was not a clear leadership structure and staff did not always feel supported by management.

- The practice did not hold a full range of multi-disciplinary meetings and locum GPs told us that with the exception of ad hoc palliative care meetings there were no opportunities to meet with clinical colleagues or other professionals to monitor vulnerable patients or discuss clinical issues. GPs, did not meet with health visitors to monitor vulnerable families and address safeguarding concerns, although would respond to concerns as they arose.
- Staff told us the practice did not hold regular team meetings and that when meetings had been planned they would regularly get cancelled.
- Staff told us there was a good deal of uncertainty about the future of the practice and did not always feel an open culture within the practice.
- Staff said that due to the uncertainty the practice was facing they did not feel they were always involved in discussions about how to develop or improve the practice.

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

The practice did not always encourage or appear to value feedback from patients and staff.

- There was no active patient participation group (PPG). We viewed a patient satisfaction survey from October 2016 where concerns had been raised around access to appointments, telephone access and prescriptions. We continued to see concerns raised about these issues during our September 2017 inspection.
- Staff feedback was generally through staff meetings, appraisals and discussion. However, these were ad hoc and not always planned. Staff told us they did not always feel involved and engaged to improve how the practice was run.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not ensure there were systems to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. The registered person did not do all that was reasonably practicable to mitigate risk. The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered person did not ensure the proper and safe management of medicines. The registered person did not ensure that equipment used by the service provider for providing care or treatment to a service user was safe for such use. The registered person did not ensure there were systems for assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated. This was in breach of regulation 12 (1) (2) (a) (b) (c) (e) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

The registered person was not able to ensure that systems and processes were established and operated effectively to ensure compliance with the requirements in this Part.

The registered person did not do all that was practicable to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (including the quality of the experience of the service users in receiving those services).

The registered person did not do all that was practicable to 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 activities.

The registered person did not ensure that patient records would be kept secure at all times.

This was in breach of regulation 17(1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **How the regulation was not being met:** The registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. The registered person was not able to ensure that persons employed by the service provider had received training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was in breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.