Chiltern House Medical Centre

Quality Report

Chiltern House Medical Centre
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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?	Good
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced comprehensive inspection at Chiltern House Medical Centre in High Wycombe, Buckinghamshire on 18 and 24 October 2016. The overall rating for the practice was inadequate with one rating of requires improvement for providing effective services; all other areas were rated inadequate. We used our enforcement powers to take action against the breaches of regulations including issuing three warning notices. We placed the practice in special measures for six months to enable the practice to improve. The significant levels of concern led to three conditions being added to the registration of the practice. The conditions were imposed to ensure timely and sustainable improvement was made. We undertook a focussed follow up inspection in January 2017 and found the warning notices had been met. However, the practice remained in special measures and the conditions of registration remained in place. The full comprehensive report from these inspections can be found by selecting the 'all reports' link for Chiltern House Medical Centre on our website at www.cqc.org.uk.

We undertook a comprehensive follow up inspection on 6 June 2017. This inspection was undertaken to determine whether all of the breaches of regulation requirements had been addressed following the inspection in October 2016. Whilst improvements had been made in relation to some of the concerns highlighted at the last inspection, there were areas relating to providing safe, effective, caring and well-led services which constituted continued breaches of regulations. The practice is rated inadequate overall, specifically inadequate for the provision of safe, effective, caring and well-led services. The practice was rated good for providing responsive services. The issues identified at this inspection impact on the care provided to all population groups which have also been rated as inadequate.

Our key findings were as follows:

- The GP partners demonstrated they had the motivation to improve the services patients experienced. However, the overall leadership and management team of the practice did not always ensure the appropriate systems were in place to ensure improvements were followed through.
- There was not an effective system or culture for identifying, capturing and managing issues and risks. Significant issues that threaten the delivery of safe and

Summary of findings

effective care were not identified or adequately managed. For example, risks related to staff background checks and infection control were not always identified, assessed and mitigated.

- Improvements to the monitoring of care and treatment had been implemented and we saw most clinical daily tasks were undertaken efficiently. However, we saw some areas where patients were at risk of delays in receiving follow up care in relation to pathology results and external correspondence.
  - Patients were at risk of harm because systems and processes were not appropriately embedded to keep them safe. For example, repeat prescribing was not always managed properly to ensure reviews of medicines were up to date or that medicine alerts were responded to promptly.
- The care of long term conditions had improved overall according to national data submission from 2016/17. However, diabetes performance data showed a decline from 2015/16.
- There was evidence of some monitoring of patients care and treatment, including seven repeated clinical audits. However, clinical audit was related primarily to medicine audits and no broader audit based on patient care outcomes was undertaken or was only in its preliminary stages.
- Staff were able to access clinical training in order to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, training requirements and qualifications were not always monitored to ensure they were being undertaken by all staff.
- There had been improvements made in the premises at the branch practice to reduce any risks to patients and enhance accessibility.
- There had been improvement to telephone access and appointment availability.
- There was a system in place for reporting and recording significant events. Reviews of complaints, incidents and other learning events were used to identify learning and improve services.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patient feedback in Care Quality Commission (CQC) comment cards showed patients felt improvements had been made to the quality of the service in recent weeks.
- The provider was aware of and complied with the requirements of the duty of candour.

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

Importantly, the provider must:

- Review the leadership and management visibility, capability, capacity and experience in order to ensure the practice effectively makes sustainable and measurable improvements to the governance processes. Including clinical audit in relation to areas where clinical data shows improvement is required and responding to feedback from stakeholders as well as all patient feedback.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure risks related to the provision of regulated activities are identified, assessed and managed. Specifically review risks related to staff background checks and infection control.
- Ensure care and treatment is provided in a safe way to patients including the prescribing of medicines and care provisions for patents with learning disabilities.
- Ensure persons employed in the provision of the regulated activities receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties
- Ensure, where appropriate, persons employed with the relevant qualifications.
- Provide staff with appropriate supervision and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.

This practice was placed in special measures in December 2016. Insufficient improvements have been made such that the practice is now rated inadequate for

Summary of findings

several key questions (safe, effective, caring and well-led). As a result, I am keeping the practice in special measures and the conditions of registration remain due to the continued concerns we identified in June 2017.

One of the conditions of registration that remain specifically prevents the practice registering any new patients without the written permission of the CQC unless those patients are the newly born babies, newly fostered or adopted children of patients already registered at Chiltern House Medical Centre or Dragon Cottage Surgery.

Chiltern House Medical Centre will be kept under close review and inspected again within six months. If we do not see satisfactory improvement we will escalate our enforcement powers, which may result in the closure of the service.

We have shared the seriousness of our concerns and potential action regarding Chiltern House Medical Centre with NHS England and the Chiltern Clinical Commissioning Group.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Patients on long term medicines were not always reviewed to ensure they were safe to continue taking their prescriptions.
- Staff background and qualification checks were not always taking place.
- We identified improvements had been made in how the practice managed infection control. However, not all infection control guidance was being followed.
- Emergency medicines and equipment were stored appropriately and were within expiry dates.
- There had been significant improvement to the safety of premises at the branch practice known as Dragon Cottage.
- There were safeguarding processes and training for staff. However, we found one instance where safeguarding processes were not followed. Furthermore, the safeguarding lead at the practice only worked two sessions each week, this may have resulted in a delay for staff seeking safeguarding advice and guidance.
- We found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Inadequate

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

- Reviews of patients' medicines were not always being recorded, which presented a risk to safe prescribing.

Summary of findings

- There was not always a focus on prevention and early identification of health needs. For example, the practice had not undertaken full reviews on the health and treatment requirements for patients with learning disabilities to ensure any health needs were identified and action taken.
- There were completed medicines audits in place but these were minimal. We saw limited evidence the practice monitoring patients care and treatment, including a lack of completed audit cycles in order to drive improvement.
- Repeat prescribing was not always managed appropriately to ensure reviews of medicines were up to date or that medicine alerts were responded to promptly.
- The care of long term conditions had improved overall according to national data submission from 2016/17. However, diabetes data showed a decline from 2015/16.
- Staff training and qualifications were not monitored and checked effectively to ensure staff had the necessary skills and experience.
- Staff were aware of current evidence based guidance when reviewed patients care and treatment needs.
- All staff had received regular appraisals.
- The practice worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was co-ordinated with other services, but according to data provided to us prior to the inspection only 54% of patients on the end of life care register had an advanced care plan in place.

Are services caring?

Inadequate

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

- Patient feedback noted improvements had been made regarding staff demeanour and patients reported staff were caring and treated them with respect.
- Not all aspects of negative feedback from the July 2016 GP national survey or feedback from NHS choices had been taken into account.
- Action had been taken to improve confidentiality.
- Staff had been trained to enhance their communication skills and improve patient experience.

Summary of findings

- The number of carers registered had been increased and support was provided through external services and a carers' board.
- It was unclear if the practice provided facilities to help patients be involved in decisions about their care. For example, the practice managers informed us that interpretation services were available for patients who did not have English as a first language. However, reception staff we spoke with were not all aware that this service was available. Furthermore, there was no information on display which advertised translation services were available.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice had improved its understanding of its population profile and had used this understanding to improve its services.
- There was a 'you said, we did board' in the waiting area to reflect the changes made as a result of patient feedback. For example, complaints about the phone system had led to a review of the system and a change to a local telephone number.
- A review of premises in terms of the experience for patients with dementia had been undertaken. This led to changes such as more distinct colour differentiations in toilets to help patients with dementia navigate their surroundings.
- Vulnerable patients were flagged on the system to enable staff to identify their needs and prioritise them as necessary.
- A weekly visit from a GP was undertaken at a local care home to review the needs of the patients residing there. The home provided us with feedback that the practice provided a responsive service to their patients.
- Patients with diabetes could use email contact with their GP for ease of communicating their blood glucose readings.
- The practice participated in the local University's fresher fair to provide GP registration information and local healthcare information to new students moving into the area
- Patients we spoke with said they were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had accessible facilities and was well equipped to treat patients and meet their needs.

Summary of findings

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

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led and improvements must be made.

- Feedback we provided in our reports from inspections in February 2016 and October 2016 had not been fully acted on to drive improvements in care outcomes for patients and the inaccurate monitoring data for repeat medicines.
- The practice had mitigated some risks we had identified at the October 2016 inspection but had not reviewed processes and systems to identify further risks associated with prescribing of medicines and infection control.
- Improvements to the monitoring of care and treatment had been implemented and we saw most clinical daily tasks were undertaken efficiently. However, patients were at risk of delays in receiving follow up care in relation to pathology results and external correspondence due to delays in processing.
- The leadership team did not ensure practice policies and procedures were being followed. For example, staff background checks and training were not being monitored properly.
- The practice had some focus on continuous learning and improvement in clinical care and was responding to existing patient feedback. However, concerns from data monitoring or care outcomes were not identified as potential areas for improving clinical care.
- There were policies in place but some did not contain full details of what was required in the related processes, such as the recruitment policy.
- There had been a significant improvement in the responsiveness to patient feedback in order to drive improvements in the practice.
- There had been improvements to telephone access and appointment availability.

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 provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

- Despite improvements to clinical care we found governance concerns which potentially affected safe and effective use of medicines patient within this population group.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. However, data provided to us prior to the inspection indicated only 54% of patients on the end of life care register had an advanced care plan in place."
- Improvements to accessibility and premises had been made since October 2016.
- There had been significant improvements in accessibility and phone access since the last inspection.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered personalised care to meet the needs of the older patients in its population.
- Regular and responsive visits were undertaken to a local care home.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

Summary of findings

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long term conditions. The provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

- Despite some improvements to clinical care we found governance concerns which potentially affected safe and effective use of medicines including a lack of recording when patients had up to date medicine reviews and action when alerts on specific medicines were received.
- National data indicators showed improvements since October 2016 in the number of patients receiving care in line with national guidance. However, patients with diabetes were not always getting the reviews and related treatment they needed.
- Nursing staff had lead roles in long-term disease management but only one member of nursing staff was providing long term condition reviews at the time of the inspection.
- Patients with diabetes could use email contact with their GP for ease of communicating their blood glucose readings.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

- There were safeguarding processes in place to protect children and we found there were systems to identify and follow up children living in disadvantaged circumstances who were at risk. However, we saw one example where action had not been recorded following a child on the at risk register who had not attended a hospital appointment.
- There had been significant improvements in accessibility and phone access since the last inspection.

Summary of findings

- Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours if requested and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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 provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

- There had been significant improvements in accessibility and telephone access since the last inspection.
- The practice participated in the local University's fresher fair to provide healthcare information to new students moving into the area.
- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, the appointment system had been amended to ensure appropriate appointments were available.
- Same day appointments were available and routine appointments could be booked.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended hour appointments were available.

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. The provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

Summary of findings

- Vulnerable patients were flagged on the system to enable staff to identify their needs and prioritise them as necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Interpretation services were available for patients who did not have English as a first language. However, reception staff we spoke with were not all aware that this service was available. Furthermore, there was no information on display which advertised translation services were available.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). The provider was rated as inadequate for providing safe, effective, caring and well-led services. The issues identified overall affected all patients including this population group. There were however examples of good practice.

- A review of premises in terms of the safety and overall experience for patients with dementia had been undertaken. This led to changes such as more distinct colour differentiations in toilets to help patients with dementia navigate their surroundings.
- The practice carried out advance care planning for patients living with dementia.

Summary of findings

- Performance for mental health indicators was 99% compared to the 2015/16 CCG average of 96% and national average of 96% (an increase from 81% in 2016). We saw 86% of patients with mental health conditions had updated and agreed care plans in place.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing worse than local and national averages. There had been 265 survey forms distributed and 115 were returned. This represented 1.2% of the practice's patient list. This data is old and does not reflect any changes in patient opinion based on the improvements made since December 2016.

- 63% of patients found it easy to get through to this practice by phone (CCG average 73%, national average 73%).
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 88%, national average 85%).
- 64% of patients described the overall experience of this GP practice as good (CCG average 86%, national average 85%).
- 63% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 80%, national average 78%).

Improvements had been made to the appointment system, phone access and training provided to help staff enhance their ability to support patients. Nearly all of the 42 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a caring service and staff were helpful, caring and treated them with dignity and respect. The only negative comments raised were by two patients regarding the telephone and appointment system. This was a significant improvement on the feedback regarding appointments from the previous inspection in October 2016. This was reflected in discussions we had with 12 patients.

The NHS Friends and Family test was used to collect feedback from patients. This showed that in 2017 there had been 25 responses of which 68% of patients were likely or extremely likely to recommend the practice and 20% of patients were extremely unlikely to recommend the practice.

Chiltern House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a GP specialist adviser, a second inspector, a nurse specialist adviser and a practice manager specialist adviser.

Background to Chiltern House Medical Centre

Chiltern House Medical Centre provides primary care GP services to approximately 8,200 patients across two locations in the High Wycombe area. The list size had reduced due to a condition imposed by Care Quality Commission (CQC) not to register new patients other than new born babies without written permission from CQC. The two locations are Chiltern House Medical Centre and the branch practice known as Dragon Cottage, the patient list is split equally between the two sites and patients can see a GP or nurse at either site. We have visited both sites during this inspection.

Both practices are located in an area of low deprivation, meaning very few patients are affected by deprivation in the locality. However, there are pockets of high deprivation within the practice boundary. There are a higher number of patients aged 45 to 54 registered at this surgery and the patient population of this area is older than national average. There are a high percentage of patients from ethnic minority backgrounds at Chiltern House Medical Centre. The practice has the highest proportion of unemployed patients registered in the CCG at 6.4% compared to the England average of 4.4%.

Chiltern House Medical Centre is located in a 17th century grade II listed building. Access to the practice is through automatic doors into a large waiting area and reception. There are two consultation rooms and three treatment rooms on the ground floor with two further consultation rooms on the first floor. A lift allows access to the first floor. The additional treatment room and a counselling room were added since our last inspection were part of the practice's refurbishment.

Dragon Cottage Surgery is located in an old residential dwelling in the Holmer Green area of High Wycombe. The house has been converted to provide three consultation rooms and two treatment rooms. There is a reception area and two small waiting rooms. On the day of inspection, we found significant improvements to the building and surroundings to improve accessibility and the suitability of the premises, including a designated disabled car parking space.

The practice has three GP partners (all female), two salaried GPs (including one male), two practice nurses (all female) and a health care assistant (female). There were 2.5 whole time equivalent (WTE) GPs and 2 WTE nurses. The staffing was complimented by a high usage of locum GPs and nurses which had increased appointment capacity. The clinical staff are supported by two practice managers, eleven receptionists, two administration staff and two secretaries.

The practice has undergone many operational and staff changes in the last three years. Two GP partners, three

nurses and two practice managers left between 2014 and 2015. Between January 2015 and November 2015 there was no practice manager and governance systems and processes were undertaken by the GP partners.

The practice successfully recruited a practice manager in November 2015 and established an improvement programme to support the practice. A second practice manager was recruited in January 2016 and between them they have commenced or implemented improvements in the plan set out by NHS England. NHS England are having regular meetings with the practice to ensure actions are being implemented and completed.

Chiltern House Medical Centre is open between 8.00am and 6.30pm Monday to Friday. Dragon Cottage is open between 8.00am and 6.30pm Monday to Friday with the exception of Thursdays when the branch practice closes at 2pm. Extended surgery hours are offered on Tuesday evenings until 8pm at Chiltern House Medical Centre. The practice have opted out of providing out of hours care when the practice is closed. This is offered by NHS 111 telephone service who will refer to the out of hours GP service if required.

Services are provided from two locations:

- Chiltern House Medical Centre, 45 – 47 Temple End, High Wycombe, Buckinghamshire HP13 5DN
- Dragon Cottage, 35 Browns Road, Holmer Green, High Wycombe, Buckinghamshire HP15 6SL

Previous inspections of Chiltern House Medical Centre have taken place February 2016 and October 2016. Following the inspection in February 2016, the practice was rated as requires improvement for providing safe, effective, caring, responsive and well led services. In October 2016 it was rated inadequate and the practice was placed into special measures.

Why we carried out this inspection

We undertook a comprehensive inspection in October 2016 at Chiltern House Medical Centre under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and placed into special measures. The full comprehensive reports following the two previous inspections from 2016 can be found by selecting the 'all reports' link for Chiltern House Medical Centre on our website at www.cqc.org.uk.

We undertook a comprehensive follow up inspection of Chiltern House Medical Centre on 6 June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting we reviewed a range of information we hold about the practice. We carried out an announced visit on 6 June 2017. During our visit we:

- Spoke with a range of staff including three GPs, two nurses, a healthcare assistant, nine support staff, the practice managers and spoke with members of the patient participation group who also used the service.
- We reviewed the previous Care Quality Commission (CQC) inspection reports and the action plans submitted by the practice outlining how they would make the necessary improvements to comply with the regulation.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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:

Detailed findings

- 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

At our inspection in October 2016 we found concerns related to the management of medicines, infection control, staff hepatitis B checks and we found risks related to the premises which had not been identified and acted on. We found some of the moderate and high risks were mitigated in a focussed inspection in January 2017 but not all of the areas were reviewed at this inspection.

During this inspection on 6 June 2017 we found the practice had taken action to mitigate some risks that we had identified at the previous inspections. However, the practice had failed to assess the requirements relating to all of the regulations and safe practice. The previous three inspections also identified safety related risks which has led to a long term continued breach of regulation. We have used our enforcement powers to ensure the provider considers and meets all of the requirements of the regulations and safety.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform their line manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported 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).
- From the sample of significant events we reviewed we found that when things went wrong with care and treatment, learning outcomes were identified and shared with staff. In one example, a two week wait referral had been delayed by two days as it had not been picked up from a fax machine. The incident was reported and staff training was identified as a requirement. We saw a sample of referrals from May 2017 and June 2017 and found that these were acted on promptly.
- We saw evidence that patients received a written apology when they raised concerns that the practice identified any failings and were told about any actions to improve processes to prevent the same thing happening again.
- The practice also monitored trends in significant events in designated meetings and evaluated any action taken.
- We reviewed medicine and other safety alerts and found they were recorded, and shared with relevant staff. Alerts were then discussed at meetings. However we identified an instance where action was not taken to identify if any patients were on a combination of medicines which was subject to an alert in April 2017. We saw that this had not been acted on by the practice but was logged on the medicine alerts system. We saw that historical alerts which may require action if patients were placed on specific medicines by external clinicians had also not been subject to repeated searches. Therefore any patients were placed at risk where they did not receive a review to ensure they were safe to continue taking any medicines subject to an alert.

Overview of safety systems and processes

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

- We reviewed data related to necessary reviews of patients on repeat high risk medicines. We saw they received the blood tests they required to ensure they could receive their medicines safely.
- Arrangements for safeguarding were in place and there was a safeguarding lead. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. However, we found an example where a child on the safeguarding 'at risk' register had not attended a hospital appointment and no follow up action was noted in the patient's records. During the inspection, we were informed the safeguarding lead at the practice only worked two sessions each week, this may have resulted in a delay for staff seeking safeguarding advice and guidance.

Are services safe?

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- Notices advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role. However, we found that some reception staff, who potentially may be asked to be chaperones according to the practice policy, were still in the process of receiving 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.
- The practice nurse was the infection prevention and control (IPC) clinical lead and had undertaken basic training. Although significant improvements had been made to cleanliness and the appropriateness of the premises in regards to infection control since October 2016, we still found minor infection control concerns. There was no evidence of hand hygiene audits. We saw further infection control concerns at Dragon Cottage Surgery, such as sink overflows which had not been removed or covered, which had not been identified through the system of infection control audit. We found that a member of support staff did not have an adequate understanding of infection control. We saw a receptionist take a sample by hand without gloves while we observed reception. This risks contamination via hand contact and is not considered good practice. The samples were placed in a designated domestic fridge which did not have any means of monitoring temperature.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- The practice carried out regular medicines checks, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The practice had removed all controlled drugs from their premises since October 2016.

We looked at staff files to determine whether the appropriate recruitment and staff checks were taking place. We saw evidence from email correspondence that disclosure and barring service check (DBS) applications for staff had been sent on 31 May 2017 after the inspection was announced. Whilst the DBS check had been applied for, the practice had not assessed the risk of using unsupervised clinical staff without the required employment checks. This included a healthcare assistant who had been employed for more than a year and a nurse who had been employed for over two months. The staff had provided care to patients without the practice undertaking required checks. We saw from records that a locum nurse was providing a variety of services including titration of insulin, child immunisations and long term condition reviews but there was no proof of their qualifications when we requested these from the management team. There was a risk this staff member had been providing services without the necessary skills and experience until this was identified by the inspection team. We found that one out of four of the locum GP staff records we reviewed did not contain a DBS check.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

Inadequate

Are services safe?

- Most electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. However, there was a spirometer (an instrument for measuring the air capacity of the lungs) onsite but staff could not locate a calibration or validation record for this to show it was regularly checked for accuracy. The practice informed us there was usually a book but it went missing around the time of the inspection.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There had been significant improvement to the premises at the branch practice (Dragon Cottage). The accessibility for disabled patients and those with limited mobility had improved to ensure access was safe. This included improvements to access and safety, for example disabled parking was clearly identified and toilet facilities had been improved to include an alarm call.
- The practice had been operating on low permanent staffing numbers and the recruitment of nurses and GPs was ongoing. High numbers of locum staff were being used. Two new GPs were due to start in July 2017 and August 2017. We saw that daily clinical and administration tasks were being dealt with promptly other than pathology results where we identified a delay on abnormal results being dealt with.

Arrangements to deal with emergencies and major incidents

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

- We saw training certificates which indicated staff received annual basic life support training.
- There were emergency medicines and equipment available on both sites. These were all within expiry dates. The medicines stored were those which may be required in a medical emergency. We saw oxygen and a defibrillator was available at both premises. A first aid kit and accident book was also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

During our inspection in October 2016, we found that the monitoring of patient care was not sufficient. There were poor data outcomes for patients with long term conditions. There was minimal evidence that the practice was identifying areas where clinical care could be improved and then using audit to improve care.

During this inspection on 6 June 2017, we found the practice had taken action to mitigate some risks related to patient care. However, data in some clinical areas still showed concerns around monitoring of patient outcomes. Patients had not always received effective care and there was insufficient assurance in place to demonstrate all patients with long term conditions, mental ill health or a learning disability were being given the right level of care and treatment to maintain postitive health outcomes.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However, we found concerns with the ongoing assessment of patients with long term conditions.

- The practice had systems to keep all clinical staff up to date with national guidance.
- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Staff had training to review patients' healthcare needs. At this time of the inspection a locum nurse was providing the majority of healthcare reviews for patients with long term conditions.
- There were 63 patients on the learning disabilities register of which three (approximately 5%) had a health check within the last 12 months. There was a risk to these patients as they may have undiagnosed conditions or exacerbations of existing conditions which required treatment.

Management, monitoring and improving outcomes for people

Patient outcomes were overall close to national and local averages. However, some were significantly worse than expected in some clinical domain areas when compared with other similar services. Necessary action was not always identified or taken to improve the patients health and well being.

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 unpublished results from 2016/17 (these results had been submitted awaiting validation and then publication in October 2017) were 94% of the total number of points available compared with the clinical commissioning group (CCG) average from 2015/16 of 98% and national average of 95%. The practice had a slightly higher prevalence of patients for 17 out of 23 long term health condition indicators, in part due to having an older than average population. Most of the higher prevalence's were not significantly different to CCG average.

Exception reporting had increased from 4% in 2015/16 to 13% overall in 2016/17, compared to the CCG average of 9% in 2016. The practice could not explain why the level of exception reporting had increased. 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. Individual exception reporting figures for 2016/17 were as follows:

- Diabetes exception reporting was 10% compared to the national average of 12% and CCG average of 10% in 2016.
- Mental health exception reporting was 3% compared to the national average of 11% and CCG average of 10% in 2016.
- Coronary heart disease exception reporting was 9% compared to the national average of 8% and CCG average of 7% in 2016.
- Depression exception reporting was 25% compared to the national average of 22% and CCG average of 18% in 2016.
- Atrial fibrillation exception reporting was 10% compared to the national average of 7% and CCG average of 5% in 2016.

Inadequate

Are services effective?

(for example, treatment is effective)

This practice's QOF data submitted to us regarding 2016/17 achievement was not significantly different to local or national averages from 2015/16. We noted improvement in some clinical areas. A new recall system had recently been implemented but the outcome of this new system was not yet measurable.

- Performance for mental health related indicators was 99% compared to the 2015/16 CCG average of 96% and national average of 96%. This was an increase from 81% in 2016.
- Performance for asthma related indicators was 100% compared to the 2015/16 CCG average of 99% and national average of 97%. This was an increase from 88% in 2016.

However, some areas specifically secondary prevention of coronary heart disease related indicators was still below local and national averages.

- Performance for secondary prevention of coronary heart disease related indicators was 87% compared to the 2015/16 CCG average of 97% and national average of 96%. This was an increase from 85% in 2016.

Furthermore, in some clinical areas performance was lower (had worsened) when compared to the 2015/16 performance.

- Performance for diabetes related indicators was 83% compared to the 2015/16 CCG average of 95% and national average of 89%. This was a decrease from 85% in 2016. Participation in the national diabetes audit in 2015/16 did improve diabetes performance between 2014/15 and 2015/16 in the key areas included in the audit.
- Performance for hypertension related indicators was 87% compared to the 2015/16 CCG average of 99% and national average of 98%. This was a decrease from 92% in 2016.

There was evidence of some monitoring of patients care and treatment, including repeated clinical audits. However, clinical audit was related primarily to medicine audits and no broader audit based on patient care outcomes was undertaken or was only in its preliminary stages:

- We saw an audit on all nine patients taking phenytoin (a medicine prescribed to some patients with epilepsy) which showed a high percentage of patients (55%) on phenytoin were not being monitored adequately in the first audit in October 2016. The audit was repeated in January 2017 which showed a 23% improvement as 78% of the patients had their monitoring up-to-date. The remaining patients did not respond back to the practice for review of their medicine.
- We were shown similar audits for amiodarone (which is used to treat ventricular tachycardia or ventricular fibrillation) and this audit also showed improvement at the second cycle in January 2017 and two other first cycle medicine audits. We saw the outcomes of the medicines audits had been discussed at clinical meetings.
- GPs told us there were other clinical audits underway but these were not yet completed first cycles.
- There was minimal audit in response to any identified poor clinical performance. For example, no completed audits had been undertaken to deduce the continued low performance in disease management.

We saw clinical data other than data collected for QOF was not routinely used, such as medicines' review data to identify and make improvements. For example, we requested data prior to this inspection regarding medicine reviews. One of the submissions the practice made showed only 76% of patients on more than four repeat medicines had up to date reviews and 56% of those on less than four medicines. A pharmacist had been employed from November 2016 to help improve prescribing. However, the low numbers of recorded medicine reviews restricted monitoring of repeat prescribing to ensure patients received effective medicines safely.

In the months prior to the inspection we received concerns from patients that prescriptions were not being processed in a timely way or inaccurately processed. During the inspection we saw that patients' repeat prescription requests were being processed effectively and that the process ensured patients received the correct medicines. We spoke with a local pharmacy who informed us they had not experienced any routine problems with the practices prescriptions. A local care home informed us they were able to receive completed prescriptions from the practice in good time.

Effective staffing

Patients received care from staff who did not always have appropriate checks on their skills or experience in order to

Inadequate

Are services effective?

(for example, treatment is effective)

ensure they delivered effective care. Support for staff to develop their knowledge, skills and experience to enable them to deliver good quality patient care was fragmented and not yet fully embedded.

- Most staff we spoke with were confident about their skills and knowledge to deliver effective care and treatment and we saw training was provided including specific clinical training. However, we also spoke with members of staff who had not received specific training and there was evidence training was not always monitored appropriately. We found a nurse was working in the practice and there had not been an appropriate check of their qualifications until the inspection team requested this information.
- We were provided with two versions of the training matrix and we saw most staff were indicated as having training in various topics such as safeguarding, basic life support and infection control. However, the matrix submitted to the inspection team prior to the inspection contained various gaps in staff training in some areas (for staff members who had worked for over 12 months in the practice) with no indication of whether the training was due or overdue according to the coding system on the matrix. This had been updated and reflected more completed or booked training in the version we saw on the day of inspection.
- The training matrix presented to us during the inspection on 6 June 2017 had been updated to show when staff were due for specific training areas in order to keep their training up to date. However, when speaking to staff we identified one member of staff who was listed as being trained in infection control in September 2016 did not recall having training and did not have a practical knowledge of infection control related to their role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- Staff received annual appraisals to identify training and support requirements.
- The practice management were not supervised or managed effectively to ensure adhereance to regulations relating to their Care Quality Commission (CQC) registration and all governance processes and procedures were in place and followed. Ongoing issues with the management at the practice and related poor performance had not been effectively dealt with to ensure improved management practices.

Coordinating patient care and information sharing

- The information needed to plan and deliver care and treatment was monitored and processed in a timely way and was accessible way through the practice's patient record system. This included care and risk assessments, care plans, medical records and investigation and test results.
- We looked at the correspondence system used to allocate patient summaries from external services, some of which required actions. We saw that this system had no backlog of correspondence and that administration staff dealt with referral letters, discharge summaries and other information daily.
- The referral system operated by administration staff ensured that urgent referrals were dealt with the same or next day. There was no backlog of urgent or routine referrals when we reviewed the system. From the same of referrals we reviewed from early May to June 2017 we saw they were processed within appropriate timescales.
- 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. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals when required.
- There were 155 patients (1.5% of the patient population) who were on the avoidable unplanned admissions register and we were informed they all care plans in place. This register and the care planning for these patients was aimed at reducing the risk of their admission to hospital and to provide any assistance or care they may need at home.
- According to data provided to us prior to the inspection only 54% of patients on the end of life care register had an advanced care plan in place.

Consent to care and treatment

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

Inadequate

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- There was a supporting consent policy in place.
- Most staff we asked understood their responsibilities regarding obtaining consent from patients under 16 years of age. However, one staff member stated they had not received training. The consent policy did not provide any details on Gillick competency assessment but did outline the principles of a child's rights if they are deemed to have sufficient understanding and intelligence to understand their choices.

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:

- Smoking cessation advice was available and over 1,300 smokers had been offered cessation advice onsite.
- Chlamydia screening was offered to six patients.
- There were 663 patients who had been offered dementia screening at the practice and 22 had been identified as having the condition.
- The practice's uptake for the cervical screening programme was 82% in 2015/16, which was comparable with the CCG average of 83% and the national average of 81%.
- Breast cancer screening rates were 77% compared to the CCG average of 76% and national average of 73%.
- Bowel cancer screening rates were 54% compared to the CCG average of 59% and national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given during 2015/16 were higher than national averages. For example, rates for the vaccines given to under two year olds ranged from 95% to 96% and five year olds from 92% to 95%.

Patients were offered health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. There had been 391 health checks undertaken in the last five years.

Inadequate

Are services caring?

Our findings

During our inspection in October 2016, we found that patient confidentiality was not always protected. Carers had not been routinely identified or provided with necessary support. Patient feedback on the national GP survey regarding consultations with nurses and GPs was poor. There had been minimal analysis to identify what the causes of the poor feedback were and minimal action to improve services based on the feedback. Some patients we spoke with described how they were not involved in decisions about their care they did not receive adequate support and advice about a new diagnosis.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very 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.
- Music was played near consultation rooms and reception areas to reduce the risk of confidential conversations being overheard.
- Patients could be treated by a clinician of the same sex due to the introduction of male GPs since the last inspection.

Of the 42 patient Care Quality Commission comment cards we received nearly all were positive about the service experienced. Patients said they felt the practice had improved in recent months and that staff offered a caring service and staff were helpful. They informed us that staff treated them with dignity and respect. There were two negative comments regarding phone access and booking appointments.

The NHS Friends and Family test was used to collect feedback from patients. This showed that in 2017 so far there had been 25 responses of which 68% of patients were likely or extremely likely to recommend the practice and 20% of patients were extremely likely to recommend the practice.

We spoke with two members of the patient participation group and 12 patients who also informed us that improvements had been made in recent months. They told us staff attitude had improved and that the practice provided a caring service on the whole.

Reception staff had been provided with training in customer service support to enhance their abilities to support patients in a friendly and caring manner. This had been reflected in patient feedback.

We reported on the results from the national GP patient survey from July 2016 in our inspection report from October 2016. The results showed patients felt they were not always treated with compassion, dignity and respect. The practice was below average for many of its satisfaction scores on consultations with GPs and nurses. For example:

- 77% of patients said the GP was good at listening to them (CCG average 90%, national average 89%).
- 76% of patients said the GP gave them enough time (CCG average 88%, national average 87%).
- 94% of patients said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%).
- 67% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 87%, national average 85%).
- 92% of patients said the nurse was good at listening to them (CCG average 92%, national average 91%).
- 90% of patients said the nurse gave them enough time (CCG average 92%, national average 92%).
- 95% of patients said they had confidence and trust in the last nurse they saw (CCG average 97%, national average 97%).
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 81%, national average 81%).
- 84% of patients said they found the receptionists at the practice helpful (CCG average 86%, national average 87%).

Since the last comprehensive inspection in October 2016, there had not been a review of patient feedback via a survey undertaken to identify the causes of the poor feedback from the July 2016 results.

Inadequate

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients reported in comment cards they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey showed patients responded less 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:

- 74% of patients said the last GP they saw was good at explaining tests and treatments (CCG average 87%, national average 86%).
- 63% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 83%, national average 82%).
- 80% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 90%, national average 90%).
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 85%, national average 85%).

It was unclear if the practice provided facilities to help patients be involved in decisions about their care. For example:

- The practice managers informed us that interpretation services were available for patients who did not have English as a first language. However, reception staff we spoke with were not all aware that this service was available. Furthermore, there was no information on display which advertised translation services were available.

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. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified an additional 34 patients as carers since the October 2016 inspection. Therefore the total number of patients with caring responsibilities was now 86, approximately 1% of the practice list. Written information was available to direct carers to the various avenues of support available to them. A local charity regularly promoted support available to carers via a stand within the practice. There was a carers' board providing information.

Staff told us that if families had experienced bereavement, they were contacted by the practice. If patients wanted they could book a consultation regarding any support needs they had.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During our inspection in October 2016, we found that the practice had not reviewed the needs of its local population in the previous two years. Patients reported considerable difficulty in accessing a named GP and poor continuity of care. Appointment systems were not working well and patients did not receive timely care when they needed it. The practice was not well equipped to treat patients. Information about how to complain was available for patients but was difficult to identify.

Data from the national GP patient survey showed patients rated the practice lower than others for being responsive.

During this inspection in June 2017 we found significant improvements had been made to the appointment and phone access. We also found the main practice and the branch practice (Dragon Cottage) had undergone extensive improvements to ensure patients who required additional support could safely access and use both practices.

Responding to and meeting people's needs

The practice had taken action to understand its population profile and used this understanding to improve the services for its population:

- A 'you said, we did board' had been put in the waiting area to reflect the changes made as a result of patient feedback. For example, complaints about the phone system had led to a review of the system and a change to a local telephone number.
- A review of premises in terms of the experience for patients with dementia had been undertaken. This led to changes such as more distinct colour differentiations in toilets to help patients with dementia navigate their surroundings.
- Vulnerable patients were flagged on the system to enable staff to identify their needs and prioritise them as necessary.
- A weekly visit from a GP was undertaken at a local care home to review the needs of the patients residing there. The home provided us with feedback that the practice provided a responsive service to their patients.
- Patients with diabetes could use email contact with their GP for ease of communicating their blood glucose readings.
- The practice participated in the local University's fresher fair to provide healthcare information to new students moving into the area.
- There were longer appointments available for vulnerable patients including those with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The premises had been adjusted at Dragon Cottage to enable patients to access the building.
- The main site was accessible and a lift enabled access for patients who required this adjustment in order to access consultation rooms on the first floor.
- There were toilets accessible for disabled patients, baby changing facilities and breast feeding area.
- Other reasonable adjustments had been made and action taken to remove barriers when patients find it hard to use or access services.

Access to the service

Chiltern House Medical Centre was open between 8.00am and 6.30pm Monday to Friday. Dragon Cottage was open between 8.00am and 6.30pm Monday to Friday with the exception of Thursdays when it closed at 2pm. Extended surgery hours were offered on Tuesday evenings until 8pm at Chiltern House Medical Centre. Patients could book appointments online and via the telephone.

Results from the national GP patient survey in July 2016 showed that patients' satisfaction with how they could access care and treatment were lower than local and national averages.

- 68% of patients were satisfied with the practice's opening hours (CCG average 72%, national average 75%).
- 63% of patients said they could get through easily to the practice by telephone (CCG average 76%, national average 73%).
- 29% of patients said they always or almost see or speak to the GP they prefer (CCG average 66%, national average 59%).

Since the last inspection the practice had responded to patient feedback regarding the telephone system and appointment booking. This included additional GP appointments provided via additional GP locums. There

Good

Are services responsive to people's needs?

(for example, to feedback?)

had also been a change to the telephone system. Patients we spoke with and feedback from comment cards indicated improvements to the appointment access and booking. We looked at the appointment system and saw that the use of locums GPs had increased appointment capacity. We saw from the live appointment system that a routine appointment could be booked the next day and there was still availability on the day of inspection for an urgent appointment.

The practice had a system to assess:

- Whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- There was a complaints policy which was in line with recognised guidance and contractual obligations for GPs in England.
- We saw that complaints received in writing were investigated and responded to.
- We looked at an example of complaints received between March 2017 and May 2017. We saw that there had been analysis of the trends which highlighted telephone access had been a concern. Written and verbal patient feedback collected during the inspection reported an improvement in telephone access. We noted from the complaints, no complaints regarding telephone access had been received during May 2017 and the first week June 2017. The practice presented findings from a telephone wait time audit undertaken between March 2017 and May 2017. This audit showed 97% of patient calls had been answered but did not identify any clear trends of improvements during the collection period (March 2017 to May 2017).

Are services well-led?

Inadequate

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

Our findings

In October 2016, we found the practice had poor governance arrangements. This led to a lack of monitoring of patient care and treatment and weak processes ensuring risks to patients were assessed and used to drive improvement. There was a leadership structure but there was limited capacity, capability and experience to make substantial improvements to the high levels of risk identified at the last inspection and from the NHS England action plan. The practice had not responded to or taken all the appropriate actions from the last Care Quality Commission (CQC) inspection report and the action plan developed with NHS England in early 2016.

During this inspection on 6 June 2017 we found the practice had taken some action to improve clinical governance and day to day monitoring of both clinical and non-clinical tasks. However, the practice had failed to assess the requirements relating to all the of regulations and good governance. The previous three inspections also identified governance related risks which has led to a long term continued breach of regulation. We have used our enforcement powers to ensure the provider considers and meets all of the requirements of the regulations.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. However, the delivery of this vision was not ensured, as there was a lack of visible leadership and a lack of detailed or realistic plans to achieve the practice vision.

- There had been a staff away day since our last inspection in October 2016. This away day led to the implementation of new practice principles including a review of culture within the practice. Staff informed us they had been informed about the new principles and felt involved in the practice's vision.
- There were details of the practice vision and practice values displayed on the practice website. However, the evidence found at this inspection and the previous inspections identified that the practice was still not meeting the aims and objectives within practice vision. Although some improvements have been made, we have identified significant concerns on all four inspections; this would have an impact upon providing good quality and safe care.
- At this inspection we identified that there was not a culture whereby staff were always clear on every aspect of their roles. Some of the leadership team were not always following their own practice processes to ensure that daily functions in the practice were functioning and monitored.

Governance arrangements

The governance arrangements and their purpose are unclear. The practice had a governance framework which was not always effective or well managed. Monitoring of patient care and daily tasks had improved but we found continued operational governance concerns which had been identified at the last two comprehensive inspections. The significant issues found on all the inspections that threaten the delivery of safe and effective care were still not adequately managed.

- At our inspections in February 2016 and October 2016, we identified and reported on a number of risks during the inspections and then reported these directly to the practice in the subsequent inspection reports. The practice was placed into special measures in December 2016 and had been offered support and guidance from the Royal College of General Practitioners (RCGP) and local commissioners. The RCGP deliver support programmes for practices placed into special measures providing a package of expert advice intended to make significant improvements. The practice accepted support from NHS England, the clinical commissioning group and RCGP. However, this support was not fully utilised to make the necessary improvements required to take the practice out of special measures. Information from the previous three CQC inspection reports had not led to full system reviews and sustainable improvement of the areas identified as requiring action.
- Arrangements for safeguarding were in place and there was a safeguarding lead. However, we found an example where a child on the safeguarding 'at risk' register had not attended a hospital appointment and no follow up action was noted in the patient's records. We were informed the safeguarding lead at the practice only worked two sessions each week, this may have resulted in a delay for staff seeking safeguarding advice and guidance. Furthermore, we found that one out of four of the locum GP staff records we reviewed did not

Are services well-led?

Inadequate

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

contain a DBS check and some reception staff, who potentially may be asked to be chaperones according to the practice policy, were still in the process of receiving a disclosure and barring service (DBS) check.

- The system for ensuring staff were fit and appropriate to work with patients was still not ensuring all the required background checks were in place, despite CQC identifying and reporting concerns after the February 2016 and October 2016 inspections. The practice rectified the specific issue identified in both previous comprehensive inspections regarding hepatitis B immunisation checks for staff but did not review their entire system for checking staff were safe to provide care and treatment to patients. Similarly the system for monitoring staff training did not ensure that staff had the skills and experience necessary to deliver care and treatment.
- The understanding of the performance of the practice had slightly improved since October 2016 via more medicine audits and monitoring of patient outcomes. However, audits were limited to medicine searches on the system and not in response to broader clinical area where performance and quality could be improved. We also saw low and in some cases reduced performance in several areas, for example in the management of patients with learning disabilities, end of life patients and the care and treatment of patients on more than four repeat medicines. This had not been identified and acted on.
- Practice policies were in place but did not always contain the detail required. For example, the recruitment procedure did not include what staff checks may be required. The consent policy did not include full guidance on the Gillick competency. Practice meetings had been implemented which provided an opportunity for staff to learn about the performance of the practice, outcomes from significant events and complaints and provided protected learning time. Staff commented they valued these meetings and that they were informed about learning outcomes from significant events and complaints.

Leadership and culture

The leaders did not have the necessary experience, knowledge, capacity or capability to lead the practice effectively. The GP partners demonstrated they had the motivation to improve the services patients experienced but they did not always ensure that systems were in place to ensure improvements were followed through. Despite having an action plan to improve the services provided, a number of regulatory breaches from February 2016 and October 2016 remained concerns at the June 2017 inspection.

The practice had experienced significant staff turnover and low numbers of permanent staff which had provided difficulties in enabling improvement. However, the core management team which remained had not ensured that governance and leadership had been clearly defined and delegated. Whilst some improvements had been made these were incremental at each inspection and the governance framework remained ineffective and poorly managed. During all of the inspections there has been a lack of clarity about authority to make decisions.

The registered manager did not make contact with CQC prior to the inspection and was not available to speak with on the day of inspection. However, we have subsequently discussed the findings of the June 2017 inspection with the registered manager. We saw the registered manager worked minimal hours at the practice, the practice told us this equated to one session a week. The Health and Social Care Act 2008 states that registered providers must have a registered manager, set out in the regulations. The intention of this regulation is to ensure that people who use service have their needs met because the regulated activity is managed by an appropriate person. Following the June 2017 inspection we discussed with the practice that we were not assured the current arrangements ensured patients at Chiltern House Medical Centre had their needs met or these arrangements met the requirements of the Health and Social Care Act 2008.

The provider was aware of and had 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). The GP partners had improved the culture towards openness and honesty. From complaint examples and significant events we reviewed we found that the practice now had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

Are services well-led?

Inadequate

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

- Staff felt supported by management.
- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice had taken some action to act on feedback from patients and staff since October 2016. However, improvements were still required.

- The service did not always respond to what people who use services or the public say. Feedback available to the practice from NHS Choices had not fully considered. We looked at the NHS Choices website prior to the inspection. Patient feedback from 2017 on NHS Choices was responded to by the practice with a standard response which indicated that patients could complain in writing. The individual feedback was not considered, investigated where possible and responded to or used to make improvements.
- There had been improvements to the appointment system and repeat prescribing process as a result of patient feedback. These were communicated on a board in reception for patients to understand how their views had been considered.
- We spoke with two members of the patient participation group (PPG). The PPG had been set up in January 2017 and met periodically to discuss local feedback on services. The PPG explained to us they had seen a change in culture regarding the recognition among the partners that openness was needed in order to improve services. The PPG was in the process of undertaking a survey.
- Patient feedback was received and considered in the form of complaints and compliments. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

We found there was a focus on improvement of patient services in relation to the CQC Commission inspections. For example:

- Improvements had been made to both the premises, concerns regarding controlled drugs had been resolved, and the identification of patients with caring responsibilities had improved. Written and verbal patient feedback collected during the inspection also highlighted improvements to the telephone system, appointment availability and staff demeanour.

However, there was not sufficient review and improvement to governance systems and as a result the practice was still not providing good quality and safe care.

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 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 provider was not ensuring care and treatment was being provided in a safe way for service users via assessing the risks to the health and safety of service users of receiving the care or treatment. The provider had not ensured the proper and safe management of prescribed medicines, staff background checks, checks of staff qualifications, infection control, action required following pathology results and health checks for patients with learning disabilities. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures 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:** There were not sufficient systems of clinical governance to ensure that the provider could assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity or assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

This section is primarily information for the provider

Enforcement actions

The provider did not act on all feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

This included not acting on risks previously identified and reported by the commission, including monitoring of training, staff background checks, the prescribing of patients' medicines and other risks to patients' care and welfare.

This was in breach of Regulation 17 (1) Good governance.