# St Lukes Surgery

## Quality Report

St Luke's Close
Hedge End
Southampton
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Tel: 01489 783422
Website: www.stlukesandbotleysurgery.co.uk

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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? | Good |
| Are services responsive to people's needs? | Inadequate |
| Are services well-led? | Inadequate |

# Key findings

## Contents



## Letter from the Chief Inspector of General Practice

**This practice is rated as Inadequate overall.** (Previous inspection December 2016 – Good)

The key questions are rated as:

Are services safe? – inadequate

Are services effective? – inadequate

Are services caring? – good

Are services responsive? – inadequate

Are services well-led? - inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. Due to the overall rating being inadequate this affects all population groups which are rated as:

Older People – inadequate

People with long-term conditions – inadequate

Families, children and young people – inadequate

Working age people (including those retired and students – inadequate

People whose circumstances may make them vulnerable – inadequate

People experiencing poor mental health (including people with dementia - inadequate

We carried out an announced comprehensive inspection at St Luke's Surgery on 12 February 2018. This inspection was planned as part of our inspection programme but was brought forward in response to concerns.

At this inspection we found:

- Since our last inspection the practice had sought support through another GP organisation for some management practices, this had been in place since October 2017. Patients were told there had been a merger; however, this is limited to the provision of support from Living Well Partnership. The registration of St Luke's remains in place and patients can only be seen where they are registered or at an out of hours hub.
- The leadership at St Luke's Surgery had declined and there was no longer a registered manager.
- There was a lack of clear leadership to deliver the practice's vision and strategy. Staff turnover had resulted in a number of vacancies including for senior or middle management and clinical roles.
- The practice had an information security breach in the few days before our inspection that was publicised on their website.
- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen.

# Summary of findings

- Risk assessments were in place but not always reviewed or updated. There was no action plan to address issues raised at the last infection control audit dated March 2017.
- Not all staff had a record of having completed safeguarding training.
- Weekly fire tests had not been documented as being carried out since 24 November 2017 at the branch site.
- The quality of information captured and evidence of learning from significant events was limited.
- The practice had higher than average exception reporting levels for several clinical indicators.
- There was limited evidence that the practice was engaging in quality improvement programmes.
- There were vacancies in the nursing team resulting in a gap in skills mix for monitoring of long term conditions such as asthma.
- Staff involved and treated patients with compassion, kindness, dignity and respect. There was mixed feedback from patients about the quality of care they felt they received.
- Patients found it difficult to use the appointment system and reported that they were not able to access care when they needed it. There was limited evidence to demonstrate how the practice was responding to concerns raised by patients around accessing the service.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

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

- Review survey results to identify what can be done to improve patient satisfaction.
- Review ways to identify and support patients registered at the practice who are also carers.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

# 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** |
| **People with long term conditions** | **Inadequate** |
| **Families, children and young people** | **Inadequate** |
| **Working age people (including those recently retired and students)** | **Inadequate** |
| **People whose circumstances may make them vulnerable** | **Inadequate** |
| **People experiencing poor mental health (including people with dementia)** | **Inadequate** |

# St Lukes 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 a second inspector, a GP specialist adviser and a practice manager specialist adviser.

## Background to St Lukes Surgery

St Luke's Surgery is commonly known to patients as St Luke's and Botley Surgeries. St Luke's Surgery is the registered location and Botley Health Care Centre is a branch site. St Luke's Surgery is based in Hedge End on the outskirts of Southampton. Botley Health Care Centre is in the nearby town of Botley. There are limited public transport links between the two. The practice (including the branch site) has a patient list size of approximately 12000 registered patients.

St Luke's Surgery is located at the following address: St Luke's Close, Hedge End, Southampton, Hampshire, SO30 2US.

The branch site is located at this address: Botley Surgery, Botley Health Care Centre, Mortimer Road, Botley, Hampshire.

St Luke's Surgery and branch site are part of the West Hampshire Clinical Commissioning Group.

We visited both the main location and branch site as part of this inspection.

The clinical team at St Luke's and Botley Surgery consisted of two GP partners and a further three salaried GPs. The nursing team consisted of two nurse practitioners and three nurses as well as two health care assistants. The clinical team were supported by managerial and administrative staff.

At the time of the inspection St Luke's Surgery were using another registered provider The Living Well Partnership for some of their management processes.

The ethnicity of St Luke's Surgery practice population has over 95% of its patient to identify as White British. The practice is in an area of low deprivation. There is a slightly higher than average number of patients who are under 18 years old when compared to the local and national averages.

Inadequate

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as inadequate for providing safe services.**

The practice was rated as inadequate for providing safe services because:

- Risk assessments were in place but not always reviewed or updated. There was no action plan to address issues raised at the last infection control audit dated March 2017.
- Not all staff had a record of having completed safeguarding training. There was no evidence to demonstrate that safeguarding awareness was covered during the induction period.
- There was not a supply of rectal diazepam in the emergency medicines box.
- Weekly fire tests had not been documented as being carried out since 24 November 2017 at the branch site.
- The quality of information captured and evidence of learning from significant events was limited.

**Safety systems and processes**

The practice had some systems to keep patients safe and safeguarded from abuse. However, some of these systems were inadequate, not updated or not fully embedded into practice.

The practice conducted some safety risk assessments. For example:

- The overarching health and safety policy was due for a review in March 2018. The risk assessment was completed in 2012 and we saw evidence that walk around checks of the premises had been completed.
- The practice had a generic Legionella policy stored on the practices shared drive. The practice had a Legionella risk assessment completed by a specialist company in December 2014. The policy had no connection to the risk assessment that was completed. We saw some attempt to address the issues raised in the risk assessment. On the day of the inspection the practice were unable to provide us with documentation to show that management controls had been undertaken. The log book did not evidence that the practice had completed regular testing of the water temperature. However, following the inspection the practice sent a copy of the certificate to evidence that water testing had been completed by an external company in December 2017.
- Staff had access to a range of safety policies on the practice's shared drive. Staff received safety information for the practice as part of their induction and refresher training. Fire safety update training was booked for March 2018.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. There was not a section in the induction checklist to evidence that staff had undertaken safeguarding training as part of their induction period. However, all staff spoken to on the day of the inspection demonstrated some awareness of what a safeguarding concern might be.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Staff were able to explain what a safeguarding concern was and some staff were able to provide an example of a situation they had been in when they had had to raise a concern.
- The Living Well Partnership managed recruitment for the practice. They carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). As part of this arrangement the practice had recently moved all staff personnel files off site and over to one of the premises of The Living Well Partnership. We visited this site to have a look at the management of this process.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- Systems for managing infection control were ineffective. For example:

- The practices infection control policy stated that regular audits would occur. The last documented infection control audit undertaken by the practice was in 2014. However the practice had asked the local clinical commissioning group to complete a full infection control audit which was undertaken in March 2017. This audit identified 13 recommendations that the practice should do and a further two that they could do. The only evidence of completion was seen in the form of a tick next to two recommendations. There was no subsequent action plan in place to evidence what the practice was going to do to address the remaining issues or expected dates of completion.
- Some recommendations were listed as requires further action and with a moderate impact on patient safety. This included addressing issues of dust on equipment such as the ECG machine trolley. On the day of the inspection we visited the branch site (Botley Health Centre) and found a thick layer of dust and cobwebs on top of the vaccine fridge that was stored in the administration office.

- The practice had failed to ensure that all facilities were safe and that equipment was maintained according to manufactures instructions. For example:
  - The July 2016 health and safety 'walk around' of St Luke's Surgery raised action points of redecoration required and filling of cracks on the stairs. It was unclear what risk assessment these issues had been raised from or what level of risk this posed and there was no date for the action to be completed by. At our inspection on 12 February 2018 we noted that the stairwell had not been redecorated and that there appeared to be some loose looking plaster near the ceiling.
  - There were systems for managing healthcare waste.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There were several vacancies that the practice were recruiting for. The practice had engaged in a business arrangement with another provider, who were registered separately with CQC, to assist with back office support (The Living Well Partnership). Under this arrangement the clinical and non-clinical staff from the other provider were able to work at St Luke's Surgery to provide support or cover when required.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, we were told that St Luke's Surgery would cap appointments to prevent overwork of clinicians as a way of maintaining staff and patient safety.

**Information to deliver safe care and treatment**

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

**Safe and appropriate use of medicines**

The practice did not have an effective system for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment did not fully minimise risks. The practice had a defibrillator and oxygen available for use in an emergency. The emergency medicines box at the practice had a record to show that in January 2018 there were two rectal diazepam medicines stored in the emergency medicines box. However, on the day of the inspection there was only an empty

box and recorded as none present and on order. The empty box had an expiry date of June 2018. We discussed this with the practice who could not account for what had happened to these medicines.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. All Patient Group Directives (PDGs) had been signed in by nursing staff when new PGDs were issued in March and April 2017. However, the counter signatory by an authorised clinician had not taken place until October 2017. The practice kept prescription stationery securely and monitored its use.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately.

**Track record on safety**

We observed a difference in the quality of reporting and monitoring of risk assessments in relation to safety issues since 2017 and particularly since the planning of the reorganisation of St Luke's Surgery which took place from October 2017. For example:

- The practice received patient safety alerts through a central email address. The spreadsheet used by the practice to record these alerts had not been updated since 2016. Alerts received via email were disseminated to staff. The practice had previously documented in the log book details of every weekly fire alarm test at the branch site. However, since 24 November 2017 these had not been recorded as having taken place.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- There were systems for reviewing and investigating when things went wrong which had changed since October 2017 with the support of The Living Well Partnership. The practice continued to submit their significant events through an online reporting tool however had stopped using their own document which had previously been used to capture information and learning alongside the online tool. There was evidence that incidents were reviewed at meetings and that learning from some but not all incidents were shared with staff.
- There was evidence to demonstrate that incidents were shared with other organisations to assist with learning however, the documenting of what learning had occurred or other changes to practice was inconsistent. For example, we saw an example of how the practice had appropriately responded to an incident. The event summary showed the incident was raised on 10 November 2017 and at a review on 16 January 2018 the recommended action by the Local Medical Committee had still not taken place. At the time of inspection the incident remained open for a final review but a date was not recorded for when this would be.

There was a system for receiving and acting on safety alerts which were received via a generic practice address and the administration team checked for updates on a daily basis disseminating information to staff as appropriate. Discussions with staff demonstrated awareness safety alerts which they said they would review as and when they came through. The practice had a log in place to capture what updates had been received but this had not been updated since 2016. A manager from the practice was unaware whether the log was being updated or not. There was no process in place to record that relevant staff had received or read the required information.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as inadequate for providing effective services overall and across all population groups.**

The practice was rated as inadequate for providing effective services because:

- The practice had higher than average exception reporting levels for several clinical indicators. The practice provided little evidence to demonstrate how they were addressing this.
- There was limited evidence that the practice was engaging in quality improvement programmes.
- There were vacancies in the nursing team resulting in a gap in skills mix for monitoring of long term conditions such as asthma.

**Effective needs assessment, care and treatment**

The practice had some systems to keep clinicians up to date with current evidence-based practice. The practice would receive information and updates through a central email address which administrative staff would check daily and disseminate to the relevant staff. However, there was no way to identify whether staff had received or read the information in the email. The practiced used templates on the electronic records system which were updated regularly.

We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was not an outlier for any prescribing data when compared to local and national averages.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

This population group was rated inadequate because the overall rating of inadequate affects all population groups.

There were some areas of good practice:

- The practice had employed a dedicated full time GP with specialist interest in frailty. This GP undertook all the home visits to housebound patients and conducted regular or routine reviews. This included follow up reviews post hospital discharge.
- The practice conducted a weekly ward round at two of the nursing homes in the local area. If patients from these homes needed to see a GP in between the ward rounds then they were able to request a visit from the dedicated GP who would attend.
- Annual flu, shingles and pneumonia vaccinations were offered in line with national guidelines.

People with long-term conditions:

This population group was rated inadequate as the rating of inadequate to safe, responsive and well-led affect all population groups. Due to a nurse vacancy asthma reviews were being conducted via the telephone and then booking a GP appointment for those whose asthma was not controlled. The practice were in the process of recruiting a nurse specialising in respiratory care.

There was however, some areas of good practice:

- The practice engaged in multi-disciplinary meetings and some patients with complex long term conditions will be included for discussion.
- The practice was generally in line with or better than local and national averages for monitoring of long term conditions. However, their exception reporting levels were higher than local and national averages. The practice could not explain what they were doing to address this beyond recruiting for staff with specialist knowledge in these areas.

Families, children and young people:

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups.

There were however some areas of good practice:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target

percentage of 90%. The practice had an average score of 9.8 out of 10 compared to the national average of 9.1. The practice consistently scored above 97% for each indicator.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

This population group was rated inadequate because the inadequate rating for safe, responsive and well-led affects all population groups.

There was however some areas of good practice:

- The practice offered an e-consult service for individuals who may not be able to attend the practice during core opening hours.
- Patients were able to access extended hours appointments as part of the Eastleigh Southern Parishes Network 'hub' which the practice was part of. Patients who were unable to book an appointment during working hours would be able to contact the practice and ask for an appointment at the hub to be seen after 6.30pm.

People whose circumstances make them vulnerable:

This population group was rated inadequate because the rating of inadequate for safe, responsive and well-led affects all population groups.

There were however some areas of good practice:

- Children highlighted as vulnerable were discussed at monthly health visitor and school nurse meetings. Flag alerts were added to these patients notes.
- Annual health checks were offered to patients with learning disabilities. The practice held learning disabilities register.

People experiencing poor mental health (including people with dementia):

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups.

There was however some areas of good practice:

- The practice had been awarded dementia friendly status.
- Patients were able to self-refer to the local talking therapies service.
- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average. Exception reporting levels were also in line with national averages.
- 91 of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average. Exception reporting levels were also in line with national averages.

**Monitoring care and treatment**

The practice provided limited evidence to show they engaged in a programme of quality improvement activity beyond those they were required to engage in. We had limited to no examples of where clinicians took part in local and national improvement initiatives. The patient services manager told us that oversight of practice performance and other benchmarking was by the clinical leadership team. However, when we spoke to the GP partners they were unable to provide us with clear examples of how improvements had been made to practice following a review of audits or other quality improvement initiatives.

St Luke's Surgery achieved 552 points out of a possible 559 points in the most recent published Quality and Outcome Framework (QOF) results for 2016-2017. Exception reporting levels were higher than local and national averages for several clinical indicators. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The combined exception reporting total for cancer indicators was 32% compared to the Clinical Commissioning Group (CCG) average of 23% and the national average of 25%.
- The combined exception reporting total for asthma indicators was 19% compared to the CCG average of 10% and national average of 6%. 434 out of 500 patients

Inadequate

# Are services effective?

## (for example, treatment is effective)

registered at the practice who had a diagnosis of asthma had a review of their asthma within the previous 12 months which included an assessment of asthma control. The practice exception reported 102 patients who were eligible for this check which was a percentage of 17% and above the local and national averages.

- The practice could not demonstrate what they were doing to make improvements to their exception reporting levels.
- We were told that there had been a high turnover of clinical staff with specialisms in management of long term conditions such as diabetes and asthma and that they had recently recruited or were recruiting to fill these gaps in expertise.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice had limited understanding of the learning needs of staff. Some clinicians told us there was limited time during core working hours to engage in study or training but that they could be paid to engage in this outside of their contracted hours. For example, we were told by a member of staff about the lack of time during practice hours to engage in mentoring activities which were required as part of a practice nursing course. A staff member also told us that they thought the biggest challenge to delivering good quality care was staying up to date on training due to the demand for appointments resulting in them missing out on opportunities to do so. Some administrative and reception staff spoke of a lack of opportunities to develop beyond their role.
- We saw evidence of the induction checklist in three staff personnel files employed since the start of January 2017. Each checklist was a blank template and had not been signed by the individual or manager. We saw partially completed review meetings completed at one week, one month and three months. Not all staff had received an appraisal in the past 12 months. There were no dates identified for these staff members' appraisals. The patient services manager was not aware that nursing staff had not been having their appraisals. The practice had not allocated an individual to oversee the appraisals of these staff in the absence of a nurse manager. Roles and responsibilities of the nurse manager had been shared out informally between the nursing team.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

**Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients receiving end of life care, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Inadequate

# Are services effective?

## (for example, treatment is effective)

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

The practice was rated as good for caring because:

- The amount of people that would recommend others to the practice was lower than local and national averages although data provided by the practice showed this was an improving picture over 2017.
- There was mixed patient feedback about the quality of care patients felt they received with some stating it was positive whilst other spoke negatively.
- Data captured from the GP patient survey was comparable to local and national averages.

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- The practice collated the data they received from the Friends and Family Test from February 2017-January 2018. This showed an improving picture with data from the last quarter of data collection identifying that over 50% of patients stating they would be likely or extremely likely to recommend the practice. The practice acknowledged this was below the target they hoped to achieve. The data captured mirrored responses in the GP patient survey where they were also below local and national averages for the same question. The practice provided us with a sample of data captured from January 2018 through the 'app' in the waiting room. Comments were mixed and ranged from the positive of being happy with the treatment given and friendly staff to the negative stating that staff were rude and a low quality of staff.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 228 surveys were sent out and 104 were returned. This represented about 1% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 57% of patients stated they would definitely or probably recommend their GP practice compared to the clinical commissioning group (CCG) average of 83% and the national average of 79%.
- 89% of patients who responded said the GP was good at listening to them compared with the CCG average of 91% and the national average of 89%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 96%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 88%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; (CCG) –94%; national average - 91%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care. Some but not all non-clinical staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Good

# Are services caring?

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 179 patients as carers (1% of the practice list).

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We received positive feedback about the support provided to family members of patients who were receiving end of life care.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 85% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 86% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 85%; national average - 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 92%; national average - 91%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as inadequate for providing responsive services.**

The practice was rated as inadequate for providing responsive services because:

- The practice had not fully understood the needs of its population and tailored services in response to those needs.
- Not all patients could get a routine appointment to see a GP when they wanted to although urgent appointments were available.
- GP patient survey scores were below local and national averages for responsiveness.
- Patient complaints were recorded but there was not always evidence of patients having received a response to their complaint or a documented outcome around learning. The practice undertook a trend analysis of complaints but showed little evidence as to how they would address these issues.

**Responding to and meeting people's needs**

The practice had not planned or delivered services to meet patients' needs. Patients' needs and preferences were not taken account of.

- The practice had not fully understood the needs of its population and tailored services in response to those needs. The practice was in the process of developing roles to allow the practice to be more responsive to patients needs but these were in their infancy. For example the practice had recruited a GP to specialise in end of life care and for the elderly.

  The practice did offer online services such as e-consultations.
- Opening times for the branch site were shorter than those offered at St Luke's Surgery.. For example on a Monday and Tuesday the branch site was open from 8.30am to 1pm. Patients would have to travel to St Luke's Surgery if they needed an appointment outside of these time, however, public transport links between the two sites were limited.
- The practice did not directly offer extended hours. However, the practice was part of the Eastleigh Southern Parishes Network which provided additional services which included the provision of extended hours appointment options.
- The facilities and premises were generally appropriate for the services delivered. When there were shortfalls with accessibility, the practice had taken some steps towards improvements. For example at the branch site patients reported that the door to access the building was heavy and difficult to open for some patients. As a result the practice added a doorbell for patients to use to gain assistance with opening the door to enter the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had purchased a machine to monitor blood levels for patients on warfarin in house. However, we were told that this machine had never been used. Patients had access to phlebotomy services at both the location and branch site as well as through the Eastleigh Southern Parishes Network which St Luke's Surgery was part of.
- We heard accounts from patients, staff and review of significant events that not all patients had received the care and treatment they required in a timely manner which in some cases had resulted in a hospital admission.

Older people:

This population group was rated inadequate because the inadequate rating for safe, responsive and well-led affects all population groups. However there was some areas of good practice, for example:

- The practice had employed a full time GP with specialist interest in frailty. This GP conducted all the home visits for this population group. They also offered telephone and email support for patients who were identified as frail, elderly or vulnerable.
- The GP was the dedicated GP for all patients under this population group to deliver continuity of care.

Inadequate

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice engaged in a care navigator service with a dedicated care navigator allocated to the practice. This person was able to visit elderly patients at home, including during weekends and offer signposting to local support groups or agencies.
- The practice had provided the nursing homes with an emergency contact number for the practice to bypass the main telephone system.

People with long-term conditions:

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups

- Due to a nurse vacancy asthma reviews were being conducted via the telephone. Face to face appointments were only being offered to patients who were deemed over the telephone to not be in control of their asthma or were unwell. The practice had recently started running the National Diabetes Prevention Programme which is a national programme aimed at identifying patients at risk of type 2 diabetes and referring them for early intervention programmes.

Families, children and young people:

This population group was rated inadequate/because the inadequate rating to safe, responsive and well-led affects all population groups. However there was some areas of good practice, for example:

- The practice offered midwifery support for mothers this included antenatal and post-natal checks.
- Young people registered at St Luke's surgery (and branch site) had access to the teenager drop in centre which provided counselling services.

Working age people (including those recently retired and students):

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups. However there was some areas of good practice, for example:

- Appointments were only available from 8.30am to 6.30pm. Extended hours appointments were available through the Eastleigh Southern Parishes Network (which the practice was part of). Patients could request an extended hours appointment by contacting the practice.
- E-consultation services were available.

People whose circumstances make them vulnerable:

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups. However, there were some areas of good practice, for example:

- Children identified as vulnerable were discussed at monthly health visitor and school nurse meetings.
- Annual health checks were offered for patients with learning disabilities.

People experiencing poor mental health (including people with dementia):

This population group was rated inadequate because the inadequate rating to safe, responsive and well-led affects all population groups. However, there was some evidence of good practice, for example:

- The practice had been accredited as a dementia friendly practice.
- Patients could self-refer into talking therapy programmes.

**Timely access to the service**

Patients were able to get an urgent appointment if required. However, not all patients were able to access care and treatment from the practice within an acceptable timescale if the needs were not urgent. The practice had recognised an increase in patient complaints, both formal and informal, around difficulties in getting an appointment. The practice had written a letter to patients and included a message on their website in response to this acknowledging difficulties in getting an appointment and encouraging patients to use the e-consult service available.

- Patients had access to initial assessment, test results, diagnosis and treatment although this was not always timely. For example, we were told that at the branch site there required to be a GP on site at all times when clinics were running. We were told that on Friday 9 February 2018 at the branch site there was not a GP available there for a period of two hours. We were told

that this meant that the nurses had to cancel all appointments for patients who were due to see the nurses during that time period. Patients were offered an appointment for Tuesday 13 February.

- On the day of inspection patients spoke of difficulties in getting routine appointments and delays to wait times when at the practice. Some spoke of delays of up to 40 minutes but they were kept informed by reception staff.
- The practices system for offering routine appointments allowed only for patients to book a week ahead. Appointments would be released at 9am each morning to book for the corresponding day the following week. For example on Monday 12 February there were six routine appointments available to book for Monday 19 February. By the end of the morning of our inspection all routine appointments for the following Monday were booked. Staff were having to turn patients away without an appointment but offered the e-consult service or to leave with the administration staff to see what they could do. We saw four patients who attempted to get a routine appointment but were unable to do so. Staff told us that patients would queue up outside the practice at 8am ahead of the appointments being released at 9am. The practice had no plan in place to address this.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and interviews with patients. 228 surveys were sent out and 104 were returned. This represented about1% of the practice population.

- 72% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 80%.
- 39% of patients who responded said they could get through easily to the practice by phone; CCG – 80%; national average - 71%.
- 48% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 82%; national average - 76%.
- 45% of patients who responded described their experience of making an appointment as good; CCG - 77%; national average - 73%.

The practice told us that they were aware the phone system was not suitable to meet the current demands. The practice told us that there were constraints with the number of phone lines able to run into the practice. The spoke of being aware of the potential options but at the time of inspection there was no definitive plan in place to resolve the issue. The practice was aware patients were unhappy with the appointment system and had issued a letter to patients encouraging the use of the e-consult service.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously. Most but not all complaints were reviewed and responded to appropriately.

Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

- The complaint policy and procedures were in line with recognised guidance. The practice had received 39 complaints in 2017. We reviewed seven of these complaints and found that only three of those were satisfactorily handled. Some but not all of the complaints received since November 2017 had a record to evidence that the patient had received a response to their complaint. There was also no evidence in the learning log to show this detail or whether the case was closed. A patient had complained about a recent data protection breach (January 2018) that occurred at the practice. We saw evidence that the practice had responded to that patient's complaint explaining that they were currently investigating this. There was also information about this breach on their website.

The practice learned lessons from individual concerns and complaints, although these were not always fully documented. The practice completed an analysis of trends. In 2017 the majority of the complaints were about consultations (12 complaints) and appointments (11 complaints). There was limited evidence provided by the practice to show what learning had occurred from these or what was being done to address the issues.

# Are services well-led?

Inadequate

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

## Our findings

**We rated the practice, and all of the population groups, as inadequate for providing a well-led service.**

The practice was rated as inadequate for well-led because:

The delivery of quality care was not assured by the leadership, governance or culture. In particular

- Shortfalls in leadership roles and responsibilities did not enable the practice to deliver the vision and strategy of the practice.
- There was a significant staff turnover and a high vacancy rate. There was a lack of defined management structures in place to have oversight of how vacancies would be covered whilst recruitment was on going.
- Information and decision making processes did not always reach all members of relevant staff.
- Staff reported feeling stressed and overworked but enjoyed working with their colleagues. Staff spoke of frustrations about inabilities to do their job to the best of their ability due to current demands.
- Not all staff considered the leadership team were open and transparent and staff were not confident in raising concerns.
- Oversight of monitoring systems and processes to mitigate risk including gaps in training records and actioning recommendations from risk assessments were not effective and did not fully minimise risk.

**Leadership capacity and capability**

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were aware of the issues and priorities relating to the quality and future of services and as such had engaged in a business agreement with another provider to assist with back office support and the sharing of staff across locations. This arrangement was from 1 October 2017 but delays in the implementation of these processes had not enabled reviews of leadership roles and responsibilities to be carried out in a timely manner. Work had only recently commenced on redefining the management structure of the practice.
- There lacked a stable leadership team. At the time of our inspection we saw there were at least four vacancies that had yet to be filled. These included key leadership roles including a nurse manager and reception site lead. The practice had significant levels of staff turnover. The practice was unable to demonstrate fully how this was being managed to ensure patient care was not affected. The delay in re-defining leadership roles had impacted on recruitment, with some roles not being able to be recruited to until specific management roles were filled for example identifying of a site lead for St Luke's Surgery.
- Leaders at all levels were visible and approachable. Some staff told us that they considered the leadership team lacked transparency and openness with regards to informing them of changes to the practice. For example, staff spoke of consultations about the reorganisation not happening within the given timescales.
- There was a lack of support and oversight of the nursing team's roles and responsibilities. At the time of the inspection the nursing team were without a nurse manager as this role was being recruited for. The nursing team spoke of informally sharing out nurse manager responsibilities between them and named someone they would approach in the team for guidance.

**Vision and strategy**

On the 1 October 2017 the practice engaged in a business arrangement with another GP provider to provide back office support to St Luke's Surgery which included centralising systems and sharing of resources. We were told that this arrangement occurred in part as they had similar visions and strategies. This had not been communicated effectively to all members of staff who worked in the practice. For example:

- Not all staff spoken to were aware of or understood the new vision, values and strategy and their role in achieving them. Some spoke of knowing the old vision as St Luke's Surgery and reported that this used to be on the wall for all staff to see but that this was not the case for the vision under the new business arrangement.
- The strategy set out to achieve the vision was not fully embedded into practice and the planned operation of service was not currently meeting the needs for some of the patients registered at the practice and in particular

# Are services well-led?

Inadequate

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the population group of long term conditions and the elderly as well as those who live close to the branch site. For example, the branch site on some days was only open until 1pm. Patients would have to access appointments at St Luke's Surgery if an appointment was required outside of these times. However, public transport links between the two sites were limited. Also the practice had a higher than average exception reporting level for some clinical indicators relating to the elderly population and long term conditions. There had been gaps in skills mix within the nursing team which the practice were recruiting for (such as asthma and diabetes). The practice could not tell us what they were doing to address these issues in the interim.

- The practice was unable to demonstrate fully how they were monitoring delivery of the vision and values to ensure they were embedded into practice.

**Culture**

The practice did not have a culture of high-quality sustainable care.

- There were low levels of staff satisfaction, high levels of stress and work overload. Staff told us that although they enjoyed their job and working within their immediate team they all reported high levels of stress and work overload.
- Staff spoke of frustrations about not being able to do the job to the best of their ability because of the current demand. For example, nursing staff sharing out managerial tasks in the absence of a manager and the difficulty in balancing this with the clinical demands. Also they spoke of always receiving the support and guidance needed when required due to the pressures the GPs were under to meet the current demand.
- The culture was top-down and directive. Some staff told us there was a lack of openness and transparency from leaders with regards to
- Involving staff in decisions about the practice or informing them of changes. Decisions were made by leaders and staff were not routinely involved in decision making. Staff reported that they were not always informed of decisions made.
- During the inspection, staff expressed a preference for their names not to be recorded in our notes as they would rather remain anonymous.
- There was evidence to show that patients were kept informed of progress in investigations into incidents and complaints although this was not always clearly documented or done in a timely manner.
- The provider lacked oversight of systems and processes to ensure compliance with the requirements of the duty of candour.
- Not all staff spoken to felt confident in raising concerns or that if they did these would be acted up.
- There were processes for providing all staff with the development they need, although some members of administration staff told us they wished there was more opportunities for them to develop in and beyond their role. Not all staff had received an appraisal or career development conversations within the past 12 months. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was limited evidence to show that leaders promoted the safety and well-being of staff. Reception staff told us that they found it draining working a full day on reception (8am to 6.30pm) having to constantly address patients frustrations with the appointment system.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- The relationship between teams was not positive. Staff did express positivity about the support received from their colleagues in the same role but that this did not relate to cross-team working or with leaders.

**Governance arrangements**

- The governance arrangements and their purpose were unclear and there was a lack of clarity about authority to make decisions and how individuals were held to account.We were told that consultation with staff about the new organisational structure was still underway with no final date for completion or implementation.
- The practice had outlined a structure which identified staff roles and responsibilities. However this process had yet to be completed as were told that not all team

# Are services well-led?

Inadequate

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

leaders had been appointed. We were also told that there were still three mid-level management vacancies to recruit to including nurse and site reception team leaders.

- There was no documentation to clearly identify what nursing staff would be responsible for what role in the absence of a nurse manager. There was no allocated infection control lead. There was no action plan in place to evidence how the practice was going to respond to the recommendations highlighted in the March 2017 audit.
- Policies and procedures had been created and there was some evidence that these had been updated. However, policies were not fully embedded. Practice policies were not being consistently implemented in line with the information and protocols they detailed. For example, regular infection control audits were not being undertaken as determined by the infection control policy; and there was no evidence to confirm that weekly fire alarm tests had taken place after November 2017.
- The practice were in the process of aligning systems and processes with those used by the provider they had entered into a business arrangement with. As such all employment, recruitment checks and payroll were completed by The Living Well Partnership. All staff files were held off site by The Living Well Partnership. Leaders from St Luke's Surgery (such as the GP partners and the patient service manager) had access to these files by driving to this location. The practice was in the process of making all recruitment files electronic although this had only just begun. We were told that confirmation would be sent currently to the patient services manager at St Luke's Surgery to provide assurances recruitment checks were completed although as the process was in its infancy we were unable to verify that this had been happening.

**Managing risks, issues and performance**

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently and not linked effectively into the planning processes. The approach to service delivery and improvement was reactive and focused on short-term issues. For example:

- Risk assessments were in place to identify current risk including risk to patient safety but not all of these had been recently reviewed or updated and some lacked action plans to address issues highlighted.
- The practice was unable to demonstrate fully how current and future performance was managed. There was little evidence to confirm that staff were participating in regular audits or quality improvement initiatives. The practice had in place a system to receive alerts sent by the Medicines and Healthcare products Regulatory Agency (MHRA) however, they lacked oversight in processes to ensure that they were up to date with the most recent alerts as the system to log when alerts came in had not been updated since 2016. The manager we spoke was unaware whether the log had been updated or not. There was also no record in place to evidence that staff had received or read the alerts once they were disseminated via email. We saw evidence that not all complaints reviewed had been handled in a satisfactory way and there was limited evidence to demonstrate what learning had occurred from complaints that had been received since October 2017.
- The practice had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used mainly for assurance rather than for improvement. For example, the practice could not tell us what actions they were taking to bring exception reporting levels down for some clinical indicators.
- There was some evidence to suggest that Quality and Sustainability were discussed in relevant meetings however, information from these meetings was not always disseminated to all staff. Staff spoke of not always being kept informed of changes. The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, in January 2018

# Are services well-led?

Inadequate

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

the practice had a serious data protection breach whereby patients private email addresses were circulated to the patient reference group. This breach was under investigation at the time of the inspection.

**Engagement with patients, the public, staff and external partners**

The practice some engagement with patients, the public, staff and external partners to support high-quality sustainable services.

- The practice had an active patient participation group.
- The practice collected patient feedback from a variety of sources including through the patient participation group, friends and family test and other data capture methods. There was some evidence to demonstrate that patient feedback was listened to such as adding a door bell to the front door of the branch surgery to notify the reception when patients need assistance to open the door. The practice had issued a letter to patients to demonstrate they had listened to patient feedback about the appointment system but there was limited evidence to demonstrate what plans were in place to make improvements.
- The practice sought feedback from staff through meetings and discussions.
- The service was collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

The practice priorities were implemented as part of the new organisational structure . There was minimal evidence of learning and reflective practice. There was some evidence to suggest that the practice were thinking of ways to improve care for their patients but these were in their early stages. For example, a GP had been employed to focus on providing care for elderly and frail patients. As this role was newly created within the organisation and the GP only recently in post there was no evidence of outcomes or improvements. The practice had also recently engaged with existing programs to provide support to patients with diabetes. At the time of the inspection the first group session had not taken place.

This section is primarily information for the provider

# Requirement notices

## 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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Transport services, triage and medical advice provided remotely | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>**How the regulation was not being met:**<br>The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.<br>Not all staff had a record of having received an appraisal in the past 12 months.<br><br>This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The practice did not have appropriate systems in place to assess the risks to the health and safety of patients receiving care and treatment and had not done all that is reasonably practicable to mitigate any such risks. There lacked suitable systems in place to ensure care and treatment were provided in a safe way. For example:<br>• There was no evidence to demonstrate how you had addressed the concerns raised in the infection control audit dated March 2017.<br>• On our inspection on 12 February 2018 we continued to find similar concerns to those raised in the audit.<br>• There was no allocated infection control lead to oversee completion of audits or implementation of subsequent action plans.<br>• Not all medicines were stored in a way that kept patients safe. There was an empty box of rectal diazepam stored within the emergency medicines<br>• Not all staff had received training in safeguarding. There was no evidence to document that this training had been completed as part of their induction records. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The registered provider did not have suitable systems in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the |

This section is primarily information for the provider

# Enforcement actions

experience of service users in receiving those services). Systems did not assess, monitor or mitigated risks related to health, safety and welfare of service users. For example:

- Health and safetyrequirements of the premises as raised in the practicerisk assessmenthad not been recorded as completed.
- At Botley Health Centre the log book showed that the weekly fire alarm tests had not been recorded since 24 November 2017.
- Staff induction training records had not been signed to evidence that the staff had received the required induction programme and training.
- The practice plans to complete a one week, one month and six month review meeting of your staff had not been recorded as completed.
- There were key staff vacancies which had resulted in shortfalls to monitoring of clinical and non-clinical systems and processes.
- There was a lack of oversight and monitoring of data collected through Quality and outcome framework (QOF) reporting including for exception reporting. You had not identified a risk assessment or action plan to evidence how you would ensure all patients had received their routine reviews and the plans to reduce the exception reporting levels and improve outcomes for patients.
- You completed an analysis of complaints and trends for 2017 which identified that the majority of complaints were about consultations and appointments. You did not record what learning had occurred as a result of this analysis or what you planned to do to address these issues.
- You had not taken action on feedback collected from patients.
- There was a lack of oversight of monitoring systems and processes to prevent data protection breaches. In January 2018 you had a serious data protection breach whereby patients personal email addresses were sent out as part of a group email to your patient reference group. The email had been sent out without ensuring that email addresses were sent as blind

This section is primarily information for the provider

# Enforcement actions

copies. This incident was under investigation at the time of our inspection. Although you had notified all patients via the practice websiteyou could not tell us what learning had occurred or planned changes to practice to prevent the issue occurring again in the future.