Sutherland Lodge Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires improvement

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. The population groups are rated as:

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

We carried out an announced comprehensive inspection at Sutherland Lodge on 7 December 2017, as part of our inspection programme and in response to concerns, raised directly with us relating to patient access, the quality of treatment, the management of prescriptions and delays in referrals.

As a result of the findings at this inspection, we asked the provider to take action to reduce the more concerning risks by 22 December 2017 and we then carried out a further focused inspection on 10 January 2018, to check whether the risks to patients had been reduced. We found that they had. The report of this inspection has not yet been completed at the time of writing this report, but it will be published on our website in due course.

Our key findings at the inspection on 7 December 2017 across all the areas we inspected were as follows:

- Systems, processes and practices to keep people safe and safeguarded from abuse were unreliable. Clinical staff were not trained to the correct level recommended by guidance.

  Also clinical staff did not always adhere to or have sufficient knowledge of the Mental Health Act Code of Practice.

- Some of the key requirements from the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection were not being met.

Summary of findings

- Risks to patients were not being appropriately assessed, or their safety monitored and managed so they were supported to stay safe. There was a lack of clinical oversite to ensure information received regarding new diagnosis and medicine changes were not completed in a timely way.
- Staff were aware of their responsibilities to manage emergencies on the premises and they had up to date information on how to identify and manage patients with severe infections, for example, sepsis.
- Medicines and associated equipment were not always in date or stored at the correct temperature and nursing staff tasked with monitoring did not take action when temperatures were above recommended levels.
- Arrangements in place to receive and comply with patient safety alerts, recalls and rapid response reports were ineffective. There was no process to ensure safety alerts were actioned and patients informed if they were at risk.
- There had been no significant events identified therefore there was no evidence of learning from incidents to improve quality. Opportunities to analysis, action change and share outcomes were missed.
- Patients with complex needs for example learning disabilities and older patients were not receiving their care in line with guidance. For example care plan reviews and health checks.
- Medicine reviews were not always taking place. There were inconsistent reviews of high-risk medicines and action to address risks was not always in line with national guidance.
- There was a corporate system for the handling of complaints. However, this did not include cascading the learning to staff working at the practice or ongoing monitoring. Action was not always taken to improve the quality of care as a result.
- Some outcomes for patients were below local and national averages. Participation in audits and quality assurance processes was limited.
- Patients reported there was a lack of continuity of care and we saw that this had a detrimental impact on the quality of patient treatment and care.
- Services were not always planned or delivered in a way that met patient's needs. There was no evidence the service took account of patient preferences.
- Appointment systems were not working well so patients did not receive timely care when they needed it, particularly in relation to GP home visits. Patient survey results and CQC comment cards identified patients had concerns about access to GP appointments and getting through to the practice by phone.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Risks within the practice were not effectively managed and risk assessments were either unavailable or insufficient. Staff responsible for the management of risks and health and safety were not aware of the scope of these responsibilities.
- Policies and procedures were not always accessible, clear or up to date.
- There was uncertainty amongst staff due to unclear changes in relation to the registered provider and a subsequent impact on the staffing structure within the practice.
- There were accessible facilities, which included a hearing loop, and interpretation services available.

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

- Ensure there are systems to assess, monitor, manage and mitigate risks to the health and safety of patients who use services.
- Ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Summary of findings

- Ensure the proper and safe management of prescribing medicines. This is to include repeat prescribing and monitoring of high-risk medicines.

The areas where the provider should make improvements are:

- Ensure there were systems for assessing the risk of, and preventing, detecting and controlling the spread of infections. Monitor and schedule cleaning of areas where debris collects.
- Continue to review how the practice could proactively identify carers in order to offer them support where appropriate.
- Review the current processes for engaging with the practice population to encourage patients to feedback on services.
- The provider should actively seek the views of a wide range of stakeholders, including people who used the service. The provider did not analyse patient feedback or made improvements.
- Ensure that equipment used by the service provider for providing care or treatment to a service user was safe for such use. Checks for out of date equipment should be made frequently.

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 vary the provider's registration 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**

Sutherland Lodge 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 GP specialist adviser.

Background to Sutherland Lodge Surgery

- Sutherland Lodge is a GP practice located in Chelmsford and is part of the Mid Essex Clinical Commissioning Group.
- Services are provided from: 113-115Baddow Road, Chelmsford, Essex, CM2 7PY
- Online services can be accessed from the practice website: sutherlandlodgesurgery.co.uk
- Sutherland Lodge Surgery is managed by the provider organisation Virgin Care Services Limited. The company took over the contract to provide NHS primary care services at Sutherland Lodge on 01 July 2016. The company currently manages 18 primary care services across the country, including GP practices, walk in centres and urgent care centres.
- The practice provides primary medical services to approximately 11,000 patients.
- The practice has a slightly higher elderly population than the national averages with 32% of the practice list aged over 65 years compared to the national average of 27%.
- The practices population is in the fourth decile for deprivation, which is on a scale of one to ten. The lower the decile the more deprived an area is compared to the national average.
- Ethnicity based on demographics collected in the 2011 census shows the patient population is predominantly white British with; 1.8% mixed, 3.4% Asian, 1.4% black.

Inadequate

Are services safe?

Our findings

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

Safety systems and processes

The practice did not have clear systems to keep patients safe and safeguarded from abuse. Patients were at high risk of avoidable harm. Some regulations were not being met.

- There were processes to conduct safety risk assessments; however, there was a lack of evidence at the inspection to demonstrate that any had been completed for the practice. The practice had safety policies, which were reviewed and updated on their practice computer system; however, some staff spoken with were unable to access them. Staff received safety information as part of their induction; however, there was no evidence of refresher training.
- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. They outlined whom to go to for further guidance. However, the safeguarding lead had not received training to the correct level as recommended by guidance.
- There was no system to monitor the welfare of children who did not attend for their secondary care appointments.
- There was no proactive monitoring of patients considered to be at risk of safeguarding concerns. This included children on child protection plans, patients diagnosed with mental health issues who were vulnerable or patients with mobility issues.
- The practice carried out (DBS
- The key requirements from the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection were not being met. Extractor fans in the clinical room had visible debris and dust. There was no schedule for cleaning them. Aninfection control audit had been carried out but actions identified had not been completed
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, we found out of date single use equipment.

Risks to patients

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

- There were some arrangements for planning and monitoring the number and mix of staff needed. However, frequent staff shortages and unsupported management of locum staff increased risks to patients who used the service. We identified information received by the practice from secondary care that was not being acted on in a timely way. We saw 343 letters had been scanned into patient's records and were waiting to be actioned by a GP. This included changes in medicines, requests to refer to a different specialist and blood monitoring. For example, one referral letter to a different service took six weeks to action. Another letter viewed was received by the practice 35 days before the inspection. We found this had been reviewed eight days before the inspection but the information from the letter was not put on the patients electronic notes.
- Clinical staff were not used in a way that ensured patient's safety was always protected. There were 108 pathology results and 32 of them required clinical attention and further contact with the patients concerned. Some of the results that required action had been received by the practice 10 days earlier.
- There was an induction system for temporary staff; however, GP locums had received inconsistent inductions and there was no evidence of clinical supervision.
- Staff were aware of their responsibilities to manage emergencies on the premises and they had up to date information on how to identify and manage patients with severe infections, for example, sepsis.

Information to deliver safe care and treatment

Staff did not assess, monitor or manage some risks to patients who used the services.

- Individual care records that were viewed were written and managed in an inconsistent way and did not always keep patients safe. Staff did not always have the complete information they needed before providing care, treatment and support. For example, patients spoken with and feedback seen for the NHS Choices website reflected that patients often had to repeat information or answer the same questions again

because they saw a different GP each visit. A complaint we viewed showed one patient had been seen by five different GPs, the fifth consultation resulting in a referral to the acute hospital where they were admitted the same day.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters did not always include all of the necessary information and some we viewed were inappropriate. For example, an urgent referral viewed did not contain clinical symptoms that would identify high levels of concern. There was no oversight or review of these referrals.

Safe and appropriate use of medicines

Patients were at risk because staff did not prescribe medicines safely and some patients had to wait over a week for a repeat prescription.

- The service did not always follow national guidelines for the storage of medicines. For example; we viewed the daily temperature log in the room where emergency medicines were stored and we identified the temperature had exceeded the recommended level on three consecutive days. The policy was within the log and it stated the requirement to inform the practice manager if limits were exceeded. There was no evidence this had been done.
- The practice kept prescription stationery securely and monitored its use.
- Patients did not always receive specific advice about their medicines. Some patients told us they did not get clear, understandable information about their medicines. This would include what the medicine was for, how to use it, possible unwanted effects and how to report them and how long they may be on that medicine.
- During the inspection, the GP specialist identified two dangerous prescribing errors. The first involved a child that was prescribed medicine not licenced for children. The second was an over prescribing issue with a medicine that was known to be open to misuse, abuse and dependence. Clinicians failed to identify that a patient had been seen five times over a 21-day period. On each appointment, the patient was given a prescription that should have lasted between 14 and 28 days.
- The practice had audited its antimicrobial prescribing at a practice level in conjunction with the local medicines optimisation team. Antibacterial prescribing was in line with local and national figures.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that these were in date and had been signed appropriately.

Track record on safety

The practice did not have a proactive safety record.

- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance. There were unacceptable levels of incidents that were not being recorded or investigated. For example during the inspection, we identified prescribing errors.
- A fire risk assessment was completed in August 2017 however, no action had been taken on the results as there were four priority one issues identified (priority one requires immediate action as identified by the providers policy). Staff spoken with told us they had not had a fire drill in the past 12 months. These were addressed by the focused inspection in January 2018 and will be recorded in that inspection report.
- The practice did not have a reliable process to monitor and review safety. The practice had risk assessed control of substances hazardous to health and infection control. A legionella risk assessment had been completed in August 2016 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) However, there was no documentation to assure us recommendations had been acted on.

Lessons learned and improvements made

Staff did not always recognise concerns, incidents or near misses. We felt the trigger for reporting a significant event or patient safety issue was not understood by the staff.

- We were told the practice used an incident reporting system known as CIRIS (used as a system to record risk and serious incidents). However, this was only available to employed staff not locums. We saw there was limited

use of this system to record and report safety concerns, incidents or near misses. Some staff were not clear how to do this. When things went wrong, reviews and investigations were not sufficiently thorough and did not always include all relevant people. Necessary improvements were not identified embedded or monitored. The practice reported to us at the time of the inspection that there had been no significant events or incidents in the past 12 months.During the inspection, we identified several issues that should have been investigated as a significant event. After the inspection we were shown a system that recorded incidents. However, there was no evidence of how actions identified were embedded or how staff were informed of outcomes.

- There was a process for receiving and acting on Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) safety alerts that was not being followed. There were no systems in place to ensure the alert was viewed and actioned by a competent staff member. We checked a recent alert that would have affected 42 patients registered with the practice. There was no evidence that appropriate action had been taken.

Since the inspection, we acknowledge that the practice has implemented improvement measures. These will be commented on in more detail in the report of the focused inspection carried out on 10 January 2018. The improvements we have been told about are as follows;

- There is a lead for safeguarding and staff were being trained to the recommended level.
- An infection control lead had been appointed and cleaning schedules have been revised.
- Non Clinical staff have received chaperone training.
- Systems are being developed to ensure all clinicians have up to date information received from other services.
- A pharmacy member of staff had been brought into the practice to review and monitor patients on medications that require regular reviews
- The practice has reviewed and actioned the fire risk assessment . It has also appointed fire marshals and commenced fire drills and tests.
- A process was being established to ensure safety and medicines were reviewed and actioned on a regular basis (MHRA,NI,CAS).

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

People received ineffective care and there was insufficient assurance in place to demonstrate otherwise.

- Patients' needs were not always fully assessed. This included their clinical needs and their mental and physical wellbeing. There were notices in the reception area that informed patients they were only allowed to discuss one symptom per appointment. Double appointments were available for patients with more complex health needs.
- Patient's care and treatment did not reflect current evidence-based guidance, standards or practice. Notes reviewed identified previous visit records were not used to assist in the patient's assessment.
- Care and treatment were based on arbitrary decisions rather than a full assessment of a person's needs, including those related to pain.
- Clinical staff did not always adhere to the Mental Health Act Code of Practice. Staff spoken with on the day of the inspection did not have sufficient knowledge to apply the act correctly and training files showed several staff had not received training.

Older people:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

The safety of care for older patients was not a priority and there were limited attempts at measuring safe practice.

- Older patients who were frail or identified as vulnerable had not received a full assessment of their physical, mental and social needs. Those identified as being frail did not always have a clinical review including a review of their medicine.
- Patients aged over 75 were not routinely invited for a health check. There was no evidence the provider identified patients aged 65 and over who were living with moderate or severe frailty.
- The practice told us they followed up on older patients discharged from hospital. However, records we checked did not always have evidence that the discharge information had been actioned as requested by the hospital. One example seen requested blood monitoring to be performed and this had not been completed.

People with long-term conditions:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- Patients with long-term conditions were offered an annual review to check their health.
- Nurses responsible for reviews of patients with long-term conditions had received specific training.
- The practice performance around the 11 measured tasks for diabetes was similar at 92% compared to the CCG average of 84% and the national average of 92%. Exception recording in this indicator was 17% compared with the CCG average of 15% and the national average of 13%. However one indicator; the percentage of patients with diabetes on the register, who have had influenza immunisation, had an exception reporting rate of 37% compared with the CCG of 24% and national of 21%.
- The practice performance around the three measured tasks for asthma was lower at 80% compared to the CCG average of 95% and the national average of 97%. Exception recording in this indicator was 13% compared with the CCG and national average of 11%.
- The practice performance around the six measured tasks for chronic obstructive pulmonary disease was lower at 77% compared to the CCG average of 92% and the national average of 95%. Exception recording in this indicator was 19% compared with the CCG average of 5% and national of 6%.
- Structured annual reviews were undertaken by the nursing staff to check that patients' health and care needs were being met. However, there were no effective systems to ensure patients received their review.

Families, children and young people:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

Inadequate

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The provider did not have operational arrangements for auditing and following up failed attendance of children's appointments following a referral for an appointment in secondary care or for immunisation.

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

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- The practice's uptake for cervical screening was 92%, which was above the 80% coverage target for the national screening programme. However, exception recording in this indicator was 19% compared with the CCG of 5% and national of 8%.
- Health promotion advice was offered at consultation and clinicians were able to print relevant leaflets for the patient.
- The practice did not actively offer health assessments and checks for example NHS checks for patients aged 40-74.

People whose circumstances make them vulnerable:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- Patients with life-limiting progressive conditions did not have any notes to identify their preferences for end of life care. One patient had to self-refer to the hospice because they could not get an appointment.
- The practice had a register of patients with learning disabilities. There were 37 on the register less than 50% had received health checks or medicine reviews in the past 12 months.
- We identified one patient with a learning disability who had received an annual review on the phone with their care worker and not the patient. Another review was documented as completed when the carer contacted the surgery stating the patient was to have a general anaesthetic and the hospital offered to collect their blood samples required for their review.

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

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis was lower at 81% compared to the CCG 85% and national of 83%. Exception recording in this indicator was 39% compared with the CCG of 23% and national of 22%.
- The practice did not consider the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 53%; CCG 87%; national 90%) exception rate of 31% compared with the CCG of 15% and national of 20%. The percentage of patients experiencing poor mental health who had a record of blood pressure in the past 12 months (practice 74%; CCG 87%; national 90%) exception rate of 21% compared with the CCG of 12% and national of 10%.

Monitoring care and treatment

There was limited or no monitoring of the outcomes of care and treatment. Patient's outcomes were variable or significantly worse than expected when compared with other similar services.

Participation in external audits and benchmarking was not seen. The results of monitoring were not used effectively to improve quality.

The most recent published Quality Outcome Framework (QOF) results were 91% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 95%. The overall exception reporting rate was 14% compared with a national average of 10%. (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.)

- Leaders at the practice did not have ongoing oversight of exception reporting. The practice had several high rates of exception reporting. We were told an administrator staff member would invite a patient three times to attend their annual review. If there was no response the patient was exception reported. This meant they were taken off the review list and would not show up on their electronic records at their next appointment. Therefore, this missed any opportunity of receiving an opportunistic review.
- We raised concerns with the leaders that administrator staff were exception reporting patients inappropriately; for example; recording a patient as'not suitable' when it was clear from the notes that they had not been seen or reviewed by a clinician and were suitable.
- We saw examples that administration staff were documenting a review had been completed when there was no evidence that the patient had been seen or reviewed by a clinician. The practice manager told us they were aware of the high exception reports and were auditing the process.
- Some respiratory checks were below CCG and national percentages. For example the percentage of patients with COPD with a record of FEV1 (a measurement during a lung function test) in the preceding 12 months was lower at 40% compared to the CCG and national average of 87%. Exception recording in this indicator was 24% compared with the CCG of 15% and national of 16%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months, was lower at 58% compared to the CCG of 73% and national of 76%. Exception recording in this indicator was 13% compared with the CCG and national of 8%.

Effective staffing

Not all staff had the skills, knowledge and experience to do their job. The learning needs of staff were not fully understood by the leaders at the practice.

- The practice did not have a programme of staff training and training undertaken was not routinely documented.
- The practice could not fully demonstrate how they ensured role-specific training and updates for relevant staff for example, for those reviewing patients with long-term conditions. Some staff told us it was their responsibility to source and attend training updates.
- Some staff told us they received on-going training that included: safeguarding, infection control and basic life support. However, this was not sufficiently recorded to be able to ascertain that all relevant staff had completed the training provided. We noted that some of the GPs life support training was out of date.

Coordinating care and treatment

Staff and teams provide care in isolation and did not seek support or receive input from other relevant teams and services. There were significant barriers to effective joint working between teams.

- The provider had arrangements to share information about patients with out-of-hours, 111 and ambulance services; however, there were no special patient notes, care plans or do not attempt cardio pulmonary resuscitation (DNACPRs) instruction for patients identified as being in their last 12 months of life.
- There were no processes to ensure safe management of incoming documentation from other services and specialists, for example, from secondary care.
- For older people and people with long-term conditions the practice did not have a process to instigate a follow up consultation following discharge from hospital. Patient's records were not updated in a timely way to reflect any additional needs.

Helping patients to live healthier lives

There was no focus on prevention and early identification of health needs. Staff were reactive, rather than proactive in supporting people to live healthier lives.

- The percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within six months of the date of diagnosis, was lower at 87% compared to the CCG and national of 95%. Exception recording in this indicator was 50% compared with the CCG of 30% and national of 25%.

Inadequate

Are services effective?

(for example, treatment is effective)

- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- 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

Consent to care and treatment had not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. There were instances where consent had not been documented prior to a procedure. We viewed two sets of notes where a patient had a minor surgical procedure; there was no verbal consent documented and there was no written consent form used.

- Clinicians we spoke with did not demonstrate they understood the requirements of legislation and guidance when considering consent and decision-making.
- The practice did not monitor the process for seeking consent appropriately.

Since the inspection, we acknowledge that the practice has implemented improvement measures. These will be commented on in more detail in the report of the focused inspection carried out on 10 January 2018. The improvements we have been told about are as follows;

- The practice is developing systems for clinicians to maintain up to date evidence based practice.
- Information about patients care and treatment, and their outcomes, has started to be collected and monitored.
- The learning needs of staff have been identified and training is being provided to meet these needs.
- Consent to care and treatment has been reviewed and is now in line with legislation and guidance.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

Kindness, respect and compassion

Feedback form patients and comment cards told us there were times when people did not feel well supported or cared for.

- Some patients who used the service and those who were close to them had some concerns about the way staff treated them. Some comments told us patients felt they were spoken to in a rude manner.
- 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.
- We received five patient Care Quality Commission comment cards, one card was positive about the service experienced. The other four had negative comments that included lack of appointments, unable to get through on the phone and having to undergo a second procedure due to the clinical staff mislabelling the sample.
- We spoke with eight patients, including four members of the patient reference group (PRG) on the day of inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 242 surveys were sent out and 101 were returned. This represented a completion rate of 42%. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 83% of patients who responded said the GP gave them enough time; CCG - 84%; national average - 86%.
- 90% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 94%; national average - 95%.
- 79% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 83%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; CCG and national average - 91%.
- 94% of patients who responded said the nurse gave them enough time; CCG and national average - 92%.
- 95% of patients who responded said they had confidence and trust in the last nurse they saw; CCG and national average - 97%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 90%; national average - 97%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG - 84%; national average - 87%.

Involvement in decisions about care and treatment

Some staff did not consider involving patients, carers or their families as an important part of care. Patients told us that clinical staff did explain things clearly; however, they were not given time to respond or help them to understand.

- Assessments of patients care and treatment needs did not always include all their needs, including emotional, social, cultural, religious or spiritual needs.
- The service did not prioritise a caring environment. Patients were not offered information, access to advocacy or helped in other ways to be involved in their care and treatment. There were information leaflets throughout the practice; however, some were out of date.
- Services were inconsistent at times, and patients did not always know who would be seeing them.
- We spoke with eight patients during the inspection. All stated they were very unhappy with the level of care they received. One older person we spoke with was visibly upset. They felt the service they received was poor and the practice had many problems. One patient told us, that they only booked an appointment with a specific locum GP because they felt other GPs did not listen to them.

Requires improvement

Are services caring?

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 118 patients as carers (1% of the practice list).

- When the practice was notified of a death of a registered patient there were systems to inform healthcare professionals involved in their care; however there was no contact made to the family to offer support.

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 83% and the national average of 86%.
- 76% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 82%.
- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG – 89%; national average - 90%.
- 82% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 84%; national average - 85%.

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.

Responding to and meeting people's needs

Services were not always planned or delivered in a way that met patient's needs. There was no evidence the service took account of patient preferences.

- The practice told us that it understood its population profile and had used this understanding to meet the needs of its population. However, there was no evidence that the practice engaged with the Clinical Commissioning Group (CCG) to discuss the needs of its population and secure service improvements.
- The practice offered extended hours on a Tuesday and Thursday evening from 6.30pm to 8pm for working patients who could not attend during normal opening hours.
- Home visits were available for older patients and patients who had clinical needs, which resulted in difficulty attending the practice.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Flu and shingles vaccinations were offered to older people.

Older people:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- The practice did not identify older patients who were approaching the end of life. Notes we viewed did not have any documentations identifying any conversations about end of life care in the last phase of life was part of planning their treatment and care, in a way which responds to their individual preferences.
- Patients told us they found it difficult to book routine appointments.
- The care of older patients was not always managed in a holistic way.
- Home visits were not always available on the day of request.
- The practice had recently employed a health care assistant, part of the role was to ensure that over 75 year health checks would be undertaken going forward.

People with long-term conditions:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- On the day of the inspection a receptionist told the inspector that requests for longer appointments were not always available as there was often only one appointment slot available.
- The appointment and staffing arrangements meant that there may not be clear communication for continuity of care for these patients with regards to GP care and treatment.

Families, children and young people:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- We found there were no systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- We were told by a receptionist that parents or guardians calling with concerns about a child under the age of 18 were not always offered a same day appointment. They were told to go to A&E if there were no appointments available for that day.

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

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- Patients told us they found it difficult to book routine appointments.
- Health promotion advice was offered. Clinicians were able to print relevant leaflets for the patient.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had offered health checks and health screening. They had only completed 26 between 1st April 2017 and 7th December 2017.

People whose circumstances make them vulnerable:

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- Not all patients with a learning disability had received an annual health check.
- The practice identified some patients whose circumstances may make them vulnerable or who had a life-limiting condition. However, their needs and preferences were not evidenced in care planning and continuity of care.

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

The practice is rated as inadequate for providing safe, effective and well led services; this affects all six population groups.

- Not all clinical staff had received training in the Mental Capacity Act 2005.
- There was no recorded evidence of patients being reviewed following a diagnosis of depression.
- There was evidence that the practice did not have enough clinical availability to ensure consistent advance care planning for patients with dementia.
- The practice had a shortage of routine appointments and therefore could not guarantee that patients suffering with a mental health need were able to make an appropriate appointment.
- Some staff had received training on how to care for people with mental health needs but specific training on dementia care had not been provided.

Timely access to the service

Patients were frequently and consistently unable to access services in a timely way for an initial assessment, diagnosis or treatment.

- The appointments system was not working. Patients told us they had to queue around the surgery at 8am to get a same day appointment. They often ran out of appointments before the queue ended.
- The next available bookable appointment was eight days away.
- There were no emergency appointments remaining for the morning session by 9am on the day of the inspection.
- There was no process for same day appointments for children or those patients with medical problems that required same day consultation. Reception staff told us that if there were no more appointments they advised the patient to call again the following day or to go to A&E.
- The practice had a system in place to manage home visits. No consideration had been given to reviewing the system in light of a patient safety alert in April 2016. This alert required general practices to have a system in place to assess whether a home visit was clinically necessary and the urgency of need for medical attention. We discussed this system with the non-clinical staff involved in the process. They had not received training to identify or escalate a home visit where a patient disclosed symptoms that would require alternative response organised for example calling an ambulance

Reception staff stated that if the patient asked for an appointment, and then complained if they did not get one, then generally they were seen as an urgent appointment if possible. All staff stated that verbal complaints had increased considerably in the last few months, and they identified the main issue as lack of GP sessions, and particularly the lack of routine appointments. NHS Choices had comments on its website that patients considered the reception triage difficult and potentially unsafe.

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 completed comment cards. 242 surveys were sent out and 101 were returned. This represented a completion rate of 42% population.

- 73% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 70% and the national average of 76%.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 56% of patients who responded said they could get through easily to the practice by phone; CCG – 56%; national average - 71%.
- 46% 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 and national average - 56%.
- 83% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 82%.
- 71% of patients who responded described their experience of making an appointment as good; CCG - 66%; national average - 73%.
- 66% of patients who responded said they do not normally have to wait too long to be seen; CCG - 56%; national average - 58%.

Listening and learning from concerns and complaints

The practice did not have an effective system in place for analysing complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Written complaints were seen to be dealt with appropriately however feedback from patients and NHS choices stated that the complainant was not always contacted.
- There was a corporate system for the handling of complaints. However, this did not include cascading the learning to staff working at the practice or ongoing monitoring. Action was not always taken to improve the quality of care as a result.
- There was no evidence the practice learnt lessons from individual concerns and complaints or from analysis of trends. There had not been any team meetings for five months; minutes viewed did not contain any lessons learnt from investigations and there was no other system to cascade the learning from complaints to staff.

We looked at 18 complaints received in the last 12 months and found that 12 of these were clinical, three were a mixture of clinical and non-clinical and three were non-clinical. We identified six of the complaints should have been dealt with as a serious incident. We were also informed that there were verbal complaints, mostly to the non-clinical staff regarding appointment availability, but also to clinical staff. These were not recorded, but were generally dealt with at the time by the staff member concerned or by the practice manager. Staff stated however that they had received a large number of verbal complaints, particularly in the last couple of months.

Since the inspection, we acknowledge that the practice has implemented improvement measures. These will be commented on in more detail in the report of the focused inspection carried out on 10 January 2018. The improvements we have been told about are as follows;

- Home visits and urgent appoints have been reviewed and a new process is being established.
- Systems were being developed to ensure patients with the most urgent needs had their care and treatment prioritised.
- Regular meetings with other services and other providers were being coordinated

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 as inadequate for providing a well-led service.

Leadership capacity and capability

The delivery of high-quality care was not assured by the leadership, governance or culture at the practice. Patients were at high risk of avoidable harm. Some regulations were not met.

The practice had salaried and locum GPs. One salaried GP had been identified as the clinical lead but was starting a length of absence and no other clinical lead had been appointed. The practice manager had been appointed three months prior to the inspection but told us they also oversaw another location.

- We spoke to the registered manager who did not show a clear knowledge of the clinical sessions and staffing levels of the practice at the current time. It was stated that there would soon be recruitment of a GP for the practice in order to reduce the reliance on locum GPs but this had not been finalised at the time of the inspection.
- Leaders did not demonstrate on the day of the inspection that they had the necessary experience, knowledge, capacity or capability to lead effectively. There was a clear lack of continuous leadership at the practice.
- There was no stable leadership team at the practice, with high level of vacancies. Leaders were out of touch with what was happening on the front line, and they could not identify the risks and issues described by staff.
- Staff told us they had not met the corporate leaders until 24 hours before the inspection. Staff also said that the practice manager had only become full time at the practice two weeks prior to the inspection and not the three months we had been told.
- Staff did not know who their leaders were or what they did, and did not know how to access them. There were no examples of leaders making a demonstrable impact on the quality or sustainability of services.
- We found that there was a lack of oversight at the practice from the corporate leaders of the practice and systems and processes in place were not being followed and there was a lack of review and monitoring taking place.

Vision and strategy

Practice staff were unable to explain to the inspection team the vision, values or direction of the practice for the future.

- The practice had a mission statement however not all staff were aware of it because it was developed without staff and wider engagement.
- The strategy was not underpinned by detailed, realistic objectives with plans for high quality and sustainable delivery and it did not reflect the health economy in which the practice was located.
- Practice staff were unsure who or what the leadership of the practice was, who it was that they actually worked for, and what the future plans were for the practice.
- There was no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans.

Culture

There was little understanding of the importance of culture. There were low levels of staff satisfaction, high levels of stress and work overload. Some staff did not feel respected, valued, supported or appreciated. There was poor collaboration or cooperation between teams.

- There were teams working in silos; management and clinicians did not always work cohesively. No one had an overarching responsibility to promote staff empowerment that would lead to service improvements.
- The practice staff felt that a culture of openness and honesty did not always exist at the practice and that the management company were not approachable or accessible.
- Patients did not always receive a timely apology when something went wrong and were not consistently told about any actions taken to improve processes to prevent the same thing happening again.

Are services well-led?

Inadequate

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

- The practice manager did not have oversight of training requirements and staff spoken with confirmed they had to arrange their own training.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The provider could not evidence staff had undertaken Equality and Diversity training. They were unable to show us an anonymised example that would demonstrate how the practice had dealt with an issue to ensure protected characteristics had been maintained.

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.

- There was a shortfall in the delivery of GP appointment sessions. The practice told us that there had been 604 face-to-face GP appointments available the week of the inspection.
- There was no overall understanding of the quality markers at the practice with no routine audits or monitoring of patient data. Clinicians, when asked, did not have a comprehensive understanding of the performance of the practice.
- There were no regular clinical meetings for the GPs and no opportunities for regular communication or peer review between the GPs. Meetings tended to be informal and during the lunch break.
- The practice manager (who was also to be the registered manager) had not yet applied to CQC to be the registered manager.
- On the day of the inspection, staff working at the location told the inspector the practice manager had been working full time at the practice two weeks prior to the inspection. Day to day clinical responsibility had been delegated to another clinician but they were now absent.Most staff when asked on the day of inspection were unsure who had the overall clinical responsibility for the practice.
- Practice staff had some concerns regarding the extensive use of locums and the varying quality of the locums that were supplied. Most locums were not regularly employed and therefore this had contributed to further issues with continuity of care for patients.
- There was no programme of continuous clinical and internal audit to monitor quality and to make improvements. Some audits had been initiated in respect of prescribing however there was limited evidence that they had resulted in quality improvement.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. However, there was no detailed policy for the management of patients on high-risk medicines. The document we were shown referred to another policy that staff were unable to locate for us on the day of the inspection.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, there were no GP lead roles for long-term conditions and nursing staff felt unsupported.

Managing risks, issues and performance

There was no demonstrable understanding of risks and issues, and there were significant failures in performance management and audit systems and processes. Risk or issue registers and action plans, if they existed at all, were not reviewed or updated. Meeting financial targets was seen as a priority at the expense of quality.

- The practice relied solely on salaried and locum GPs input with ad hoc support from the registered provider. Locum GPs were not always clear about where to access support.
- There was no evidence risk was being assessed monitored or mitigated. The practice were not aware of mitigating actions such as water temperature testing in relation to managing legionella risk. There was no evidence of fire evacuation risk assessments from the first floor, fire alarm test or drills taking place. Fire extinguishers had not been tested for over 18 months.
- There was no quality improvement programmes including clinical or internal audit to monitor quality of care and treatment as well as operational processes; there were no systems to identify where action should be taken.

Are services well-led?

Inadequate

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

- There were no clinical meetings for five months (we were told they held a meeting three days prior to the inspection however minutes were not available). Minutes viewed from when meetings were held did not demonstrate that complaints were discussed or lessons learned shared.
- Prior to the inspection the practice declared to us they had no significant events at the practice in the past 12 months. During the inspection we identified several issues that should have been raised as a significant event (one serious issue was addressed immediately).
- The process for the management of significant events and complaints did not include clinical oversight; this had resulted in a lack of investigation and delays in addressing issues. Staff, including locum GPs and nurses were not involved in discussions about significant events or complaints and there was no independent or clinical scrutiny through the process. Staff coordinating significant events and complaints made contact with the registered provider on an ad hoc basis to discuss individual concerns but there was no clear guidance around this. There was not an understanding or clear guidance on what incidents should be reported externally.
- Appropriate checks of locum GPs in relation to conduct in previous roles, disclosure and barring service (DBS) checks and medical indemnity insurance were inconsistent.
- The system for actioning safety alerts was unclear as there was no lead clinician to assign them to within the practice. There was no process to ensure safety alerts were investigated and patients notified if they were put at risk.

Appropriate and accurate information

The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant.

- Leaders and staff did not always receive information to enable them to challenge and improve performance.
- Information was used for assurance and rarely for improvement.
- Required data or notifications were inconsistently submitted to external organisations. There was no clinical oversight or audit process to ensure accurate information is sent in a timely way.

Engagement with patients, the public, staff and external partners

There was a limited approach to sharing information with or obtaining the views of staff, patients, external partners and other stakeholders.

- Patients told their views and experiences were gathered; however, they felt little or no action was taken to shape and improve the services.
- There was an active patient reference group that met bi-monthly.
- There was no evidence that the practice attempted to build collaborative relationships with external partners that would build a shared understanding of challenges within the system and the needs of the relevant population.

Continuous improvement and innovation

There was no innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement was not a priority among staff and leaders.

- There was minimal evidence of learning and reflective practice.
- The impact of service changes on the quality and sustainability of care is not understood.
- The practice did not make use of internal and external reviews of incidents and complaints. Learning was not shared or used to make improvements.
- There was no evidence that leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Since the inspection, we acknowledge that the practice has implemented improvement measures. These will be commented on in more detail in the report of the focused inspection carried out on 10 January 2018. The improvements we have been told about are as follows;

Are services well-led?

Inadequate

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

- Regional leaders have been undertaking the role of clinical leads and had identified issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Progress against delivery of the strategy and local plans was being monitored and reviewed and there was evidence of this.
- Monthly Clinical Governance Meetings have been established.
- Leaders were promoting a culture of learning and continuous improvement to improve quality and outcomes from their services, including multi-professional engagement .

Local oversight of complaints handling was being developed.

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 Family planning services Maternity and midwifery services 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 did not ensure there were systems for assessing the risk of, and preventing, detecting and controlling the spread of infections. There were no cleaning schedules for the extractor fans. The provider did not proactively identify patients that were carers. The provider did not engage with the practice population or act on their suggestions/concerns to improve the service. The provider did not ensure that equipment used by the service provider for providing care or treatment to a service user was safe for such use. This was in breach of regulation 12 (1)) 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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider was not able to ensure that systems and processes were established and operated effectively to ensure compliance with the requirements in this Part. The provider did not do all that was practicable to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities (including the quality of the experience of the service users in receiving those services). The provider did not do all that was practicable to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, which arise from the carrying on of the regulated activities. The provider did not ensure that patient records would be kept secure at all times. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.