Doctors Lewis, Hawkes and Dicks

Quality Report

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

Ratings

Overall rating for this service	Inadequate
Are services well-led?	**Inadequate**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Doctors Lewis, Hawkes and Dicks, known as Victoria Park Medical Centre on 3 February 2016. Following our comprehensive inspection overall the practice was rated as inadequate with an inadequate rating for the safe and well led domains and requires improvement for the responsive domain. We were so concerned following this inspection we placed the practice into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Both the domains of effective and caring were rated as good. We were so concerned with some aspects in the safe and well led domain that we took further steps to ensure that the practice made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices by 13 June 2016.

We issued warning notices in regard to:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
- Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014,Staffing.

The warning notice in relation to regulation 17 was that the provider must implement the necessary changes to ensure an effective system or process. This is in order to assess, monitor and improve the quality and safety of the services provided. This included for the provider to have a system to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying out of the regulated activities.

The warning notice in relation to regulation 18 was that the provider must implement the necessary changes to ensure that they deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons. This is in order to meet the requirements of the population they served. The provider also needed to ensure that persons that are employed are receiving appropriate support and training as required in line with their role and responsibilities.

A copy of the full report detailing our findings from the inspection 3 February 2016 can be found at www.cqc.org.uk.

This inspection undertaken on the 16 June 2016 was to check compliance had been met in regard to the warning notices for regulations 17 and 18 and will not change the current rating of the service. Other areas of non-compliance will be reviewed at a later date when a full rated comprehensive inspection is undertaken and the practice have had time to implement the changes required.

Summary of findings

Our key findings across all the areas during this focused inspection were as follows The provider had made steps to ensure the significant concerns that had been found previously in relation to the warning notices for regulations 17 and 18 had or were in the process of being addressed:

- The provider had taken steps in increasing the stability of clinical provision in order to provide treatment and care to patients. The lead GP has maintained a regular group of either salaried GP, locum GPs or a salaried nurse practitioner to provide clinical care to patients, ensuring there was continuity of care.
- The provider had made changes in order that two staff were always covering the reception desk and ensuring that staff were answering the telephone as promptly as possible. We saw positive feedback received by the practice from patients that the changes already implemented had improved the patient experience in regard to accessing the service either by telephone or at reception.
- The provider had put processes in place to support new staff and locum GPs and nurses when they started working at the practice to ensure they were well equipped to provide a safe service.
- The provider had reviewed how they responded and managed any significant events. Significant events had been incorporated into the regular Wednesday meetings and there was evidence that all aspects were discussed and actions to be taken planned for and reviewed for their effectiveness.
- The provider had implemented changes to the arrangements in place at the practice to safeguard children and vulnerable adults from abuse. Ensuring that information and support was available for staff in order to respond to concerns effectively.
- Steps had been made by the provider in regard to a management system to ensure clinical and non-clinical staff were up to date with their routine immunisations and immunisations for staff for specific disease prevention.
- We found the practice was now following legal requirements and national guidance when administering vaccinations and immunisations. The practice had a process to ensure that Patient Group Directions (PGDs) were adopted allowing nurses to administer medicines in line with legislation.
- The practice had implemented changes to the management and administration processes for recruitment of staff. Disclosure and Baring Service (DBS) were being carried out on all staff and a risk assessment process to determine the suitability of staff had been implemented whilst this was being completed.
- The practice had commenced a programme to assess and implement a system. This was order to identify, monitor and to ensure the provider had an oversight of risk assessments and safety checks and to promote patient and staff safety. Progress in this area will be reviewed when we next undertake a comprehensive inspection at the practice.
- The provider had made changes in how patients were informed and supported on how to make a complaint.They had set up a new process for how complaints were managed and we saw evidence that this was effective.
- The provider had implemented changes to the management and governance systems. The provider had engaged a new interim practice manager to take the lead, working with the provider in shaping the changes in the organisation of the service.
- We saw that progress was being made in implementing a structured filing system for non-clinical practice business. This meant that information was more accessible to staff in the absence of the practice manager. Progress in this area will be reviewed when we next undertake a comprehensive inspection at the practice.

In this situation with the issuing of warning notices, we returned to check the progress the provider was making in regard to the key concerns. The practice remains under special measures until we have returned to carry out a comprehensive inspection at the end of this six month period after the initial report was published. If the service has failed to make sufficient improvements the CQC will consider taking steps to cancel the provider's registration.

Summary of findings

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

Doctors Lewis, Hawkes and Dicks

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP Specialist Advisor**.**

Background to Doctors Lewis, Hawkes and Dicks

The practice is located in Bridgwater, a town located close to the M5 motorway eight miles south west of Taunton, on the edge of the Somerset Levels in the Sedgemoor district of the county of Somerset. The practice provides primary medical services for the town and some surrounding rural villages and hamlets.

The practice is located in a purpose built building within a community development which was built in 2006 in the grounds of a recreation park. The facilities include a pharmacy, children's nursery and a children's centre. Active living programmes and a green gym within the park are examples of services provided to the local community.

The practice has a population of approximately 4600 patients. The practice has a higher than England average number of patients under the age of 30 years and a lower than England average number of patients over 50 years of age. The practice has a high level of deprivation with a score of 25 which is higher than the England average of 23.6 and the Somerset average of 18.

The public health profile for the practice shows it has a higher rate of mortality and a much less healthy population when compared to local and national data. For example, obesity, smoking and drug and alcohol addictions are all higher than the Somerset average. The practice population has a high level of unemployment and 32% of the patients live in one of the most deprived areas in Somerset. The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the 10th least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. It is important to remember that not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

The practice has a Primary Medical Services contract (PMS) with NHS England to deliver primary medical services. The practice provides enhanced services which include facilitating timely diagnosis and support for patients with dementia; childhood immunisations and enhanced hours patient access.

In April 2015 Dr Hawkes (a GP partner) left the practice. The practice is currently registered with the Care Quality Commission (CQC) with two partners. An application to change the registration with the CQC has been received and is in the process of being assessed.

The practice team is led by the principal GP Dr Lewis and includes one salaried GP and a regular locum GP, two female and one male. Additional locum GPs were employed ad hoc when required. In addition the practice employed a nurse practitioner (female), two practice nurses (female), and two health care assistants, a practice manager and administration and reception staff.

Detailed findings

The GPs had special interests and additional skills in areas including substance misuse; obesity and bariatric surgery; occupational medicine and medicines management.

The practice is open between 8am to 6.30pm Monday to Friday. Appointments are bookable six weeks in advance and are for 10 minutes each. The practice offers later appointments 6:30pm until 7:30pm Monday evenings. The national GP patient survey (July 2015) reported that patients were less than satisfied with the opening times and making appointments. The results were below local and national averages.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 and Vocare provide an Out Of Hours GP service. Information for patients on how to access this service can be accessed via the practice telephone system and the practice website.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced focussed visit on 16 June 2016. During our visit we:

- Spoke with a range of staff including the, GP, practice manager and other staff on duty
- Reviewed documentation and information available for the management and administration of the service.

Are services well-led?

Inadequate

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

Our findings

Governance arrangements

During the comprehensive inspection undertaken on 3 February 2016 we found a number of concerns regarding the overarching governance framework to support the delivery of the service to the practice population. We identified that some of these concerns were so significant that the provider was required to take timely changes to either eliminate or reduce the concerns in order to provide a safe, responsive and well led service. We carried out this focussed inspection on 16 June 2016 to check the progress that the provider had made in respect of the following issues.

The significant issues identified during the comprehensive inspection undertaken on 3 February 2016 in regard to staffing were:

- We had found that the practice was failing to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the requirements to meet the needs of the patient population served. We also found that persons employed were not receiving appropriate support and training.
- We had seen patient comments from completed NHS Friends and Family Test questions, patients had fed back about the difficulty they experienced accessing the practice due to the telephone system and the difficulty they experienced accessing appointments. This had been supported by the national GP patient survey (July 2015) which rated the experience of patients lower than local and national averages.
- Only one of the three telephone lines accessible to patients to contact the practice for urgent care, appointments, test results and other needs was in use. We had observed two members of staff managing calls into the practice during our initial visit. On average each member of staff answered four calls a minute. We saw that a member of staff had no time to complete tasks before the phone rang again and when one member of staff went to have a break the phone was left unattended. This meant patients had difficulty accessing appointments in respect of their care and treatment.
- We had been told by the lead GP the practice had had difficulty recruiting additional GPs. We had found the overall numbers of clinical and non-clinical staff and range of skills required to meet the needs of patients (13 sessions a week between Dr Lewis and a newly qualified GP for a patient list of 4500) had not been systematically assessed and routinely monitored. We identified that there were insufficient GP sessions to effectively manage the on-going health care needs of patients and insufficient staff to manage the administrative tasks required to support the provision of effective clinical care, including telephone administration.
- We reviewed the practice recruitment processes and found new members of staff had sufficient information, support and training to enable them to carry out their duties in a competent manner. We had found although there was an induction programme for new administration staff there was no practice induction packs for new GPs or practice nurses. There was also no practice specific information provided to them. This meant there was no assessment of clinical staffs' ability to meet a patient's care and treatment needs or an induction process that prepares clinical staff for their role. Also there was a potential risk to patients as locum staff were not equipped to work safely and effectively if they were unfamiliar with the practice.

At this inspection 16 June 2016 we found that the provider had taken steps in increase the stability of clinicians to provide treatment and care to patients. The lead GP had retained a regular group of either salaried GP, locum GPs and a salaried nurse practitioner to provide clinical care to patients ensuring there was continuity of care. The lead GP had ensured that the clinical sessions that were available, originally 13 sessions plus 3.5 sessions, nurse practitioner, now equated to 20 per week. The lead GP had allocated specific time, when not carrying out direct patient care, to carry out the management, leadership and governance of the service. The practice had employed a new interim practice manager to manage the practice, and changes had been made to how the administration staff were deployed in the practice. Administration staff who were mostly part time worked flexibly to meet the needs of the service. Additional hours (20) for administration had been budgeted for and the practice was in the process of recruiting new staff.

Are services well-led?

Inadequate

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

The practice, with support from NHS England had explored upgrading the telephone system and was in the process of obtaining quotes for a new system. In the interim period changes had been made so that two staff were always available covering the reception desk and answering the telephone as promptly as possible. We saw positive feedback from patients received by the practice that the changes already implemented had improved the patient experience in regard to accessing the service either by telephone or at reception. Likewise, patient comments left on the NHS Choices website acknowledged the positive changes, but this was not the experience of all patients who left made a comment.

We looked at the processes the practice had put in place to support new and locum GPs and nurses with sufficient information so that were well equipped to provide a safe service. We found the practice continued to use a recognised locum induction checklist from the Local Medical Committee (LMC). LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. We saw that the checklist highlighted topics of information, locations and other resources available to locums. However, the detail of what this entailed had yet to be recorded in depth but there was evidence they were being used when locums first attended the practice.

The significant issues identified on 3 February 2016 in regard to effective systems or processes to assess, monitor and improve the quality and safety of the service were:

- We had found that the provider was failing to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activities.
- We had looked at how the practice managed and responded to significant events. Staff had access to a recording form available on the practice's computer system to raise and record any significant events. However, some staff had told us that they did not follow the practice policy and would provide written details in their own format. This was not picked up as part of an effective system or process to assess, monitor and improve the quality and safety of the services provided or to assess monitor and mitigate any risks.
- We had been told that staff were updated on significant events during the monthly practice meeting; a significant event meeting was held twice yearly to review each event in detail however minutes for these meetings did not contain action points or lessons learnt.We saw no evidence that when there were unintended or unexpected safety incidents that appropriate steps were taken. We did not find information to evidence that patients received reasonable support, truthful information, and a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We had looked at the arrangements that were in place to safeguard children and vulnerable adults from abuse and to check what information and support was available to staff which reflected relevant legislation and local requirements. We found although policies were accessible to all staff, staff told us they did not know and were not confident of where to locate the vulnerable adult policy. This meant that staff were not able to access referral pathways. We looked at the safeguarding adult policy and saw that the contact numbers for staff, if they had concerns about a patient's welfare, was confusing. For example, there was a list of telephone numbers with no explanation as to which telephone number was the referral line. Staff were unclear which number they should telephone.We looked at the safeguarding children policy and saw that it contained information that was seven years out of date. This meant there was no surety that staff could respond appropriately should any concerns arise.
- The practice did not have a management system in place to ensure clinical and non-clinical staff were up to date with routine immunisations and immunisations for staff for specific disease prevention, for example, Hepatitis B, Tuberculosis and Chickenpox. We were told GPs and practice nurses were self-directed, and managed their own immunisation status. This meant the practice was not complying with the requirements for this as set out in the Health and Safety at Work Act (HSWA) 1974 and the Control of Substances Hazardous to Health (COSHH) Regulations 1992. Patients could not be assured that they were being cared for and treated by staff who did not put them at the potential of risk from preventable disease or illness.

Are services well-led?

Inadequate

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

- We found the practice was not following legal requirements and national guidance when administering vaccinations and immunisations. The practice did not have a process to ensure that Patient Group Directions (PGDs) that had been adopted by the practice to ensure nurses were administering medicines in line with legislation. We found PGDs that had not been signed by an authorised person.This meant practice nurses had not been authorised to administer these medicines. We found one PGD was out of date.
- We reviewed the management and administration processes for recruitment of staff. We had checked three personnel files and found appropriate recruitment checks had been undertaken prior to employment in two staff files. However, in the third personnel file we saw that the staff member had commenced work prior to their Disclosure and Baring Service (DBS) check being concluded. We saw no evidence of a risk assessment being completed prior to this staff member commencing work or appropriate assurances sought from NHS England that a check had been undertaken by them.
- We identified the provider did not have an oversight of risk assessments and safety checks for monitoring and managing risks to patient and staff safety. For example, we were told that fire drills had taken place however, the record of staff attendance and dates were not held by the practice. The practice had a legionella risk assessment, which documented checks required, however the practice was unable to locate the checklist documenting when checks had been carried out. We were shown information to support that the health and safety, building management and fire risk management had been outsourced to different companies. During our inspection the practice was unable to locate the checklist documenting when checks were carried out. The practice did not have a planned and recorded process for a premises audit or checks. We were told one member of staff took responsibility for a weekly premises inspection. These checks were not recorded and there was no checklist available to understand what the weekly inspection included or if any actions were necessary to promote safety for patients and staff.
- We found the practice did not have a safe management and administration system for ensuring all electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The records for testing were not current and related to 2009. We found medical equipment that had no evidence of checks being undertaken. For example, blood pressure machines. It was unclear if the practice had maintained a list of medical equipment available to staff and those that required annual calibration checks.
- We had looked at how the practice informed and supported patients about how to make a complaint and how the complaints process was managed. We saw information was available to help patients understand the complaints system in the practice waiting area. However the practice website did not direct patients to the complaints process. We saw that the practice used complaint logs to record receipt and management of complaints which were not always completed in full. For example, the logs did not contain action plans or lessons learnt. The complaint logs did not evidence processes undertaken to manage the complaint. This meant that we were unable to determine if action was taken to improve the quality of care. Complaints were not always responded to quickly by all staff members. The practice did not have suitable systems in place to gather feedback from patients.
- We looked at how the practice was overall managed and governed. Non-clinical management roles were delegated to internal staff or external organisations. For example, payroll, medicine alerts, QOF, health and safety, prescription management and reviews, infection control and fire safety. We found that there was limited oversight on the strategic planning, performance, quality and premises management of the practice. A comprehensive non-clinical understanding of the performance of the practice was not maintained.
- There was not a clear, structured filing system for non-clinical practice business. This meant that staff would have difficulty accessing information in the absence of the practice manager.
- We had found practice specific policies were available to all staff. However, policies were filed in a system relating to out of date Care Quality Commission regulations. This meant that staff had to refer to a reference list and then find where the policy was located. For example, we saw that safeguarding children processes were found in two places and information in each place was different. We

Are services well-led?

Inadequate

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saw information around checks required to ensure that staff did not have a criminal conviction and were safe to work with vulnerable patients was out of date and did not reflect a separate DBS policy that the practice also had in place.

- The provider did not have an effective system to review practice policies and procedures, to demonstrate that all staff understood and were trained in practice procedures and that all staff were regularly updated when processes changed.

At this inspection on 16 June 2016 we reviewed what the provider had implemented in order to ensure that they had effective systems or processes to assess, monitor and improve the quality and safety of the service.

We found the practice had reviewed how they responded and managed any significant events. We saw they had implemented a new recording tool for all staff to use; this included recording any near misses that occurred. All staff appeared to be using the new recording tool. Significant events were part of the regular weekly meetings. There was evidence in the minutes of the meetings that all aspects were discussed and actions to be taken planned for and reviewed for their effectiveness. We saw that complaints were assessed were then escalated where necessary to significant events process. Significant events were also investigated as complaints where appropriate. For example, we reviewed documentation about the actions taken following the receipt of a complaint regarding a child's care. The parents had felt that their concerns were not effectively responded to when they had been able to obtain an appointment. This led to a review of how children's needs were assessed and addressed, actions were taken and the parents were appropriately responded to and an apology given.

We looked at what changes the practice had implemented for the arrangements to safeguard children and vulnerable adults from abuse and to check what information and support was available to staff which reflected relevant legislation and local requirements. We found that the practice had ensured the current clinical commissioning group (CCG) safeguarding policies and procedures were available to staff. A copy of a document with the key steps and contacts was kept in in each consulting and treatment room. Evidence in staff meeting minutes showed that safeguarding children and adults and policies and procedures were discussed with all levels of staff. The practice had yet to ensure that the safeguarding documents were on the practice intranet, we understood this would occur when the CCG updated their documents which was due to take place later in 2016. We will review this area during our next comprehensive inspection at the practice.

We reviewed what steps the practice had made in regard to a management system to ensure clinical and non-clinical staff were up to date with routine immunisations and immunisations for staff for specific disease prevention. The provider had risk assessed each member of staff, using current information held about individuals, had developed and put an action plan in place. This included undertaking blood tests to check staffs immunisation status and providing immunisation boosts where required. Immunisation checks were now included in the recruitment process for all new staff.

We found the practice was following legal requirements and national guidance when administering vaccinations and immunisations. The practice now had a process to ensure that Patient Group Directions (PGDs) were adopted by the practice to allow nurses to administer medicines in line with legislation and were effective. We found PGDs were in date and had been signed by an authorised person. The practice had a new process that required the responsible lead member of staff to monitor that all new information and PGDs were identified and adopted in a timely way.

We looked at the changes the practice had implemented for the management and administration processes for recruitment of staff. We revisited the information regarding two members of staff and saw that applications had been made for an up to date Disclosure and Baring Service (DBS) check to be carried out. The practice had implemented a risk assessment process for staff whilst this was being completed.

We reviewed the systems the practice had implemented to identify any risks to patient and staff safety. We saw there were systems, documentation and information to assess, respond and manage the health and safety including risk assessments. For example, the recording detail of fire drills that had taken place, the legionella risk assessment checks carried out and the safe handling of substances that should be managed under the Control of Substances Hazardous to Health Regulations 2002. We saw that the practice staff had worked together to gather information, ensure that

Are services well-led?

Inadequate

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processes were in place and a number of tasks were delegated to a specific member of staff to take responsibility. For example, there was a system for electrical equipment checks, which now included the equipment taken on home visits. The interim practice manager had some oversight to what was in place and what and when should be occurring to manage safety at the practice. We saw that this was work in progress and there were still minor amendments to be made. For example, ensuring the correct detailed information, the data sheets from the manufacturer, matched the chemicals used at the practice and ensuring detail of the checks carried out for the emergency lighting.

We looked at how the practice was informing and supporting patients to make a complaint and how the complaints process was managed. We saw information, that a new complaints form was available to help patients understand the complaints system in the practice was accessible in the waiting area. However, detail was still not included on the practice website to direct patients to the complaints process. We saw that the practice used complaint logs to record receipt and management of complaints. We reviewed three complaints that had been received since our last inspection in February 2016. We saw that the system for managing complaints was more detailed and included ensuring they were assessed appropriately, actions identified and the complainants responded to formally. We saw that complaints and how to manage complaints were topics discussed at staff meetings, including how to diffuse patients concerns from escalating when they could be acted upon immediately.

We looked what changes the provider had implemented to how the practice was managed and governed. The provider had engaged a new interim practice manager to take the lead in shaping the changes in the organisation of the service. We saw that there had been a sharing of roles across the staff team, although a number of the non-clinical management roles remained delegated to external organisations. We found that there was evidence of progress in the provider and senior staff having oversight on the strategic planning, performance, quality and premises management of the practice. This was through a programme of practice meetings, redevelopment of policies and procedures and ensuring that there was a sharing of information across the staff team. Examples of updated policies and procedures included those relevant to health and safety, recruitment and those related to employment of staff.

We saw that progress was being made in implementing a structured filing system for non-clinical practice business. This meant that staff were able to access information in the absence of the practice manager. We saw that changes in policies, procedures and systems were discussed during staff meetings. Feedback from staff we spoke with during this inspection showed that this was a positive approach and staff felt engaged and involved in how the practice was being run.