The Practice Hangleton Manor

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection of The Practice Hangleton Manor on 23 February 2016.

We had previously carried out a comprehensive inspection of The Practice Hangleton Manor on 8 September 2015. Breaches of regulations were found and the practice was required to make improvements. Following the comprehensive inspection, the practice sent us an action plan detailing what they would do to meet the regulations. We undertook this focused inspection on 23 February 2016 to check that the provider had followed their action plan and to confirm that they now met the regulations in relation to good governance.

This report only covers our findings in relation to those requirements. A further comprehensive inspection will be undertaken to follow up the remaining breaches of regulations and to check that improvements have been

Summary of findings

made. At this stage the overall rating for the practice will remain unchanged. You can read the report from our last comprehensive inspection by selecting the 'all reports' link on our website at www.cqc.org.uk

Our key findings across the areas we inspected were as follows:

- The practice had made some improvements to governance arrangements but continued to have a lack of effective systems to assess, monitor and improve the quality and safety of services provided.
- There was a lack of processes for sharing the outcome of audit findings and the learning from complaints and significant events, in order to ensure continuous improvement.
- There was no permanent GP employed within the practice and a lack of clearly defined clinical leadership within the practice on a day to day basis.
- There was an over-reliance upon telephone triage consultations in place of face to face consultations with patients. The practice had not adequately assessed the impact or potential risk of the appointment system.
- Multi-disciplinary meetings with other health care professionals were not held within the practice. The practice had not recently held a meeting to review patients receiving end of life care.
- There was a lack of documented care planning for patients with complex needs.
- Patient recall systems had been reviewed and improved but were restricted due to a lack of nurse appointments.
- The practice had established their own virtual PPG and had conducted a survey to gather feedback from patients.

The areas where the provider must make improvements are:

- Ensure clearly defined clinical leadership within the practice on a day to day basis, including areas of responsibility and allocation of tasks for locum GPs.
- Ensure processes for sharing the outcome of audit findings in order to ensure continuous improvement.
- Ensure that learning and changes to processes as a result of significant event analysis and complaints management are clearly recorded and shared with staff to ensure continuous improvement within the practice.
- Ensure that risks to patients' health are appropriately managed and that there are systems and adequate resources in place to support patient recall, review and care planning.
- Ensure multidisciplinary meetings are in place in order to review the care of all vulnerable patients and those receiving palliative care.
- Ensure that the practice appointment system is adequately risk assessed and subject to regular quality review.
- Ensure there is a robust plan and clear lines of responsibility in place to implement improvements to patient treatment outcomes, including action planning and review.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services well-led?

At this inspection we focused upon the breaches of legal requirements which we found at our last inspection in relation to good governance within the practice. We found that the practice had made some improvements to governance arrangements but continued to have a lack of effective systems to assess, monitor and improve the quality and safety of services provided.

- There was no permanent GP employed within the practice and the practice relied solely upon locum GPs. The lack of a permanent team of clinical staff resulted in a lack of clearly defined clinical leadership within the practice on a day to day basis.
- The practice had not adequately assessed the impact, potential risk of the appointment system. There continued to be an over-reliance upon telephone triage consultations in place of face to face consultations with patients.
- Multi-disciplinary meetings with other health care professionals were not held within the practice in order to discuss those patients with multiple long term conditions, mental health problems or patients from vulnerable groups. The practice had not recently held a palliative care meeting.
- Patient recall systems had been reviewed and improved and were coordinated by a dedicated administrator. However, a lack of nurse appointments meant that some patient reviews, for example routine foot checks for diabetic patients, were not consistently being carried out.
- There was a lack of documented care planning for patients with complex needs, for example patients who were identified as being at high risk of admission to hospital, or those with a learning disability or dementia.
- Improved processes were in place for communicating with ambulance and out-of-hour's services about patients with complex needs.
- The practice had taken some steps to monitor patient treatment outcomes and progress towards achieving QOF targets. However, there was a lack of clarity around who was responsible for implementing actions to address identified shortfalls.
- The practice had undertaken some clinical audit, however there was a lack of processes for sharing the outcome of audit findings in order to ensure continuous improvement.
- The practice held some team meetings but their frequency and approach to discussing performance, quality and risks remained inconsistent.
- The practice remained unable to demonstrate how the learning and changes to processes as a result of significant events and complaints were shared with staff to ensure continuous improvement within the practice.
- The practice had established their own virtual PPG and had conducted a survey to gather feedback from patients.
- The practice had developed a patient newsletter in order to improve patient awareness of services provided and to inform patients of changes within the practice

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure clearly defined clinical leadership within the practice on a day to day basis, including areas of responsibility and allocation of tasks for locum GPs.
- Ensure processes for sharing the outcome of audit findings in order to ensure continuous improvement.
- Ensure that learning and changes to processes as a result of significant event analysis and complaints management are clearly recorded and shared with staff to ensure continuous improvement within the practice.
- Ensure that risks to patients' health are appropriately managed and that there are systems and adequate resources in place to support patient recall, review and care planning.
- Ensure multidisciplinary meetings are in place in order to review the care of all vulnerable patients and those receiving palliative care.
- Ensure that the practice appointment system is adequately risk assessed and subject to regular quality review.
- Ensure there is a robust plan and clear lines of responsibility in place to implement improvements to patient treatment outcomes, including action planning and review.

The Practice Hangleton Manor

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector**.** The team also included a GP specialist adviser.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 8 September 2015, as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Breaches of regulations were found and the practice was required to make improvements. As a result we undertook this focused inspection on 23 February 2016 to follow up on whether action had been taken to deal with some of the breaches of regulations. We specifically looked at how the practice ensured that good governance arrangements were in place.

Are services well-led?

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

Our findings

Governance arrangements

At our previous inspection we found that there was a lack of formal governance arrangements in place. The practice did not have effective systems to assess, monitor and improve the quality and safety of services provided. The practice had not always assessed, monitored and mitigated risks relating to the health, safety and welfare of patients and staff. Action had not been taken to seek and act on feedback from patients for the purpose of evaluating and improving the service.

At this inspection we found that the practice had a number of policies and procedures in place to govern activity and these were available to staff. The policies and procedures we looked at had been reviewed annually and were up to date. Staff had signed to confirm that they had read the policies and when.

The locality lead GP and the practice manager for The Practice group/Chilvers and McCrea Ltd held leadership roles with the practice and were responsible for overseeing that there were systems in place to monitor the quality of services provided. However, the practice manager had responsibility for four of The Practice group/Chilvers and McCrea Ltd practices within the locality and the lead GP was based in another practice for eight sessions a week, with an additional two sessions of administrative time allocated to provide support to four practices within the group. In addition, there was governance support from the central team of The Practice Group/Chilvers and McCrea Ltd.

We spoke with six members of practice staff and most were clear about their own roles and responsibilities. However, there was no permanent GP employed within the practice and the practice relied solely upon locum GPs. The practice employed one nurse who worked for 12 hours each week. The lack of a permanent team of clinical staff resulted in a lack of clearly defined clinical leadership within the practice on a day to day basis. Some staff considered one regular locum GP, who worked between two and three days each week, to be the lead GP within the practice. For example, staff told us they would discuss progress relating to QOF outcomes with that GP. However, no formal arrangements were in place for the locum GP to assume any clinical leadership responsibilities. They told us they did not routinely attend practice meetings and had no time allocated to them to complete clinical governance activities. Other staff told us they would raise immediate safeguarding concerns with the locum GP. However, the practice held no information to confirm that locum GPs working within the practice had undergone appropriate safeguarding training.

The practice had failed to assess the risks associated with reliance solely upon locum GPs and the lack of a permanent GP present within the practice. For example, with respect to continuity of care, clinical governance, information sharing and the allocation of tasks. One locum GP told us that they were regularly required to review a back-log of patients test results which had accumulated when other locum GPs had been present within the practice. Although staff were aware of the role of the locality lead GP, some staff told us that communication with them was predominantly by email. The locality lead GP did not routinely attend meetings within the practice.

At our previous inspection we identified an over-reliance upon telephone triage consultations in place of face to face consultations with patients. The practice had not adequately assessed the impact or potential risk of the appointment system. At this inspection we found that the practice continued to allocate GPs high numbers of telephone consultations on a daily basis. Same day appointments were available but patients were required to have a telephone consultation with the GP before they were booked into one of these appointments. One GP we spoke with told us that in a typical day they would conduct more than 30 telephone consultations, and approximately 10 to12 face to face consultations. We examined appointment scheduling records which confirmed this. Staff told us they considered the current system to be inflexible and to present risks to patients. Staff also told us that the high number of telephone consultations represented an unmanageable workload for GPs within the practice. The practice's central governance team had recently assessed the number of telephone triage consultations which were converted to face-to face appointments with a GP. This revealed that on average 20% of patients who underwent a telephone consultation were subsequently invited into the practice for a face to face consultation. However the assessment did not consider the risks to staff and patients in maintaining such a system.

Are services well-led?

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There were no nurse or healthcare assistant appointments available to patients on two days each week. Staff told us that where possible they would utilise nurse appointments at another particular practice within the group. However, we noted that there was no nurse employed within that practice at the time of our inspection. The practice participated in an extended hours project within the locality. This service enabled the practice to book patients in to see a GP or nurse at another practice for evening and weekend appointments. Staff told us they regularly utilised this service to address the lack of nurse appointments within the practice.

At our previous inspection we found that the practice had not held meetings with other health care professionals to discuss those patients with multiple long term conditions, mental health problems, people from vulnerable groups or children on the at risk register. We found that the practice did not have adequate systems and processes in place which enabled them to identify patients who were nearing the end of life.

At this inspection we found that the practice had not held a meeting to discuss patients on their palliative care register since August 2015. The practice had three patients on their palliative care register. We noted that there was a palliative care meeting planned for the week following our inspection. The practice had recorded that a locum GP and a practice nurse would attend that meeting. However, neither staff member was aware of their requirement to attend the meeting and both told us they had not been involved in attending a palliative care meeting previously. One practice nurse told us how they had conducted a number of home visits to housebound patients at the end of 2015 in order to carry out outstanding reviews of their long term conditions and provide flu vaccinations and blood pressure checks. However, staff told us that multi-disciplinary meetings were not held within the practice. Therefore information gathered from those visits about those vulnerable patients had not been formally shared with other agencies and professionals.

At our previous inspection we found that the practice did not have systems in place for patient recall, monitoring and care planning to ensure that risks to health were managed safely and appropriately. At this inspection we found that patient recall systems had been reviewed and improved and were coordinated by a dedicated administrator. However, a lack of appointments such as nurse appointments meant that some patient reviews, for example routine foot checks for diabetic patients were not consistently being carried out. We found that where patients who were identified as being at high risk of admission to hospital, or those with a learning disability or dementia, had undergone a review appointment, care planning had not been carried out. For example, we noted that the practice provided care to nine patients with a learning disability. We reviewed patient records and found that seven of those patients had undergone a recent review but none had a documented care plan in place.

At our previous inspection we found that the practice did not have clear processes in place for communicating with ambulance and out-of-hour's services about patients with complex needs. At this inspection we found that the practice had reviewed their processes in this regard and all staff were aware of the system for sharing appropriate information with these services.

At our previous inspection we found that the practice did not use the Quality and Outcomes Framework (QOF) data effectively to monitor outcomes for patients and to measure their own performance in key clinical areas. At this inspection we found that the practice had taken some steps to monitor QOF data and had employed an administrator to analyse treatment outcomes and progress towards achieving QOF targets. However, there was a lack of clarity around who was responsible for implementing actions to address identified shortfalls. For example, the practice was experiencing difficulty in accessing appointments with a practice nurse for patients with diabetes who required a foot examination. The administrator told us they had discussed their concerns with a locum GP who was available to them on a regular basis. However the locum GP told us they held no formal clinical governance responsibility within the practice.

At our previous inspection we found that whilst the practice had made some use of clinical audits, there was a lack of a structured programme in place which demonstrated the use of audit to monitor quality and a lack of systems to identify where action should be taken. At this inspection we found that the practice had held an audit meeting in November 2015 in order to plan an audit schedule. We reviewed the minutes of that meeting and noted that there was no GP in attendance, however the meeting had been

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attended by two nurses. There was a lack of clarity around how the practice had identified the areas of possible audit which were discussed at the meeting and how they had identified areas where action needed to be taken.

We reviewed two audits which had been undertaken since our last inspection. For example, the locality lead GP had carried out a comprehensive audit of all safeguarding processes within the practice in response to a significant event which occurred in August 2015. This had led to revisions to the practice's safeguarding policies and processes. Another audit had been undertaken by a clinical pharmacist who worked across the practice group, to review the prescribing of potentially dangerous medicines to patients, such as anti-rheumatic and anti-coagulant medicines. However, we found there was a lack of processes for sharing the outcome of audit findings in order to ensure continuous improvement. We noted that the outcome of those audits recently undertaken had not been discussed at team meetings and clinical staff within the practice were unaware of the undertaking or the outcome of the audits.

Leadership and culture

At our previous inspection we found that the practice did not hold regular staff meetings where governance issues were discussed. Meetings were held on an ad hoc basis and staff told us they were not always regular. Minutes of meetings were limited and we found that the approach to discussing performance, quality and risks was inconsistent.

At this inspection we found that the practice had held some team meetings but that their frequency and approach to discussing performance, quality and risks remained inconsistent. We reviewed the minutes of two meetings held in January 2016. Although minutes of the meetings were headed as clinical meetings, we found that those meetings lacked clinical input and therefore references to clinical auditing or review of patient treatment outcomes were minimal and administration based. Locum GPs told us they were not routinely invited to those meetings and the locality lead GP did not attend.

At our previous inspection we found that the practice had not completed comprehensive reviews of significant events and other incidents they had recorded. It was unclear how the practice monitored their systems and processes in order to identify when things went wrong and to ensure improvements were made. Whilst the practice had taken some action to address each individual incident there was no evidence that they had taken action to review or monitor the systems in place using tools such as audit or risk assessments. Therefore, the practice could not be sure that the risk of similar incidents occurring in the future was sufficiently mitigated or that the system itself was adequately robust.

The practice had recorded two significant events since our last inspection. We noted that those significant events had not been discussed at team meetings. We reviewed correspondence received by the practice from the central governance team of The Practice group, who had reviewed information relating to one significant event. Guidance from the central team specified the need to ensure the recording and sharing of lessons learned as a result of the incident within team meetings. However, this instruction had not been followed locally by the practice. The practice was unable to demonstrate how the learning and changes to processes as a result of significant events were shared with staff to ensure continuous improvement within the practice.

We were informed of one incident which had occurred recently within the practice but which had not been recorded as such. This involved the short notice absence of one locum GP which resulted in a lack of availability of GP appointments on one day and highlighted a lack of contingency planning within the practice. Staff told us that patients were encouraged to rebook their appointments for the following day and a small number of urgent home visits were covered by a GP from within the practice group. However, the practice was unable to demonstrate that they had recorded or reviewed the learning from this incident or assessed the risks associated with a recurrence, in order to ensure that improvements had been made.

At our previous inspection we found that whilst action was taken to promptly address individual complaints, the practice had been unable to demonstrate how changes were made to implement improvements to service provision and reduce the likelihood of further complaints. We found at this inspection that the practice had recorded one complaint since our last inspection which had been discussed at one team meeting. However, staff told us they had received telephone calls from patients who made verbal complaints, for example, about the telephone triage system. Staff told us that verbal complaints were not

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recorded and were managed verbally. This meant that the practice was unable to monitor the volume and nature of verbal complaints made and opportunities to detect themes and areas for improvement were missed.

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

At our previous inspection we found that the practice did not seek and act on feedback from staff and patients for the purpose of continually evaluating and improving the service. The practice did not have its own patient participation group (PPG). Instead, patients participated in a multi-surgery PPG. The practice had not undertaken their own patient surveys and there was no evidence to show that the PPG had been involved in analysing patient feedback to improve services. The practice had not reviewed results from the national GP patient survey or utilised information from patient feedback to implement improvements to the service.

At this inspection we found that the practice had established their own virtual PPG and had conducted a survey to gather feedback from patients about the telephone appointment system. In response to the findings of the survey and feedback from staff, the practice planned to introduce a two week trial period in which they would significantly increase the number of face to face consultations with patients. The practice had also introduced electronic prescribing systems which enabled patients to request repeat prescriptions and have them sent directly to a pharmacy of their choice. We saw that the practice had developed a patient newsletter in order to improve patient awareness of services provided and to inform patients of changes within the practice.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not always assessed, monitored and improved the quality and safety of services provided in the carrying on of the regulated activity. We found that the registered provider had not always assessed, monitored and mitigated the risks relating to the health safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. We found that the registered provider had not always evaluated and improved their practice in respect of the processing of information related to mitigating risk and improving the quality of the services provided. This was in breach of regulation 17 (1) (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.