The Woodrow Medical Centre

Quality Report

Woodrow
Redditch
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Date of inspection visit: 14, 15 and 19 March 2018
Date of publication: 11/06/2018

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

Ratings

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

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (Previous inspection September 2017 – Good)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Inadequate

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 unannounced comprehensive inspection at The Woodrow Medical Centre on 14 March 2018 due to patient safety concerns raised by a whistleblower. The practice had previously been inspected in 2014, 2016 and 2017. We found serious concerns about patient safety and therefore we went back to complete the inspection on 15 March 2018. We asked the practice to submit an action plan on 19 March 2018 to ensure that the serious concerns which put patients at risk had been addressed. We went back to inspect on 19 March 2018 and found that the actions the practice stated they had completed had not been actioned putting patients at extreme risk.

At this inspection we found:

- There were multiple outstanding tasks dating back over several months on the practice computer system. This meant that numerous patients had not been informed of new diagnoses and had not had appropriate or adequate monitoring of their long term conditions such as diabetes, anaemia and high blood pressure.
- There were numerous letters found in one of the GPs' intray dating back to October 2017 with overdue actions that put patients at risk.
- Work labelled as completed was found to be incomplete again placing patients at risk.
- The practice was found to be approximately three months behind with scanning. This posed a serious risk to patients in that if they had a GP appointment, the GP might not have access to the latest information about their care and treatment.
- There were 70 patient records waiting to be summarised which were stored in a cupboard. The backlog of summarising meant that clinical

Summary of findings

information about patients was not being transferred to the patients' electronic records in a timely manner; therefore important information might not be available to clinical staff. There is a serious risk to patients if the notes summary misses key information about a patient.

- We found several examples where monitoring blood tests had not been completed in accordance with national guidelines.
- We found a large number of uncollected prescriptions dating as far back as April 2017. These patients had not been reviewed to see why the prescriptions were not collected. In some cases several months supply of a medicine for the same patient remained uncollected.
- There was a significant risk to patients because there was insufficient clinical capacity to ensure patients received safe care and treatment.
- At the time of our inspection there was one receptionist and one secretary which meant that administration tasks were not getting done. The practice manager had also resigned. We were informed that 11 members of staff had left in the last nine months.
- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen. We found that significant events were not always reported and acted upon. There was no evidence of learning from incidents or and communication of outcomes with staff.
- Patients were at risk of harm because there was a lack of monitoring of the care and treatment of patients. There was a failure of the GPs to treat patients in accordance with national clinical guidelines.
- Children were not protected as there was not an effective system in place to highlight or identify safeguarding concerns.
- The practice provided two urgent appointments per day which was not sufficient as patients were getting turned away.
- There was no focus on continuous learning and improvement.
- Theprovider wasnot managing safety alerts appropriately.
- The practice had not carried out any audits in the last 12 months in order to improve outcomes for patients.
- We found that care and treatment for patients with multiple long-term conditions was below standard. We saw numerous examples of misdiagnoses and inappropriate coding so that patients were not being treated for conditions such as diabetes.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The provider is no longer providing care or treatment from The Woodrow Medical Centre.

As a result of the inspection team's findings from the unannounced comprehensive inspection, as to non-compliance, but more seriously, the continuing risk to service users' life, health and wellbeing, the Commission decided to apply to Redditch Magistrates' Court to cancel the providers registration to carry out these regulated activities under section 30 of the Health and Social Act 2008.

Section 30 of The Health and Social Care Act 2008 is one of the most severe enforcement powers available to the Commission. Section 30 allows the Commission to make an urgent application to the Magistrates Court seeking urgent cancellation of registration, if, unless the order is made, there will be a serious risk to a person's life, health or wellbeing. The order for cancellation was granted by the Magistrates Court on Wednesday 21 March 2018 and served upon the provider with immediate effect. The provider, which was a partnership of three GPs and one nurse practitioner, is therefore unable to carry on the regulated activity.

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**

The Woodrow Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

On 14 March 2018 our inspection team was led by a CQC lead inspector. The team included a second CQC inspector, a GP specialist adviser and a practice nurse specialist adviser. On 15 March 2018 and 19 March 2018 the inspection team was led by a CQC lead inspector and the team included a GP specialist adviser.

Background to The Woodrow Medical Centre

The Woodrow Medical Centre was a GP practice which provided primary medical services under a General Medical Services (GMS) contract to a population of approximately 3,900 patients living in the Woodrow and surrounding areas of Redditch, Worcestershire. A GMS contract is a nationally agreed contract used for medical services providers. The practice had a branch practice at Millstream Surgery, Cherry Tree Walk, Redditch. We did not inspect this branch as the practice had closed it at the time of our inspection due to being short staffed.

The practice operated from a single storey building which had parking facilities on site and an easily accessible car park opposite the premises. There was a disabled access approach to the main reception with a bell system to alert staff to provide assistance to open the main door if required. There was a spacious waiting area allowing easy access for patients with mobility aids to manoeuvre.

The practice population had a higher than average number of patients aged 0 to 40 years and a significantly lower than average number of patients in the 60 to 85 year age group. National data indicated that the area was one that experienced high levels of deprivation. The practice population was mixed with high numbers of patients from ethnic groups, whose first language was not English such as Indian and Pakistani. The practice had four partners; three of these were GPs and the fourth partner was a nurse practitioner who worked full time at the practice. One of the GP partners did not carry out clinical work in the practice and was a silent partner. The practice employeda salaried GP and a practice manager who were supported by two administration and reception staff.

The practice was open at the following times:

- Monday: 7am to 6pm
- Tuesday: 8.30am to 6pm
- Wednesday: 8.30am to 5pm
- Thursday: 8.30am to 6pm
- Friday: 8.30am to 6pm

The practice did not provide out of hours services beyond these hours. Patients were provided with information about the local out of hours services provided by Care UK which they could access by using the NHS 111 telephone number.

Inadequate

Are services safe?

Our findings

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

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

- There were multiple outstanding tasks dating back over several months on the practice computer system. This meant that numerous patients had not had conditions diagnosed and had not had appropriate or adequate monitoring of their long term conditions such as diabetes, anaemia and high blood pressure.
- There were numerous letters found in one of the GPs intray dating back to October 2017 with overdue actions that put patients at risk.
- Work labelled as completed was found to be incomplete again placing patients at risk.
- The practice was found to be approximately three months behind with scanning. On 14 March 2018, the receptionist was scanning documents from December 2017. This posed a serious risk to patients in that if they had a GP appointment, the GP might not have access to the latest information about their care and treatment.
- The inspection team counted 70 patient records waiting to be summarised which were stored in a cupboard. The backlog of summarising meant that clinical information about patients was not being transferred to the patients' electronic records in a timely manner, therefore important information might not be available to clinical staff. There is a serious risk to patients if the notes summary misses key information about a patient.
- The inspection team found several examples where patients on high risk medicines had not received their blood tests in accordance with national guidelines.
- The inspection team found a large number of uncollected prescriptions dating as far back as April 2017. These patients had not been reviewed to see why the prescriptions were not collected. In some cases several months supply of a medicine for the same patient remained uncollected.
- At the time of our inspection there was one receptionist and one secretary which meant that administration tasks were not getting done. The practice manager had also resigned. We were informed that 11 members of staff had left in the last nine months.
- There is a significant risk to patients because there is insufficient clinical capacity to ensure patients receive safe care and treatment.

Safety systems and processes

The practice did not have clear systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies including adult and child safeguarding policies but we did not find evidence that they were regularly reviewed and communicated to staff.
- The safeguarding lead was not aware of children on the safeguarding register. We were unable to find any minutes of safeguarding meetings.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients. We were concerned that the last time the practice had reviewed the child protection register was on 25 September 2017. The last time the practice had reviewed the vulnerable adults search on the computer was 12 December 2017. We would expect both of these searches to be run regularly so that relevant practice staff could review patients on the register and discuss them at safeguarding multidisciplinary team (MDT) meetings.
- During the inspection we found examples where children at risk were not being followed up. For example a child had an alert to say they were on the child protection register for neglect. There were multiple letters filed in the child's records informing the practice that they had missed hospital appointments, but no action had been taken by the Practice. This could put the child at risk from having an untreated condition due to not being seen by the appropriate specialist. It is usual practice to follow up if a child has not attended a hospital appointment especially if they are on the safeguarding register.
- All staff received up-to-date safeguarding and safety training appropriate to their role. Reports and learning from safeguarding incidents were not available to staff. We saw a folder with significant events from the last year. There was a lack of trend analysis. When we asked one of the partners about this they told us that these meetings were not minuted but were discussed informally. The last incident in the folder was from 1 September 2017 which suggests not all incidents were

being recorded and discussed. There were no details of who attended the meetings, no details of what was discussed, no clear actions or review dates and no evidence that learning was shared amongst the team.

- We saw an example where a significant event had been logged as a patient collapsed when blood was taken. This happened in April 2017. The action plan from this significant event was for patients to lie down if they felt uncomfortable and to have the phone nearby so that the panic alarm could be raised. The practice had not learned from this significant event as the same thing happened in August 2017. The practice were not following their own action plan.
- The salaried GP informed us during the inspection that they were not aware if significant events were discussed and in the five months they had worked at the practice they were unaware of any discussions.
- The practice did not always carry out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were usually undertaken however we did find examples where members of staff had been recruited without a DBS check or without references in place. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff who acted as chaperones were trained for the role and had received a DBS check.
- During the inspection we were informed that the senior partner would often make decisions about recruitment without following the necessary policies and procedures. We were informed by the practice manager that there was no clarity over jobs and tasks by the practice partnership.
- There was an effective system to manage infection prevention and control. We saw an infection control audit from January 2018. However during the inspection we found one of the GPs' consulting rooms was not an appropriate clinical environment. It had a two seater leather sofa instead of a proper examination couch and a standard domestic washbasin with popper plug, instead of a proper clinical handwashing basin with appropriate handwashing soap. It had a thick pile carpet which was not visibly clean.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were inadequate arrangements for planning and monitoring the number and mix of staff needed. When we carried out the unannounced inspection at the practice there was one receptionist and one secretary. This impacted on patients as administration tasks were stacking up and people were being required to do tasks that they weren't trained or qualified to do. The practice manager was working her notice period as she had resigned. The practice were planning on advertising for a new practice manager when we asked for this during the inspection. We were informed that several reception staff had left recently.
- There was inadequate clinical cover as patients were unable to get an appointment with a GP and there was limited urgent appointment cover which put patients at risk. The salaried GP was working at the time of the inspection but was going to be leaving soon after. They told us they had been asked to leave by the senior partner without having been given the proper notice period in line with their contract of employment. The salaried GP had been working 10am to 1pm then 3pm to 6pm then 6.30pm to 7.40pm on a Thursday. The salaried GP informed us during the inspection they had been asked to leave. This would leave the practice short of clinical staff. We were told that a replacement had been recruited but we saw no evidence of this during the inspection.
- We were told that the senior partner worked one session per week. At the time of the inspection the senior partner was on leave and no-one could tell us when they were coming back. One of the other partners was working eight sessions per week but only had indemnity cover for five sessions.
- The practice was equipped to deal with medical emergencies. We did not feel that staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention as there was lack of guidance for reception staff for what to do when a patients condition deteriorates.

Inadequate

Are services safe?

- When there were changes to services or staff the practice did not assess and monitor the impact on safety. For example the lack of administrative staff in reception which in turn impacted on patients.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- There were multiple outstanding tasks dating back over several months on the practice computer system. This meant that numerous patients had not had conditions diagnosed and had not had appropriate or adequate monitoring of their long term conditions such as diabetes, anaemia and high blood pressure.
- The practice computer system showed that 411 registrations of patients were still awaiting processing; these included 149 patient deductions. Deductions are carried out when a patient moves to another practice or when they have deceased. These dated back to 29 December 2016 indicating that the practice had not been managing this process effectively for 15 months.
- There were 29 patient notifications from the diabetic eye screening and learning disability services which were still awaiting processing. These dated back to February 2017.
- During the inspection we reviewed correspondence awaiting action in one of the GP's trays. We identified numerous issues of concern including referrals which had not been made, patients with potentially serious mental health issues who had not been reviewed, requests for blood tests which had not been followed up, patient records which had not been updated and medicines which had not been adjusted.
- Due to the concerns identified on reviewing the tasks and patient records we looked at a random set of consultations. We discovered additional areas of concern such as:
- An asthmatic patient who presented with a worsening of symptoms. There was no record of a peak flow being taken to assess severity of the asthma attack and no review arranged for 48 hours as recommended by NICE guidelines.
- A 10 year old boy who had been seen on several occasions with vomiting. On the latest consultation, the child had been prescribed an anti-sickness medicine over the telephone without them being seen or reassessed. A child who has persistent vomiting should be seen and assessed to determine a cause and this medicine is not recommended in children due to potential side effects.

Safe and appropriate use of medicines

The practice did have systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised some risks. However we were concerned that emergency medicines were being checked by administrative staff. When we asked if the receptionist had received training to check the medicines they declined to answer the question. We found that the emergency medicines had not been checked for two months at the time of our inspection.
- The practice had not carried out an appropriate risk assessment to identify medicines that it should stock in case of an emergency.
- The practice did not keep prescription stationery securely.
- The practice did not have a paediatric pulse oximeter. This is equipment for measuring oxygen levels in the blood.
- The salaried GP informed us that they used their own bag rather than rely on the practice equipment.
- The practice had not been transporting flu vaccines in line with current guidelines. They were using freezer packs in the cool box instead of cool packs.
- Patient Group Directions required to allow nurses to administer medicines in line with legislation were available but five of these had not authorised by the practice.
- Staff did not prescribe, administer or supply medicines to patients in line with legal requirements and current national guidance. We saw an example where a discharge letter from hospital dated 29 January 2018 regarding a patient suggested their insulin should be changed to a different type. This had not been actioned by the practice.
- The practice offered a number of telephone consultations per day. During the inspection we found that these patients did not receive appropriate follow up.
- Patients' health was not monitored to ensure medicines were being used safely and followed up on

appropriately. During the inspection we found an example of a patient who did not have a diagnosis of diabetes in their records. The patient had been in the diabetic range since August 2013 and had not been informed or treated.

- During the inspection we reviewed the notes of patients taking high risk medicines. These medicines require regular and close monitoring to ensure that patients are not developing side effects or complications of the drugs and that the dosages are in the correct range when relevant. We reviewed the notes of seven patients taking a medicine for mental health problems. We found that not all patients had an alert on their records that they were taking a high risk medicine. Two patients had not had their blood checked at the recommended interval in the last year whilst being on Lithium. Several patients had not had mental health annual reviews done. In one instance we saw a code had been added to the patient's records to indicate that a review had been completed but there was no evidence in the notes to suggest it had.

Track record on safety

The practice did not have a good safety record.

- There were comprehensive risk assessments in relation to safety issues but they were not always followed, for example the recruitment procedures. The practice did not have enough staff at the practice to function safely. For example administrative tasks were building up and this impacted on patients.
- The practice did not review repeat prescriptions in line with its own policy. At the time of our inspection we found prescriptions that were several months out of date which had not been collected. The practice had not reviewed the uncollected prescriptions or contacted patients. For example there were four separate prescriptions for one patient of the same medicine that is used in an emergency to treat epileptic seizures, which had been printed in September, twice in October and again in November 2017. We found a prescription for medicines to treat epilepsy, a significant mental health condition and depression for a patient with learning difficulties which was printed in June 2017 and not reviewed since.
- The practice did not monitor and review activity.

Lessons learned and improvements made

The practice did not learn and make improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses but these were not discussed or analysed in any way.
- There were inadequate systems for reviewing and investigating when things went wrong. The practice did not identify themes and take action to improve safety in the practice. There was evidence that learning was not taking place with similar incidents happening repeatedly.
- There was no effective system for receiving and acting on safety alerts. We reviewed the notes of patients taking a medicine in view of the recent Medicines and Healthcare products Regulatory Agency (MHRA) safety alert which highlighted that this medicine could cause foetal abnormalities and recommended it should not be prescribed to women of child bearing age. We identified a patient who was not on any contraception but had an alert on their records highlighting they were on this medicine and were of child bearing age. There was no mention of any precautions taken or advice given. There was another patient who currently had a coil for contraception, but the risks of the medicine and pregnancy had not been discussed with her so if the coil was removed she would not have been aware of the risk. A further patient had an alert regarding the issue and a statement in her record to discuss at next review, but there was no evidence the patient had been contacted since the note was added in September 2017.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

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

The practice is rated as inadequate for providing effective services. This is because:

- There were multiple outstanding tasks dating back over several months on the practice computer system. This meant that numerous patients had not had appropriate or adequate monitoring of their long term conditions such as diabetes, anaemia and high blood pressure. This presents extreme risk in terms of them not receiving the appropriate treatment, adjustment to their medicines or ongoing monitoring.
- There were numerous letters found in one of the GPs' intray dating back to October 2017 with overdue actions that put patients at risk.
- Correspondence labelled as completed was found to be incomplete again placing patients at risk, as issues were not followed up.
- The practice was found to be approximately three months behind with scanning documents such as correspondence from hospital consultants into patients' records. On 14 March 2018, the receptionist was scanning documents from December 2017. This posed a serious risk to patients in that if they have a GP appointment, the GP may not have access to the latest information about their care and treatment.
- The inspection team counted 70 patient records waiting to be summarised which were stored in a cupboard. The backlog of summarising meant that clinical information about patients was not being transferred to the patients' electronic records in a timely manner, therefore important information might not be available to clinical staff. There is a serious risk to patients if the notes summary misses key information about a patient.
- The inspection team found several examples where monitoring blood tests had not been completed in accordance with national guidelines.
- There was a significant risk to patients because there was insufficient clinical capacity to ensure patients receive safe care and treatment.

Effective needs assessment, care and treatment

The practice did not have systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians did not assess needs and deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The salaried GP had their own resources and links on their phone to keep up to date with current guidelines for example NICE and GP notebook.

- Patients' immediate and ongoing needs were not fully assessed. This included their clinical needs and their mental and physical wellbeing. We found there was no system to monitor the timeliness and appropriateness of clinical referrals. For example we saw a letter in a tray with an abnormal electrocardiogram (ECG) result from January 2018. An electrocardiogram is equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. This was not actioned and therefore could have put the patient at risk.
- We found a patient with bladder problems and blood tests showed a raised Prostate Specific Antigen (PSA) which was above the normal range for the patient's age. (PSA is a protein produced by both normal and cancerous prostate cells. It is normal for all men to have some PSA in their blood. A high level of PSA can be a sign of cancer.) The blood tests were filed for an urgent appointment in mid- February. The patient had not been contacted when this patient should have been given an appointment to see a hospital consultant for suspected cancer under the two week referral pathway.
- We saw examples where NICE guidelines had not been followed and the two week cancer referral pathway had not been followed.
- For example a male patient had seen one of the GPs with symptoms suggestive of a urinary tract infection. The patient had been prescribed a three day course of antibiotics. NICE guidance recommends seven days antibiotics for treatment of urinary tract infections in men.
- We were concerned to see that a patient with raised blood pressure had not had this reviewed as intended. On reviewing the notes we found that the blood sugar level was raised indicating a diagnosis of pre-diabetes. This had been filed by the GP as normal and the patient had not been given any advice about the diagnosis of pre-diabetes. In addition, this patient reported that they had been experiencing a change in bowel habit for 6

months with blood per rectum. These symptoms required further investigation and urgent referral, as they could potentially indicate an underlying bowel cancer. No referral had been made.

- We saw another example where an optician had requested that a child be seen by a GP to investigate the cause of their headaches. They had written twice to request this . The child had not been seen and there was no evidence that there had been any attempt made by the practice to contact the child's family to arrange an appointment.
- The police had written to the practice following an incident involving a patient with mental health problems. The police were concerned for the patient's safety and mental state. The letter had not been scanned and no action had been taken by the practice.
- The salaried GP had suggested using a Dictaphone to improve referrals; this had recently been implemented by the practice.
- Staff were not using technology to improve treatment and support patients' independence. For example, patients with long term conditions were not being coded appropriately.
- Reception staff were routinely told by the partners to advise patients to contact 111 as there were not enough urgent appointments at the practice. The practice manager put a stop to this when it came to their attention before our inspection.

The practice is rated as inadequate for the following population groups because the issues identified apply to each of these population groups:

•Older people

•People with long-term conditions

•Families, children and young people

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

•People whose circumstances make them vulnerable

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

- The practice's uptake for cervical screening was 58%, which was below the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was lower than the national average.The percentage of females, 50-70 years, screened for breast cancer in last 36 months was 54% compared with the national average of 70%. The percentage of persons, 60-69 years, screened for bowel cancer in last 30 months was 34% compared with the national average of 55%. The practice did not have any plans to improve their figures.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The practice was unable to provide the inspection team with the numbers of the health checks carried out in the last year. There was no appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity and did not review the effectiveness and appropriateness of the care provided. We found the practice's disease registers were incomplete and did not contain all the relevant patients presenting with a particular clinical condition.

During the inspection the salaried GP raised concerns regarding the safety of the blood thinning medicine monitoring and prescribing system within the practice. They said that there were insufficient safety nets in place to check the blood clotting test results when prescribing the tablets. This could put patients at risk of harm.

Clinicians attended meetings with Redditch and Bromsgrove clinical commissioning group (CCG). The CCG were concerned as the practice had the highest number of A&E attendances in the region.

The most recently published QOF results were 97% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 96% . The overall exception reporting rate was 8% compared with a national average of 10%. (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.)

Any Quality Outcomes (QOF) data relates to 2016/17.

- Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing

Inadequate

Are services effective?

(for example, treatment is effective)

Unit (STAR PU) was above the CCG and national average which demonstrated that the practice was not prescribing in line with NICE guidelines. During the inspection we asked one of the partners the reason why there was a higher than average number of elderly patients on hypnotics but they were unable to provide an explanation.

- The practice was not actively involved in quality improvement activity. The practice had not carried out any clinical audits in the last year. During the inspection one of the partners informed us that the practice had done some work on prescribing and the CCG had noticed an improvement in this area, but we did not see any evidence of this work.

Effective staffing

Staff did not have the skills, knowledge and experience to carry out their roles. For example,

- We were informed that staff were expected to complete induction and training in their own time. There was not sufficient training for staff to enable them to carry out their roles effectively. The reception staff, who need to be at work prior to 8.30 am to complete opening up tasks, were not paid until 8.30 am thus they were expected to complete this work without remuneration.
- Staff at the practice did have appraisals and revalidation. The salaried GP informed us that they had to postpone their appraisal for the first time in their career since working at this practice. The salaried GP informed us they were given no protected learning time. Clinical supervision was more on an ad-hoc basis when required. We did not see any evidence to suggest they had a structured process in place for clinical supervision.

Coordinating care and treatment

Staff did not work together and with other health and social care professionals to deliver effective care and treatment. The practice did not have an established system to help ensure care and treatment was planned and delivered in a coordinated way. The practice was unable to share any minutes from multidisciplinary meetings.

- We saw records that showed that all appropriate services were not involved in assessing, planning and delivering care and treatment. During the inspection we asked to see care plans for palliative care patients and patients with a learning disability. The practice was unable to find this information for us despite looking in several sets of patient notes. Eventually we were shown one example of a paper copy of a learning disability care plan but this was not in the patient records. The salaried GP did care plans for diabetes using their own template.
- The salaried GP told us that there were no MDT meetings at this practice.. They told us nothing was done for palliative patients at this practice.
- During the inspection we saw a letter from the hospital from asking the practice to refer an patient to a neurologist for investigation of blurred vision and headaches. The patient had not been referred and the letter had not been scanned into the records so when another GP saw the patient later they were not aware of the request or letter. These symptoms could indicate a serious underlying cause.
- We saw a lack of coordinated and person centred cared. This included when they moved between services, when they were referred, or after they were discharged from hospital. We saw scanning that went back three months at the time of the inspection which demonstrated that person centred care was not being delivered as follow up appointments were not being actioned in a timely way.
- We saw a multi-agency risk assessment conference meeting letter from November 2017 regarding a patient who was alleged to be a perpetrator of domestic violence. This patient had children and this would raise safeguarding concerns for the children. We found that there was no code on their records alerting staff to them being an alleged perpetrator of domestic abuse and the letter was not scanned. This demonstrated that the practice was not working together with other health and social care professionals to deliver effective care and treatment to patients.
- On 14 March 2018 we saw that the medical secretary had been handed a pile of patient records to be deducted. This is the process when a patient moves to another practice or when a patient has deceased. These dated from 2016. However, according to the status history tab for the patients in the clinical computer system, the records had been sent back. We also saw an email from November 2017 from the Crisis resolution team regarding this practice quoting “The coroner in Worcestershire has previously raised concerns about pertinent patient records and medical history not being reviewed or available and the clinical risks this can present.” A crisis resolution team is a team of mental

health professionals who can support you at your home during a mental health crisis. It usually includes a number of mental health professionals, such as a psychiatrist, mental health nurses, social workers and support workers.

Helping patients to live healthier lives

Staff were not consistent and proactive in helping patients to live healthier lives.

- Long term conditions were not being monitored appropriately. We found several examples of misdiagnoses, long term conditions not being coded appropriately and referrals not dealt with in a timely manner.
- Staff did not encourage patients to be involved in monitoring and managing their health. Often patients were not getting their test results in a timely manner due to the backlog of administration work that had accrued.
- When we spoke with one of the partners at the practice they informed us that they were not coding for pre-diabetes. We informed the partner that a number of the outstanding tasks showed patients with pre-diabetes and they had not been contacted. The partner seemed surprised by this.
- Staff did not discuss changes to care or treatment with patients and their carers as necessary. For example a hospital discharge letter detailed that a patient had taken a significant overdose of a particular medicine. The patient had several chronic health conditions. The discharge letter had requested the practice make amendments to the patient's medicines as a result. On reviewing this patients repeat prescription we found the medicine changes had not been made putting the patient at risk. It would be usual practice for the patient to be contacted and followed up but there was no evidence of this here.
- The partners did refer patients to a community weight loss clinic. They also referred patients to an exercise programme nearby where they were able to undertake a six week course.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. We did see evidence of a completed learning disability care plan but this was not scanned in the patient's records.
- The practice monitored the process for seeking consent appropriately.

Inadequate

Are services caring?

Our findings

We rated the practice, and all of the population groups, as inadequate for caring because:

- Patients were not receiving timely support and information.
- There was below average patient survey results particularly regarding care and concern, being listened to and involved in care, and there were no plans to improve.
- Lack of support for carers.

Kindness, respect and compassion

- On the day of the inspection we saw the secretary and practice manager dealing with patients with compassion and respect.
- Staff understood patients' personal, cultural, social and religious needs.
- 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.
- However, on 15 March 2018 we saw a patient waiting 50 minutes to be seen because they had not been checked in by the receptionist.

Results from the July 2017 annual national GP patient survey showed patients felt they were not treated with compassion, dignity and respect. 374 surveys were sent out and 92 were returned. This represented about 2% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 73% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 79% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 96%.
- 70% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 87%; national average - 86%.
- 85% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 84% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpreting services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them. The partners at the practice spoke a number of different languages and the practice manager informed us during the inspection that the partners often spoke in different languages with patients.
- The practice did not proactively identify patients who were carers.The practice's computer system alerted GPs if a patient was also a carer. The practice had identified fewer than 1% of patients (30 in total) as carers.
- We found no evidence to support the practice trying to identify more carers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time or by giving them advice on how to find a support service.

Results from the national GP patient survey showed that patients responded lower than the national and CCG averages to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages:

- 70% 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 88% and the national average of 86%.
- 68% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 70% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 88%; national average - 86%.

Inadequate

Are services caring?

- 81% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity to some extent.

- If a patient was upset a room was available for patients to speak in confidence.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

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

- The practice did not organise and deliver services to meet patient needs
- There was poor access to urgent appointments
- There was a lack of response to patient feedback about access

Responding to and meeting people's needs

The practice did not organise and deliver services to meet patients' needs. It did not take account of patient needs and preferences.

- The practice did not understand the needs of its population and did not tailor services to respond to those needs. The practice did not have enough appointments. The practice was short staffed and had already closed the branch surgery at the time of our inspection.
- The practice was only offering two urgent appointments each day for patients and when asked for evidence of details of patients who had requested urgent visits on a particular date, the inspection team were told by the receptionist that the list had been shredded.
- The inspection team was provided with details of patients who had received telephone consultations because they could not get an urgent appointment. The inspection team were concerned that treatment was being prescribed without the GP adequately assessing patients. During the inspection we saw an example where concerns were raised by a parent of a child who had a high temperature. The parent had asked for an urgent appointment when they rang.The parent was told that an appointment was not available. The child was later taken to A&E and prescribed antibiotics for tonsillitis. This child could have led to a serious condition and should have been assessed by the GP to exclude this.
- There was further evidence clinicians were not carrying out full assessments of patients during consultations.
- During the inspection we found examples of patient care that fell below the standards we would expect. We would have expected the practice to provide extra support to patients with mental health problems. We found a letter from the Acute Mental Health team from early February asking the practice to refer a vulnerable elderly patient to the Early Intervention Dementia service. The mental health worker had rung the practice on the day of assessment to inform them of the situation. No action had been taken by the practice and the letter had not been scanned onto the records.

This practice was rated inadequate for the following population groups. The issues identified affect all of the following population groups:

- Older people
- People with long-term conditions:
- Families, children and young people:
- Working age people (including those recently retired and students):
- People whose circumstances make them vulnerable:
- People experiencing poor mental health (including people with dementia):

Timely access to care and treatment

Patients were not able to access care and treatment from the practice within an acceptable timescale for their needs.

- There were not enough appointments as there were not enough clinical staff at the practice.
- There were not enough urgent appointments per day.
- Patients did not have a timely access to test results and diagnosis because many documents were waiting to be scanned and actioned hence there was a delay. We also found large amounts of tasks which had not been dealt with in a timely manner again causing a delay to patients.
- We found examples where patients with the most urgent needs had not been prioritised. For example patients with abnormal blood results indicating a two week potential cancer referral had not been referred. Their results had been scanned on the system but not actioned.
- In the national patient survey patients were concerned about the appointment system. No members of staff we spoke with were able to tell us about any improvements the practice had made in response to this feedback. Following the inspection the provider told us that

changes had previously been made to the appointment system. We would expect a provider to monitor the effectiveness of any such changes. We have no evidence that this happened.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and below national averages. 374 surveys were sent out and 92 were returned. This represented about 2% of the practice population.

- 62% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 80%.
- 70% of patients who responded said they could get through easily to the practice by telephone; CCG – 77%; national average - 71%.
- 63% 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 - 76%; national average - 76%.
- 63% of patients who responded said their last appointment was convenient; CCG - 76%; national average - 76%.
- 66% of patients who responded described their experience of making an appointment as good; CCG - 74%; national average - 73%.

Listening and learning from concerns and complaints

The practice manager took complaints and concerns seriously and responded to them appropriately to improve the quality of care. During the inspection we noted that the practice did not undertake a trend analysis into complaints to prevent complaints from recurring. The practice had a book of verbal complaints behind the reception desk. Some of these were concerning and did not have adequate clinical follow up.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. Eleven complaints were received in the last year and we reviewed a sample. For example one patient had been concerned about the lack of care from one of the GPs. The practice manager had written a response to the patient and offered for the family to come in to discuss their concerns further.
- Although complaints were mentioned in the staff meetings we did not see any examples where lessons had been learned to improve the quality of care for patients.

Are services well-led?

Inadequate

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

Our findings

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

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

- The leadership did not have capacity to deliver high quality care.
- There was a culture of intimidation which inhibited staff from raising concerns.
- Inadequate governance arrangements, including lack of clarity over roles and accountability, systems to ensure safe staffing levels
- Lack of oversight and clinical supervision, which led to patients being put at risk of harm.

Leadership capacity and capability

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

- Leaders did not demonstrate that they had the capability to deliver the practice strategy and address risks to it. During the inspection we were informed that the salaried GP was leaving at the end of March 2018 having been given three weeks' notice by the practice which was in breach of his contract. The practice manager was due to leave at the end of March having given their notice. Following the CQC inspection the practice manager was asked not to work their notice period as they were not willing to share details of their discussion with CQC inspectors with the partners.
- The senior partner did one clinical session per week and occasionally provided extra cover but had not been working at the practice for the last six months.
- One of the partners did eight clinical sessions and one administrative session. They only had indemnity cover for five sessions which meant that they were not insured to treat patients for the reminder of the time. The lead GP was aware of this discrepancy and had taken no action.
- We found that NHS pension contributions were not paid for three members of staff who had since left the practice.
- It was clear at the time of the inspection the practice was already having difficulty managing access and demand for appointments, the imminent loss of the salaried GP caused the inspection team great concern regarding patient access to appointments with a GP.
- The large back log of administrative tasks and registration workflow demonstrated that there was significant lack of capacity in reception. Both of these aspects were having an adverse effect on patient care and would only deteriorate as the practice manager left with no replacement.
- The salaried GP told us during the inspection that they felt work was not allocated proportionately. The secretary was asked to do all reception and secretarial duties in addition to her own work.
- The practice manager informed us that the partners displayed a bias towards staff and as practice manager they had little authority to make decisions.
- The inspection team were advised that staff had been told by the lead GP that they would lose their jobs if they spoke out about their concerns, which created an extreme risk to patient safety and evidenced the bullying culture.

Vision and strategy

The practice had a written vision and strategy to deliver high quality, sustainable care.

- There was a vision and set of values. However when we spoke to one of the partners about this during the inspection they were not able to tell us what this vision was.
- Staff we spoke with were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region.

Culture

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

- Staff we spoke with during the inspection and after told us they did not feel respected, supported or valued by the partners. The practice manager had been very concerned about the high turnover of staff and raised this with the partners.
- We were informed that several reception staff had left recently due to the bullying and intimidating culture within the practice. When we spoke with the secretary they were worried that conversations might be overheard. They shared an example of the lack of confidentiality where they had sent an email in confidence to the senior partner with concerns

Are services well-led?

Inadequate

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

regarding outstanding work relating to one of the other partners and the impact this would have on patient care. This had been circulated to the whole practice team which made things very difficult for this member of staff.
- The salaried GP had had thought that their time at the practice would provide opportunities for continuing professional development, but his had not happened.
- We were told during the inspection that staff morale was badly affected by staff resignations.
- The partners did not follow the practice values. The senior partner made decisions about recruitment not following recommended recruitment guidance and disregarding the practice manager's advice on several occasions.
- The senior partner did not follow the recruitment policy when terminating contracts of employment.
- We did not find that the practice was responding to all incidents or recording them appropriately. Although the provider was aware of the requirements of the duty of candour they were not ensuring compliance.
- Staff we spoke with before and after the inspection did feel encouraged to raise their concerns with the practice manager. They did not feel they could approach the partners.
- The practice did not understand the learning needs of staff and did not provide protected learning time to train staff.
- All staff had appraisals but there were not adequate processes in place for providing staff with the development they needed.
- There was a lack of emphasis on the safety and well-being of staff which explained the high turnaround of staff.
- Staff had received equality and diversity training.
- There was a negative relationship between the partners and staff.

Governance arrangements

There were a lack of responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were lacking. The governance and management of partnerships, joint working arrangements and shared services was lacking. For example we asked to see safeguarding team meeting minutes. These were not available to the inspection team. The safeguarding lead was not aware of children on the safeguarding register.
- There was a lack of oversight of the medicines management system.
- Staff were not clear on their roles and accountabilities. For example the secretary was having to work extra hours to help the senior receptionist as there was no other staff. The secretary was completing insurance forms which should have been done by clinicians but was given this task by the partners.
- Practice leaders did not have sufficient established policies, procedures and activities to ensure safety.
- The senior partner would often make decisions about recruitment without following the necessary policies and procedures. We were informed by the practice manager that there was no clarity over jobs and tasks by the practice partnership.
- The lead GP was aware of the discrepancy with the indemnity arrangements.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There was no effective process to manage patient safety risks. For example there was lack of learning from significant events. There was a lack of complaints analysis. During the inspection in September 2017 the provider was told that they should ensure that the sharing of learning outcomes from complaints and significant event was documented thoroughly and this has still not happened in March 2018 during this inspection.
- When we reviewed the prescription box there were uncollected prescriptions dating back several months. We found a prescription for blood pressure medicine and pain killers, which had been issued in April 2017. The patient had not had their blood pressure measured since February 2017 and were more than 12 months overdue for their medicine review.
- We reviewed correspondence awaiting action in one GP's tray. We identified numerous issues of concern including referrals which had not been made, patients with potentially serious mental health issues who had not been reviewed, requests for blood tests which had not been followed up, patient records which had not

Are services well-led?

Inadequate

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

been updated and medicines which had not been adjusted. The practice did not have adequate processes to manage performance. Its lack of clinical supervision allowed these things to happen.
- The practice had not carried out any clinical audits in the last year.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice did not have appropriate and accurate information.

- We noticed that the clinical computer system showed that 411 registrations of patients were still awaiting processing; these included 149 patient deductions. These dated back to December 2016.
- We also identified that there were 29 patient notifications dating back to February 2017 from the diabetic eye screening and learning disability services which were still awaiting processing.
- The practice was approximately three months behind with scanning. This posed a serious risk to patients in that if they had a GP appointment, the GP may not have access to the latest information about their care and treatment.
- There were70 patient records waiting to be summarised. In the Action Plan submitted by the practice on 19 March 2018, confirmation was given that all the outstanding summarising had been completed. We found incomplete summarising when we inspected on 19 March 2018. There was a serious risk to patients if the summarising omitted key information about a patient.
- Quality and sustainability was not discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- We did not find any evidence to suggest that patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was a patient participation group which met on a quarterly basis.
- The clinical commissioning group had concerns about the practice. They had commented on the high number of A&E referrals and the high turnover of staff. They had also received whistleblowing concerns about the bullying culture within the practice.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation. We were informed by two of the partners that representatives came in to give lectures on an ad-hoc basis about conditions such as asthma and diabetes.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: •Multiple outstanding tasks dating back over a month where patients should have been contacted about diagnoses and had not been contacted. •Letters from one of the GPs' in tray where action was needed and was overdue – the letters dated back to October 2017 •The practice was approximately 3 months behind with scanning. On 14 March 2018, the receptionist was scanning documents from December 2017 •70 sets of patient records were waiting to be summarised. •Patient deductions were outstanding from 2016. 149 patient records were waiting to be deducted. However, according to the practice's clinical computer system, the records had been sent back. •GP consultations we reviewed were not carried out in accordance with relevant guidelines. •Patients on high risk medicines were not monitored appropriately and did not receive blood tests in a timely manner. •There was a large number of uncollected prescriptions that the practice had not followed up on. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 How the regulation was not being met: The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: The practice had a book of verbal complaints behind the reception desk. Some of these were concerning and did not have adequate clinical follow up. There was a lack of trend analysis for significant events. The last recorded incident was from 1 September 2017. There were no details of who attended the meetings, no details of what was discussed, no clear actions or review dates and no evidence that learning was shared amongst the team. Near misses were not documented. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** **The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. In particular:** • **Due to the lack of sufficient staff, administration staff were required to carry out tasks they were not trained for.** • One of the GPs was clearly underperforming and was not receiving appropriate support and development.

This section is primarily information for the provider

Enforcement actions

- The practice was already having difficulty managing access and demand for appointments. This situation was going to be made worse by the imminent loss of the salaried GP.

This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.