The Barn Surgery

Quality Report

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

Ratings

Overall rating for this service

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Overall summary

Letter from the Chief Inspector of General Practice

Following our inspection undertaken on 17, 18 and 19 May 2016 of all practices at Christchurch Medical Centre, we rated the Barn Surgery practice overall as inadequate. The domains of caring and responsive were assessed as providing good services. The domains of safe and well led were rated as inadequate and the effective domain required improvement. We placed the practice in Special Measures and received an action plan from the practice outlining the steps they would take to improve the service. The ratings published in August 2016 will remain in place until we have been assured all concerns have been rectified.

We carried out an announced focused inspection at the Barn Surgery on 14 December 2016. This was to check compliance to the serious concerns we found during a comprehensive inspection of the Barn Surgery in May 2016 which resulted in the Commission issuing a Warning Notice in regard to Regulation 17, Good Governance. Other areas of non-compliance found during the inspection undertaken in May 2016 will be checked by us for compliance at a later date.

This report covers our findings in relation to the warning notice requirements only and should be read in conjunction with the comprehensive inspection report published in August 2016. This can be done by selecting the 'all reports' link for the Barn Surgery on our website at www.cqc.org.uk

At this inspection, we checked the progress the provider had made to meet the significant areas of concern as outlined in the Warning Notice dated 25 July 2016, for a breach of Regulation 17 (Good Governance). We gave the provider until 30 November 2016 to rectify these concerns about governance of the practice. This Warning Notice was issued because we found there were inadequate systems or processes to effectively reduce risks to patients and staff covering:

- Systems in support of effective communication were not in place between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback.
- Effective governance arrangements were not in place to monitor and improve the quality of services provided to patients. This included: lack of clinical audits and systems in support of training to address gaps in a timely way;
- There was a significant shortage of GPs, with GP partners working excessive hours, which could increase risks for patients.
- Systems were not in place to ensure staff undertaking chaperone duties were trained to undertake this role.
- The practice did not have a system to monitor whether prescriptions were collected in a timely way.

Summary of findings

At our inspection on 14 December 2016 we found the provider had complied with the warning notice and was now compliant with the regulation 17 as set out in the warning notice.

Our Key findings were:

- Systems in support of effective communication had been implemented between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback.
- Effective governance arrangements were in place to monitor and improve the quality of services provided to patients. Clinical audits focussing on safe prescribing had been completed and systems in support of training to address gaps in a timely way were in place.
- The practice had taken steps to reduce any potential risks for patients resulting from a shortage of GPs. Extended hours services and new patient registrations had been temporarily suspended. Named locum staff were working at the practice on longer term contracts.
- Systems implemented ensured that staff undertaking chaperone duties were trained to undertake this role.
- The practice had set up a system to monitor whether prescriptions were collected in a timely way.

The other key lines of enquiry will be reassessed by us at a later date as a comprehensive inspection when the provider has had sufficient time to meet the outstanding issues.

The outstanding issues that the practice must address are:

- Ensure all staff receive training in infection control and the practice must introduce and undertake comprehensive infection control audits.
- Ensure systems are put in place so that all staff receive up to date training in fire safety and undertake regular fire drills.
- Ensure systems in support of recruitment are effective so that roles requiring a Disclosure and Barring service check or risk assessment are appropriately assessed.
- Ensure systems and processes are established and operated effectively to prevent the possible abuse of service users, including providing up to date Safeguarding and Mental Capacity Act 2005 training for all staff, and chaperone training for those staff undertaking this role.

Ensure measures such as clinical audits and re-audits are put in place to improve patient outcomes and reduce any safety risks.

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 our inspection in May 2016 we found the provider needed to make improvements. We issued a Warning notice dated 25 July 2016 requiring the provider to establish and operate effective systems for good governance:

- Systems in support of effective communication in place between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback.
- Effective governance arrangements in place to monitor and improve the quality of services provided to patients. This included: clinical audits and systems in support of training to address gaps in a timely way;
- Systems in place to reduce the increased risks due to the significant shortage of GPs, with GP partners working excessive hours.
- Systems in place to ensure staff undertaking chaperone duties were trained to undertake this role.
- A system to monitor whether prescriptions were collected in a timely way

Improvements had been made since the previous inspection and we found that the Warning Notice had been met. These were:

- Systems in support of effective communication had been implemented between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback.
- Effective governance arrangements were in place to monitor and improve the quality of services provided to patients. Clinical audits focussing on safe prescribing had been completed and systems in support of training to address gaps in a timely way were in place.
- The practice had taken steps to reduce any potential risks for patients resulting from a shortage of GPs. Extended hours services and new patient registrations had been temporarily suspended. Named locum staff were working at the practice on longer term contracts.
- Systems implemented ensured that staff undertaking chaperone duties were trained to undertake this role.
- The practice had set up a system to monitor whether prescriptions were collected in a timely way.

The Barn Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Background to The Barn Surgery

The Barn Surgery is situated at Christchurch Medical Centre, with the practice working collaboratively with two other GP practices located there (Farmhouse Surgery and The Orchard Surgery). The practice provides general medical services in Christchurch, Dorset. The area covered incorporates the coastal town of Christchurch, attracting temporary residents on holiday during the Summer months. There is low social deprivation in the area. At the time of the inspection, 6638 patients were registered with the practice and the majority of patients are of white British background. The practice does have some patients with Polish, Pakistani, Indian and Russian backgrounds and uses translation services and information in different languages where needed. The Barn Surgery has more than double the number of patients over 75 years (15.7% of the practice list) compared with the national average of 7.7%. There is a higher prevalence of chronic disease and life limiting illness for patients, with associated risks of isolation and vulnerability in old age. All of the patients have a named GP.

The practice has three GP partners (two male and one female), the whole time equivalent is three, with 27 GP sessions provided each week. The practice uses the same GP locums for continuity where ever possible. The nursing team consists of four female nurses, one of whom is a nurse practitioner shared with Farmhouse and Orchard surgeries. All the practice nurses specialise in certain areas of chronic disease and long term conditions management. The Barn Surgery is managed by a business manager who works for all three practices at Christchurch Medical Centre, a practice support manager, plus administrative and reception staff. Some of these roles are shared across all three surgeries promoting close working with Farmhouse and Orchard surgeries.

The practice has an Action Management Before Emergency Risk team (AMBER), which is co-ordinated on behalf of the Barn Surgery by a GP from Orchard Surgery. The team works across all three practices based at Christchurch Medical Centre. The purpose is to support vulnerable people, provide home visits and proactive monitoring to avoid unplanned hospital admissions where ever possible. It comprises of two female nurses, three healthcare assistants and a dedicated administrator.

The practice is open 8.30am to 6.30pm Monday to Friday. Phone lines are open from 8am and between these hours with the out of hours service picking up phone calls after this time. Phone lines from 8am to 8.30am are answered by the out of hours service, as are calls after 6.30pm. The practice is staffed from 8am to ensure any calls from out of hours can be handled. GP appointment times are from 9am to 12pm and 4pm to 6.30pm every weekday. Extended opening hours have previously been provided: these were evening appointments were available on alternate Monday's and Tuesday's from 6.30pm until 7.45pm. At this time, due to recruitment pressure, the extended hours provision has been suspended, in agreement with commissioners, and will be reviewed again in 2017. Telephone appointments are available daily. Information about opening times and appointments are listed on the practice website and in the patient information leaflet.

Detailed findings

Opening hours of the practice are in line with local agreements with the clinical commissioning group. Patients requiring a GP outside of normal working hours are advised to contact the out of hours service provided by the 111 services in Dorset. The practice closes for two afternoons a year for staff training and information about this is posted on the practices website.

The practice has a General Medical Service (GMS) contract.

The following regulated activities are carried out at the practice Treatment of disease, disorder or injury; Surgical procedures; Family planning; Diagnostic and screening procedures; Maternity and midwifery services.

Why we carried out this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We visited the practice and reviewed documentation and checked on the progress of actions taken in respect of a Warning Notice issued after the comprehensive inspection in May 2016.

This report covers our findings in relation to the warning notice requirements only and should be read in conjunction with the comprehensive inspection report published in August 2016. This can be done by selecting the 'all reports' link for the Barn Surgery on our website at www.cqc.org.uk .

The ratings published in August 2016 will remain in place until we have been assured all concerns have been rectified. A comprehensive inspection will take place to check compliance has been met against outstanding areas and will determine whether the practice is removed from the special measures scheme.

Are services well-led?

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

Our findings

At our inspection on 17, 18 and 19 May 2016 we found that the provider needed to make improvements and we issued a Warning Notice. This was because the delivery of high-quality care was not assured by the leadership and governance in place. This was a team under considerable pressure, which did not have the capacity, ability or time to reflect and identify where improvement was needed. The practice did not have an effective governance framework which supported the delivery of the strategy and good quality care.

Areas of governance which were less well managed and required improving were for example;

- Governance arrangements in support of recruitment and chaperone processes did not ensure staff followed the practice procedures. Disclosure and Barring Service checks or risk assessments for some staff had not been completed.
- Systems in support of medicines management were not robust; for example, the monitoring of the collection of prescriptions by patients.
- Systems were not in place to ensure training was monitored effectively to ensure all staff had completed basic learning or annual updates potentially placing patients at risk of harm
- There was no programme of continuous clinical and internal audit to monitor quality or make improvements, making monitoring patient outcomes difficult.
- Arrangements for identifying, recording and managing risks, and implementing mitigating actions were not in place, particularly around alerting clinical staff about patient safety concerns, latest prescribing guidance and staff awareness of patients' mental capacity, appropriate recording of consent, and maintaining a safe environment through fire drills.
- Governance arrangements to support the meetings which took place and the actions identified were not robust, affecting how information was shared amongst staff.

At this inspection on 14 December 2016, we specifically assessed gaps highlighted in the warning notice dated 25 July 2016 which were:

- Systems in support of effective communication were not in place between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback.
- Effective governance arrangements were not in place to monitor and improve the quality of services provided to patients. This included: lack of clinical audits and systems in support of training to address gaps in a timely way;
- There was a significant shortage of GPs, with GP partners working excessive hours, which could increase risks for patients.
- Systems were not in place to ensure staff undertaking chaperone duties were trained to undertake this role.
- The practice did not have a system to monitor whether prescriptions were collected in a timely way.

Improvements had been made since the previous inspection, which provided assurance of the warning notice requirements having been met. For example;

- The practice had set up systems which supported effective communication between all staff teams; particularly in regard of sharing learning from significant events, complaints, medicines and healthcare products alerts, prescribing guidelines, audits and service feedback. Including:
- The significant events process had been overhauled so these were discussed at all staff meetings and learning and actions recorded within minutes. Any new and ongoing significant events were initially discussed weekly by the GP partners and actions minuted. For example, actions following a significant event included setting up a prompt in the patient record system requiring clinical staff to always check allergy information before prescribing any medicines for a patient. We saw the prompts were in place; this demonstrated that GP partners had oversight of all significant events and monitored whether agreed actions were implemented improving patient safety.
- Minutes seen by the inspection team demonstrated staff were informed about the changes to the significant event process and discussion covered what constituted an event and should be reported. Seven staff verified any learning from significant events, complaints and other feedback was shared with them at their meetings.

Are services well-led?

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

- Medicines and healthcare product alerts were reviewed with a named lead GP partner, who decided which staff the alert should be disseminated to and what actions were required. The practice manager demonstrated this was then followed up and the outcome reported back to the GP partners at a weekly meeting. For example, following a medicine safety alert the practice had carried out an immediate search of all patients who were taking a medicine used to manage heart conditions such as angina and high blood pressure. Records showed letters were sent out to patients inviting them to attend for a review of their medicines as soon as possible.
- Nurse meetings were now recorded and demonstrated there was both a clinical updating element as well as communication of business such as changes to policies and procedures.

Effective governance arrangements had been put in place to monitor and improve the quality of services provided to patients. The practice had made some progress towards carrying out clinical audits, focussing on priority areas to ensure medicines prescribing was safe for patients. Risks had been assessed, which looked at the GPs availability to undertake clinical audits whilst also ensuring safe delivery of care for patients. GP partners told us they were committed to undertaking audits and had extended staff skills for this to take place. Examples of clinical audits seen included:

- Since the last inspection, the named prescribing lead GP had received peer support from another GP in a neighbouring practice and was working closely with the clinical commissioning group medicines optimisation team. Minutes of a meeting with the clinical commissioning group in September 2016 highlighted agreed actions for the rest of the financial year. The practice was able to demonstrate progress against a number of these actions. For example, data showed that the practice was a higher prescriber of pain relieving medicines in the form of patches used for patients receiving palliative care. A search of patients was undertaken and the lead GP was in the process of analysing prescribing decisions to ensure that locally agreed guidelines promoting patient safety and cost effectiveness were being followed.
- A practice nurse specialising in diabetic care management carried out a number of audits to improve patient safety and cost effectiveness. For example, a blood glucose test strip audit had been undertaken and resulted in agreed actions which were completed. Patients using blood testing equipment were invited into the practice, where appropriate, to change over to a product that was on the local prescribing formulary monitored by the clinical commissioning group.

A system to monitor training needs had been implemented and was being monitored monthly to ensure any gaps were addressed in a timely way. Examples seen included:

- The practice now had a training matrix and spreadsheet to monitor all mandatory and role specific training for every member of staff. The business and practice support manager showed us how they monitored training needs and were using a traffic light system to denote the level of priority and whether it had been completed or not.
- Nursing staff told us they were accessing e-learning via a national training provider. We looked at the e-learning records for a practice nurse which demonstrated they had completed training covering safeguarding adults and children, fire safety and infection control practice.
- Records showed all staff had completed basic life support training, with gaps seen at the last inspection having been rectified. All clinical staff had undertaken resuscitation training in addition to this. Three clinical staff had completed a mental capacity act awareness course, with plans in place for other staff to do this in the next few months.
- The practice was working collaboratively with the clinical commissioning group locality safeguarding lead GP to deliver face to face safeguarding training for staff. The registered manager GP, business strategic manager and practice support manager told us they had made the decision to continue with an amber risk rating within the practice action plan because this was an ongoing area of staff development that needed to respond to changing policy and procedures.
- Since the last inspection, the practice had identified an infection control lead and records demonstrated they had received appropriate training for the role in November 2016. The infection control lead nurse told us they had received support from the clinical commissioning group infection control lead and set up an infection control quality monitoring system with the practice support manager. The infection control lead nurse had delivered in house infection control training and raised awareness of policies and procedures with

Are services well-led?

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all staff having attended it. Hand hygiene assessment and training was underway with nearly all staff having had an assessment and feedback to improve their practise. An infection control audit was undertaken in November 2016, from which an action plan had been developed. Actions completed included the implementation of cleaning schedules and audits. The practice was able to demonstrate through written correspondence when issues were raised with the cleaning company so the standard of cleaning improved.

- The chaperone policy had been reviewed and stated that only nursing staff could fulfil this role. Records showed all nursing staff had completed chaperone training in July 2016. At the last inspection, we reviewed disclosure and barring service (DBS) records for nursing staff and found that the practice had not obtained a DBS check for one of the nursing staff. This was immediately rectified during the inspection and reported upon in the last report. The DBS for this member of staff had since been received by the practice. We spoke with seven staff during the inspection and were consistent in their understanding of which staff were authorised to chaperone during consultations with patients. During this inspection, information about the chaperone policy was added to the induction information given to locum staff.

The practice had been supported by external stakeholders, such as the clinical commissioning group (CCG) and NHS England (NHSE) to look at ways to reduce any potential risk arising from the staffing shortages. Examples of actions taken to reduce any potential risks included:

- It had been agreed that the practice would suspend some services such as extended hours to alleviate some of the pressures caused by the shortage of GPs. There had been no adverse comments received from patients about this change.
- Immediately following the inspection in May 2016, the practice consulted with patients and stakeholders including the CCG and NHSE about the need to suspend patient registrations for six months as a temporary measure during the recovery period for the practice. NHSE had agreed a three month list closure in October 2016.
- Since the last inspection, the practice had continued to advertise GP partner vacancies and was looking at other ways to increase patient access having reviewed skill mix there. This included: the joint recruitment of a nurse practitioner with the other two practices at Christchurch Medical Centre who was due to start working at Barn Surgery in January 2017. We were told that interviews were about to take place to recruit an emergency care practitioner with a view to developing the role to provide proactive management of vulnerable patients with long term conditions and/or who were frail.
- The practice had carried out a risk assessment which looked at the continuing impact of GP vacancies to consider the challenges and priorities for the short and longer term. This placed patient care at the centre. A named locum GP had been engaged for an indefinite period to provide additional support to the clinical team.
- A named locum advanced nurse practitioner had been booked to work at the practice for a month to assist with patient reviews and minor illness issues.

The practice had set up a system to monitor whether prescriptions were collected in a timely way.

- The practice had developed a policy and procedure that implemented safeguards around the collection of prescriptions. Since implementation, the practice had reviewed the frequency of monitoring specified in the earlier version of the policy and had changed it to monthly checks following this review.
- Named staff were responsible for checking prescriptions every month. Staff showed us the records kept demonstrating that this system had been in place since June 2016. The records enabled the practice to know how many prescriptions had not been collected and for which prescribing GP. GPs explained they then reviewed each prescription and decided what course of action was necessary, in some circumstances this required a telephone call to the patient to check why the prescription had not been collected. We discussed the benefits of utilising this information as a safety net for patients. The practice told us they would make slight changes to the way prescriptions not collected would be recorded so that patient records could be audited to determine whether there had been any follow up and identify any learning to act on.