Aegis Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Are services safe?	
Are services effective?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

On 16 June 2016 we carried out a comprehensive inspection at Dr NG Newport's Practice now known as Aegis Medical Centre. Overall the practice was rated as inadequate and placed in special measures for a period of six months.

As a result of that inspection we issued the practice with a warning notice in relation to the governance at the practice. The issues of concern were as follows;

- Non clinical staff were reviewing, prioritising and filing clinical information independently of clinical input.
- The practice was an outlier for prescribing medicines within their CCG.
- The practice had failed to ensure the safe prescribing of medicines
- The practice Quality Outcome Framework (QOF) performance was below the local and national levels
- Data for the national cancer intelligence network showed the practice had lower rates of screening for their eligible patients.
- The practice had above the local average for accident and emergency admissions.
- The practice did not consistently code patients who failed to attend hospital appointments and follow up with them to check on their welfare.
- The provider had failed to assess, monitor and improve the quality and safety of services. For example; difficulties obtaining appointments and poor engagement by the GP partners with their patient participation group.
- The practice confirmed there were no arrangements in place to cover the full extent of the practice nurse responsibilities in their absence.

The practice was required to be compliant with the warning notice by 20 October 2016. We conducted a focused inspection of the practice on 7 December 2016 to establish whether the requirements of the warning notice had been met. We found;

- Non clinical staff were no longer reviewing, prioritising and filing clinical information.
- The practice had improved their prescribing practices and were no longer an outlier for prescribing medicines wirthin their CCG. However, we found high risk medicines were not being appropriately monitored and patient safety and medicines alerts were not being appropriately actioned.

Summary of findings

- The practice had improved their QOF performance compared to local and national levels.
- The national cancer screening data for 2015/2016 showed improved attendance by eligible patients. It was comparable or above local and national averages for breast and bowel cancer.
- The practice had above the local average for accident and emergency admissions.
- The provider had improved their assessment, monitoring and improvement of the quality and safety of services. The GP partners had met with their PPG and improved the availability of appointments for patients.
- The practice had revised their scheduling of nurse appointments to plan for absence and a GP partner was to undertake additional training to perform their duties.
- The practice was actively reviewing attendance by their patients at out of hours, accident and emergency and walk in services. They coded their attendance and followed up with them to ensure their needs were being met.

The areas where the provider must make improvements are:

- Ensure the effective and safe management of high risk medicines and consistent actioning of patient safety and medicine alerts.

The practice had complied with the majority of the issues identified at the first inspection but further improvements were required in relation to their medicines management. The practice will remain in special measures until their reinspection in 2017. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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 safe?

The practice was rated as inadequate for providing safe services and improvements were required to be made following their initial inspection in June 2016. We found:

- The GPs partners received, reviewed and actioned all clinical information.
- Patient safety and medicine alerts were shared amongst the clinical team but inconsistently actioned.
- High risk medicines were not being appropriately monitored exposing patients to risk of harm.
- The practice had improved their prescribing practices.

Are services effective?

The practice was rated as inadequate for providing effective services and improvements were required to be made following their initial inspection in June 2016. We found:

- The practice had significantly improved their performance in respect of the Quality and Outcomes Framework, since the last inspection.
- The practice had started to implement governance arrangements including systems for assessing, monitoring and mitigating risks and ensuring the quality of the service provision such as through the appropriate actioning of patient information, medicine and safety alerts and conducting medicine reviews in a timely manner by an authorised person.
- The practice had revised their scheduling of nurse appointments to plan for absence and a GP partner was to undertake additional training to perform their duties.
- 2015/2016 national cancer screening data showed the practice were comparable or above local and national averages for screening of patients for breast and bowel cancer.

Are services responsive to people's needs?

The practice was rated as requires improvement for providing responsive services following their inspection in June 2016. We found:

- Patients reported improvements in obtaining appointments with the GP.

Summary of findings

- The practice had opened up the availability of appointments to patients, enabling them to book three weeks in advance with the GPs.
- The practice experienced high rates of patients failing to attend for appointments but were actively addressing this to reduce the prevalence in line with their policies.
- The practice coded patients who failed to attend hospital appointments and followed up with them.
- The practice actively reviewed attendance by their patients at out of hours, accident and emergency and walk in services. They coded their attendance and followed up with them to ensure their needs were being met.

Are services well-led?

The practice was rated as inadequate for providing well led services and improvements were required to be made following their initial inspection in June 2016. We found:

- The practice was improving their monitoring of the practice performance. Their clinical performance against QOF had improved as had their prescribing behaviour. However, high risk medicines were not being safely monitored.
- The practice reviewed attendance by their patients at out of hours, accident and emergency and walk in service to identify trends. They read coded their attendance and followed up with them to ensure their needs were being met.
- The practice GP partners attended patient participation group meetings, listening to patient feedback and increasing the availability of GP appointments in response.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure the effective and safe management of high risk medicines and consistent actioning of patient safety and medicine alerts.

Aegis Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Aegis Medical Centre

Dr NG Newport's Practice is now known as Aegis Medical Centre. They have approximately 4458 patients registered with the practice. There are two male GP partners, who are supported by a full time female practice nurse, two female health care assistants, reception/administrative team, cleaner and overseen by the practice manager

The practice is open a range of times, varying each day. However, they are open every day between 8am and 6.15pm closing between 1pm and 2pm most days except Tuesday when they are open all day. Appointments were available from 7.45am until 12.30pm and 3.30pm to 5.50pm on Monday and either 9am or 9.30am until 5.50pm Tuesday, Wednesday, Thursday and Friday.

Drop in surgeries are provided twice a week on Monday and Thursday mornings. The practice did not offer extended hours appointments. Appointments were permitted to be booked three weeks in advance with the GPs.

The practice is located in a deprived residential area of Basildon. The local population has a lower life expectancy for males and females than the local clinical commissioning group and national averages.

When the practice is closed patients are advised to call the surgery and be directed. Alternatively they may call the national NHS 111 service for advice. Out of hours provision is commissioned by Basildon and Brentwood CCG, and provided by IC24.

The practice has a comprehensive website providing details of services and support agencies patient may find useful to access.

Why we carried out this inspection

The focussed inspection was to check whether the requirements of the warning notice had been met.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit to follow up on the warning notice issued on 7 December 2016. During our visit we:

- Spoke with a range of staff (practice manager, GPs, practice nurse, health care assistant, and reception team).
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?

Detailed findings

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

We last inspected the service in June 2016 and found the practice had insufficient systems in place to manage Medicines and Health Regulatory products Agency (MHRA) alerts and patient safety alerts. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us that they shared the alerts with their clinical team and discussed them. We saw that both GPs maintained individual MHRA alert folders confirming sight and actioning of information.

Following the inspection, the practice reviewed their clinical management of safety alerts. We found all clinicians were signed up to receive the safety notifications. We were shown their records of all alerts and confirmation they had been read by all relevant staff. The practice produced evidence of searches already conducted in response to the alerts received.

We searched the patient record system to ensure recent MHRA alerts had been actioned. For example;

- In October 2016, an MHRA was issued in relation to an anti-inflammatory medicine. We found the clinicians had been informed of the alert. They had also undertaken a search of their patient records for those being prescribed above the recommended dose. Those patient's potentially affected had been identified and the medicine removed from the patient's repeat prescribing list. However, we found that despite this, a patient had been represcribed the medicine by their GP. This was contrary to guidance and without evidence of discussion with the patient.
- We found some improvements were required in the practices response to an MHRA specifically their monitoring of patients on heart failure medicines. We identified 11 patients prescribed the combination of medicines which require careful monitoring of renal function and potassium levels. We found only six patients had received appropriate monitoring of their renal functioning and potassium levels within the last three months, but all had had this checked within 6 months.

We checked the patient system to ensure previous risks identified to patients had been appropriately actioned. The practice were revising and reducing their prescribing of medicines. For example;

- Previously we found six patients were receiving an anti-sickness tablet on repeat prescriptions. Such medicine is prescribed for symptom control and therefore should be regularly reassessed. The practice had not prescribed any of the medicine since September 2016.

Overview of safety systems and processes

We found the practice had made improvements to keep patients safe and safeguarded from abuse. We found:

- Previously we found a medicine review for a patient with a long term condition had been conducted by a member of the nursing team, not an approved clinical prescriber. The practice had revised their prescribing and authorisation templates to ensure this could not occur again.
- We found patients were no longer being prescribed cholesterol lowering medicine which conflicted with another of their medicines.

We found improvements were still required to ensure the safe prescribing and monitoring of patients on high risk medicines. For example:

- We found 14 patients on methotrexate that had not had their renal function checked over the last four months. The guidance requires it to be conducted every three months. There was no evidence on their patient record system of the checks having been conducted by secondary care.
- We found one patient on methotrexate that had been prescribed ten weeks supply of the medicine with six authorised repeats. This was unsafe practice due to prescribing being in excess of the monitoring period.
- We also checked the practices monitoring of a high risk medicine azathioprine prescribed for inflammatory conditions. The medicine requires monitoring every three months. We found 13 patients had been initiated on the medicine by secondary care. We sampled three patient records. We found one patient initiated on the medicine in 2006 had no blood test results on their system. A second patient initiated on the medicine in 2013 also had no blood test results on their record

including within hospital correspondence. A third patient had had their received a blood test in June 2016 but had been issued 10 weeks supply with six authorised repeats in excess of the monitoring period.

- We asked to see the practices policy on their management of high risk medicines. They told us they did not have one.

After our inspection the practice submitted additional evidence to show how they had addressed the risks relating to their prescribing and monitoring of patients on high risk medicines. They had identified all patients who required monitoring and had written to them and required them to undertake immediate monitoring tests.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). QOF data for 2015/2016 showed the practice achieved 65% of the total number of points available. Their exception reporting was 3.1% which was below the local average of 4.1% and the national average of 5.7%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The practice told us they had experienced a decline in their QOF performance from 2014/2015 to 2015/2016 of 6% and a fall in their exception rate from 5.4% to 3.1%. They explained that this was due to them reviewing the coding of their patient data and amending it to accurately reflect the clinical needs of their patients. Staff were also reminded of the importance of accurately recording all actions taken, ensuring they counted towards the overall clinical performance of the practice.

Therefore, we checked the most recent unverified QOF data for the practice. This data had been taken over the past twelve months and showed the clinical performance for the practice had improved, with them achieving 83%.

The 2015/2016 practice data had shown the practice to be an outlier for QOF (or other national) clinical targets in the following areas;

- The practice had achieved below the local and national average for their asthma reviews of patients. For example, 52% of patients with asthma, on the register, had received an asthma review in the preceding 12 months that includes an assessment of asthma control. The local and national average was 75%. However, when we checked the practices performance for the past 12 months we found that they had reviewed 65.5% of their patients. Whilst this remains below the local and national averages it is a significant improvement on their previous performance.
- In 2015/2016 the practice had, had below the local and national averages for achieving a target of blood pressure control for patients with hypertension in the preceding 12 months. They achieved 71% as opposed to the local average of 80% and the national average of 83%. The practice had showed an improvement against the recent performance indicators, achieving 77.5% for their performance over the past 12 months.
- The practice had, had low review rates for their percentage of patients with COPD (including an assessment of breathlessness using the Medical Research Council dyspnoea scale) in the preceding 12 months in 2015/2016. The practice had achieved 64% in comparison to the local average of 88% and the national average of 90%. Current performance was 75.7%. Review of the clinical record showed that this could be attributed to coding discrepancies with the practice. We found a simple administrative error had contributed towards the poor performance figure resulting in assessments not being counted.
- In 2015/2016 the practice achieved below the local and national averages for the percentage of patients they diagnosed with dementia and had held a face to face review in the preceding 12 months. The practice previously achieved 45% as compared to the local average of 83% and the national average of 84%. We checked the practices most recent data and found that 100% of their patients had their care reviewed in a face to face consultation with the GP within the last 12 months.
- The practice had below the local and national averages for their monitoring of alcohol consumption for some patients with poor mental health (schizophrenia, bipolar affective disorder and other psychoses) in 2015/2016. The practice had achieved 56% in comparison to the local average of 86% and the national average 89%. We checked the practices most recent data and found they had made improvements in their screening of patients. The data for the past 12 months showed they had achieved 82%.
- In 2015/2016 the practice reported below the local and national averages for recording comprehensive care plans in the preceding 12 months for patients with poor mental health (schizophrenia, bipolar affective disorder and other psychoses). The practice had achieved 31% in

comparison with the local average of 87% and the national average 89%. The practice had made significant improvements achieving 82% over the last 12 months.

The practice was previously found to have been high prescribers for antibacterial medicines prescription items and hypnotic medicines for patients with poor mental health. The practice had attributed this to historical prescribing behaviour which they were actively reviewing to determine their patient's clinical needs. Following the inspection, the medicine lead for the practice reviewed their performance and focussed on key areas to make improvements. We found the practice was no longer an outlier for prescribing and the improvements were evident with their prescribing practices. For example:

- We looked at the practices prescribing history for antibacterial medicines. Between September 2015 and 30 November 2015 the practice had written 712 prescriptions. This had reduced to 494 prescriptions over the same period between September 2016 and 30 November 2016. The practice nurse also provided patients with literature to educate patients on viral and respiratory viruses.
- We found that the practice had reduced their prescribing of hypnotic medicines. In the three months prior to our June 2016 inspection the practice had 130 patients on the medicine. This had reduced to 100 patients since September 2016.

Effective staffing

Previously the practice had no provision in place to cover the full extent of the practice nurses duties during her absence, such as cervical smears and child immunisations. The practice had spoken with neighbouring surgeries to discuss their management of nursing provision. A managing partner GP had been appointed to undertake cervical screening training and the practice were now scheduling and managing child immunisations around leave commitments.

Coordinating patient care and information sharing

The practice had revised the appropriateness of their systems to ensure the timely sharing of information via their patient record system. Previously we had found that electronic information received by the practice such as out of hours consultations, test results and hospital letters were screened and prioritised by non-clinicians. However, the GPs were now reviewing and actioned all information to ensure patients were receiving appropriate care and treatment.

Supporting patients to live healthier lives

The practice reported below the national rates for cancer prevalence in all ages with 1.3% as opposed to 2.4%. The practice actively monitored non-attendance by patients for national screening programmes such as breast and bowel cancer. We reviewed the practice records and saw they had identified and contacted patients who had failed to attend screening appointments. They had recorded the patient preference such as where they declined to attend the service. Where the patient wished to engage with the screening they supported them to do so.

In 2014/2015 data from the National Cancer Intelligence Network showed the practice's uptake for the screening of women age 50-70 years for breast cancer in the last 36 months was 63% in comparison with the local average 67% and the national average 72%. This had improved with the practice achieving 66% compared to the national average 72.5% in 2015/2016.

The practice had also improved their screening rates for women within the same age band for attendance within six months of their invitation. Data from the National Cancer Intelligence Network showed in 2014/2015 the practice achieved 50% in comparison with the local average of 71% and the national average of 73%. In 2015/2016 the practice achieved 76% screening above the national average of 73.5%.

Data from the National Cancer Intelligence Network (2014/2015) showed the practice uptake for screening patients aged 60-69 years of age for bowel cancer within 6months of their invitation was below the local and national average achieving 48% as opposed to 54% locally or 55% nationally. In 2015/2016 the practice had improved their screening of bowel cancer patients over 30months achieving 51.5% below the national average of 57.8%.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

The practice was open at a range of times, varying each day. They were open every day between 8am and 6.15pm closing between 1pm and 2pm most days except Tuesday when they were open all day. Appointments were available 7.45am until 12.30pm and 3.30pm to 5.50pm on Monday and either 9am or 9.30am until 5.50pm Tuesday, Wednesday, Thursday and Friday. Drop-in surgeries were provided twice a week on Monday and Thursday mornings.

The practice had opened up their appointment system to patients, enabling them to book an appointment with the GP three weeks in advance. The practice told us this had been well received by patients who had told them they felt they could schedule appointments and make them at a convenient time. Practice staff had also noticed that the demand for appointments had reduced. This was supported by appointments being available with both GPs and members of the nursing team the following day.

The practice was actively reviewing their patient's attendance at accident and emergency to identify trends and reduce their prevalence. In October 2016, 102 patients had attended the accident and emergency departments reducing to 75 attendances in November 2016. Analysis of the dates and times of attendance during August 2016 and September 2016 showed the majority of patients attended accident and emergency whilst the practice was open between 8am and 6.30pm. The practice was hopeful that patient attendance would continue to decline with greater appointment availability.

The practice was actively monitoring the number of patients who failed to attend or walked out of surgery after registering for the appointment. The number of wasted clinical appointments remained high, 132 appointments were wasted in August 2016, increasing to 159 in September 2016 and 175 in October 2016. The practice had revised and was enforcing their non-attendance policy. Patients who failed to attend their appointments were contacted, advised of the practice policy and required to book appointments in person if they failed to attend on three or more occasions.

Are services well-led?

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

Our findings

Governance arrangements

Since the inspection in June 2016 the practice had spoken with the practice staff members and revised the allocation of duties. Improvements had been made in the defining of responsibilities and demonstrated greater accountability. For example, we found;

- The GPs were now reviewing and prioritising external clinical information.
- Improvements had been made to the receipt and actioning of safety alerts although these remained inconsistent.
- The practice had opened up their appointment system enabling patient's greater flexibility and choice. Patients were able to book appointments three weeks in advance with GPs.
- The practice was actively following up with patients, parents/guardians where patients failed to attend appointments.

We found insufficient monitoring systems were in place for some patients on high risk medicines. This was accepted by the practice who gave an undertaking to make immediate improvements to manage risks to patients. We contacted the practice following our visit and ensured this had been conducted and the immediate risks to patients were being appropriately managed.

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

The GP partners had recognised the importance of listening and responding to patient feedback. They had attended the last two meetings held with the patient participation group (PPG). In response to patient feedback they had redecorated the patient toilet. The practice told us they had provided guidance to all members of their PPG on their role and responsibilities during the August 2016 meeting.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure the safe management of high risk medicines and consistent actioning of medicine safety alerts.** **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**