The Surgery, Ashby

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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Surgery Ashby on 29 June 2017.

Breaches of legal requirements were found in relation to safeguarding service users from abuse and improper treatment and governance arrangements within the practice.

We issued the practice with two warning notices requiring them to achieve compliance with the regulations set out in those warning notices by 20 October 2017.

We undertook this focused inspection on 6 December 2017 to check that they now met the legal requirements. This report only covers our findings in relation to those requirements.

Summary of findings

At the inspection on 6 December 2017 we found that not all the requirements of the warning notices had been met.

Our key findings across the areas we inspected for this focussed inspection were as follows:

- The practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe. Further work was required in regard to patient safety alerts, significant events, fire safety, management of legionella and quality improvement. Further evidence was required to demonstrate shared learning in regard to discussion and actions from significant events, complaints, NICE guidance and quality improvement. Meeting minutes needed to be more detailed.
- Safe systems were now in place for high risk medicines, monitoring of the cold chain, patient group directives, staff recruitment and training, policies and procedures.
- Effective systems were now in place to safeguard service users from abuse and improper treatment.
- At this inspection we still had concerns in regard to the leadership capacity and clinical oversight of the practice.

As the legal requirement of the warning notice for Regulation 17 was not met in full the Care Quality Commission has issued a requirement notice in which we require the practice to send us an action plan on how they will meet these requirements.

The areas where the provider must make improvements are:

- Put in place an effective system for the management of patient safety alerts.
- Continue to review the system in place for significant events to ensure all events are captured, investigations are detailed, actions are identified and implemented. Ensure trends are analysed and action is taken to improve the quality of care as a result
- Complete the required actions from the October 2017 legionella risk assessment.
- Further review the arrangements in place for quality improvement to monitor and improve patient outcomes.
- Further consolidate the complaints process and ensure all complaints are captured and learning from complaints is documented, discussed and shared with staff. Ensure trends are analysed and action is taken to improve the quality of care as a result.
- Embed a formalised process for the recording of meeting minutes and have a set agenda to ensure learning is shared and actions are put in place.
- Ensure there is leadership capacity and clinical oversight in the practice.
- Ensure Care Quality Commission inspection report ratings are displayed in the practice.

In addition the provider should:

- Ensure there is monitoring for external training required by staff members.

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 system in place for patient safety alerts was still not effective.
- We found the practice had made improvements to its system for significant events, near misses and incidents but the system required further development to evidence that all events were captured, fully investigated, learning identified and actions implemented. Themes and trends had not been identified to improve the quality of care as a result.
- Fire Safety had been reviewed and the practice now had an effective system in place with the exception of fire marshall training.
- The management of legionella had been reviewed and the practice now had a system in place but were still required to complete the actions from the risk assessment carried out on 12 October 2017. Since the inspection the practice had sent an action plan with a completion date of end of January 2018.
- An effective system was in place for safeguarding service users from abuse and improper treatment.
- Patients on high risk medicines had been reviewed and in patient's records we looked at alerts were found on the clinical system and blood monitoring had taken place.
- The practice had reviewed and updated the system and process for the management of the cold chain and it was now effective.
- Patient Group Directions were in place to provide guidance to clinical staff.
- An effective system was now in place for the recruitment of staff.

Are services effective?

- Since the last inspection we saw a limited programme of continuous audits had been put in place. We reviewed one audit carried out since the last inspection. Data gathering had taken place but had not been written up to evidence the actions, outcomes and shared learning achieved as a result.
- We saw an improved system in place to monitor training.

Summary of findings

- We saw that both GPs had access to information to keep them up to date on current evidence based guidance. However we found that this was not regularly discussed at clinical meetings to share learning and put actions in place to improve patient outcomes.

Are services responsive to people's needs?

- At this inspection we found that the practice had made improvements to address the issues with the complaints system but further work was required to ensure all complaints discussed were documented and investigations, actions and learning had taken place. Themes and trends had not been identified to improve the quality of care as a result.

Are services well-led?

- At this inspection we found that the practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe.
- The practice had met the legal requirements for Regulation 13 but Regulation 17 was still not met. As the legal requirements of the warning notices for Regulation 17 were not met in full the Care Quality Commission has issued a requirement notice in which we require them to send us action plans on how they will meet these requirements.
- Policies and procedures were now in place to provide guidance to staff.
- At this inspection we still had concerns in regard to the leadership capacity and clinical oversight of the practice.
- The provider had awareness of the requirements of the duty of candour but some of the systems and processes in place still did not support this.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Put in place an effective system for the management of patient safety alerts.
- Continue to review the system in place for significant events to ensure all events are captured, investigations are detailed, actions are identified and implemented. Ensure trends are analysed and action is taken to improve the quality of care as a result
- Complete the required actions from the October 2017 legionella risk assessment.
- Further review the arrangements in place for quality improvement to monitor and improve patient outcomes.
- Further consolidate the complaints process and ensure all complaints are captured and learning from complaints is documented, discussed and shared with staff. Ensure trends are analysed and action is taken to improve the quality of care as a result.
- Embed a formalised process for the recording of meeting minutes and have a set agenda to ensure learning is shared and actions are put in place.
- Ensure there is leadership capacity and clinical oversight in the practice.

Action the service SHOULD take to improve

- Ensure there is monitoring for external training required by staff members.

The Surgery, Ashby

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.

Why we carried out this inspection

On 29 June 2017 we had carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Breaches of legal requirements were found in relation to safeguarding service users from abuse and improper treatment and governance arrangements within the practice.

We issued the practice with two warning notices requiring them to achieve compliance with the regulations set out in those warning notices by 20 October 2017.

We undertook an announced focussed inspection of The Surgery Ashby on 6 December 2017. This inspection was carried out to check that improvements to meet legal requirements in respect of the warning notices planned by the practice after our comprehensive inspection on 29 June 2017 had been made. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, NHS England and the West Leicestershire CCG to share what they knew.

We carried out an announced visit on 6 December 2017.

During our visit we:-

Spoke with the Lead GP, salaried GP, interim practice manager and a member of the administration team.

Are services safe?

Our findings

At the comprehensive inspection in June 2017 we rated the practice as inadequate for providing safe services as the arrangement in place for the assessment of risks to the health and safety of service users who received care or treatment were not effective.

We issued warning notices in relation to Regulations 13 and 17 of the Health and Social Care Act 2008.

Safe track record and learning

- At the inspection in June 2017 we found that the practice had a system in place for reporting, recording and monitoring significant events. However this was not operated effectively.

At this inspection we found that the practice had reviewed and improved the SEA system in place. There was evidence that some work had taken place on this area. They told us they had reviewed the process for highlighting and discussing significant events, created an improved process, which had been embraced by the whole practice.

Six significant events had been recorded since the last inspection. Currently no log in place or a unique identifier in place. It was evident that staff had an increased awareness of the SEA process as the management team had discussed this with all staff following the inspection. However it was not a standing agenda item for staff meetings to ensure that learning is cascaded to all staff. Minutes of the meetings held since the last inspection did not document the actions and learning shared with staff or who was responsible.

The practice had encouraged staff to complete a form if they had any concerns.

However when we looked at five of the significant events in detail we found that the investigation, documentation of the investigation, initial findings, learning and follow-up was still not effective.

For example, when a patient collapsed There was no detail in the summary of the patient impact/outcome, whether staff followed the protocol and any actions to be put in place due to the event.

- At the inspection in June 2017 we found that the practice did not have an effective system in place for receiving, discussing and monitoring of patient safety alerts.

At this inspection we found that the practice had looked at the system they had in place for patient safety alerts, made some changes but the system was still not effective.It was not clear who received the patient safety alerts in the practice. The practice manager told us they kept the alerts in a folder on the practice shared computer system. These were reviewed and when relevant to the practice a notification was sent to staff to advise them. At the time of the inspection there were seven alerts in the folder but the practice did not have a way to record them, evidence who had received them actions and any learning identified. When we reviewed the alerts against the Care Quality Commission alert log where we found that there was a considerable number of alerts that the practice did not appear to have received. Meeting minutes we looked at did not demonstrate that these were discussed with staff. The practice safety alert protocol and procedure was not practice specific and did not provide any guidance to staff on the process that should take place, who received the alerts or how they would be disseminated and actioned. Since the inspection the practice the practice had commenced a patient safety alert log which will be reviewed on the next inspection.

Overview of safety systems and processes

- At the inspection in June 2017 we found that some of the systems, processes and practices in place to keep people safe and safeguarded from abuse were not effective.

On the day of the inspection we could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment.

- At this inspection we found that arrangements were now in place to safeguard adults and children from abuse and improper treatment and they reflected relevant legislation and best practice. The practice had received support from both the West Leicestershire Clinical Commissioning Group and the North West Leicestershire GP Federation. The federation had taken the lead role and we were told this would continue over the coming months.

Are services safe?

At the inspection in June 2017 we found that the arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- We checked the system in place for the management of high risk medicines, which included regular monitoring in accordance with national guidance

At this inspection we found an effective system now in place to monitor patients on high risk medicines. However we found on one patient record we looked at who was on a medicine to used to treat an underactive thyroid. They had not had a repeat blood test and had only received one recall letter in September 2017. We brought this to the attention of the management team who told us they would make further contact with the patient.

- At the inspection in June 2017 we found there was no effective system in place to ensure that monitoring of the cold chain across the whole practice was being managed in accordance with national guidance.

At this inspection, we found two data loggers had been bought and were downloaded if a problem with the fridge temperatures had been identified. A data logger is a self-contained, miniature computer that continuously monitors refrigerator temperature, records the temperature at pre-set intervals and stores the data until it is downloaded to a standard computer. Medicines and vaccine fridge temperatures were checked in accordance with national guidance and temperatures recorded on an electronic document management system. A cold chain policy was now in place to provide guidance to staff.

- At the inspection in June 2017 we found the practice had Patient Group Directions (PGD's) in place to allow nurses to administer vaccines and other medicines produced in line with legal requirements and national guidance. However we found that these had not been signed and dated by the nurse and GP

At this inspection we found that PGD's in place at the practice had been signed and dated by the lead GP and the practice nurse. A locum nurse had been employed and we found that they had also signed the PGD's in order to administer vaccines and other medicines in line with legal requirements and national guidance.

- At the inspection in June 2017 we found inconsistencies and gaps in the recruitment checks undertaken prior to employment.

Since the last inspection staff files have been reviewed. Where possible documents had been added to the file, for example, photo ID and Disclosure and Barring certificates.

Monitoring risks to patients

At the inspection in June 2017 we found that most risks to patients were assessed but the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

- In June 2017 we looked at the system in place for fire safety and found that it was not effective. Regular fire alarm testing had not taken place and fire marshalls had been identified but had not received any training.

At this inspection we found the practice now had an effective system in place for fire safety. All information was kept in one place and monthly testing of fire alarm had taken place. An external company had tested the emergency lighting and the practice planned to commence regular testing. A fire drill had been held but more detail required in report and to be shared with all staff. We were told that staff had received training as fire marshalls but they could not show us the training certificates in relation to this. Since the inspection the practice had sent us evidence that six members of staff had completed fire marshall training on 20 October 2017.

- In June 2017 we looked at the arrangements in place for the management of legionella and found it was not effective. The practice did not have a legionella risk assessment in place in order to mitigate the risk of legionella (a bacterium which can contaminate water systems in buildings). On the day of the inspection we found that regular water temperature monitoring was carried out by a member of staff who had not had the relevant training.

Since the last inspection the staff, in particular, the housekeeper had undertaken blue stream training for legionella management. A legionella risk assessment by an external company had been completed on 12 October 2017. The building facilities were classified as low to medium risk whilst users of the building were classified as high risk. Since receiving the risk assessment report at the

Are services safe?

end of November the practice had yet to commence the actions set out by the external company. Since the inspection the practice had sent an action plan with a completion date of end of January 2018.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- At the inspection in June 2017 we found that the practice did not have a formal system in place to keep staff up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

At this inspection we found access to NICE guidance on both GP computers and in one set of meeting minutes we reviewed we found evidence of an update to staff. However NICE guidance was still not a regular agenda item to share updates with staff. The practice nurse had commenced her nurse prescribing course and would benefit from being included in the access and shared learning at meetings.

Management, monitoring and improving outcomes for people

- At the inspection in June 2017 we found that there was limited evidence of quality improvement including clinical audit. The practice did not have a programme of continuous audits to monitor quality and to make improvements

At this inspection a limited audit programme was seen. Since the last inspection the practice had carried out one cycle of an audit in regard to a medicine used to treat breast cancer and antidepressants. The practice had also completed some data gathering exercises but none had been written up as audits. Two further audits had been commenced in relation to new oral anti-coagulants (NOAC) and patients who were recorded on the patient electronic records with high blood pressure. The completed audits would be reviewed at the next inspection.

Effective staffing

- At the inspection in June 2017 we found that the system in place in relation to the identification and monitoring of the training needs of all staff was not effective. For example, safeguarding, fire safety, basic life support, infection control and information governance.

At this inspection we found bluestream training matrix now in place. This was training which staff were able to access on-line. The practice manager downloaded monthly reports to see what training was outstanding. We looked at the latest report and found that all staff had completed 100%. However there was still not an effective process for external training, for example, basic life support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Listening and learning from concerns and complaints

- At the inspection in June 2017 we found that the practice had a system for handling complaints and concerns but it was not clear or consistent. Verbal complaints had not been recorded.

At this inspection we found that four verbal complaints had been recorded since the last inspection. However further work was required as they lacked a unique identifier, documentation required further detail with evidence of actions and shared learning.

Are services well-led?

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

Our findings

At the comprehensive inspection in June 2017, we rated the practice as inadequate for providing well-led services as we found that arrangements to improve the quality and safety of services provided required significant improvements in oversight and monitoring of governance arrangements.

We issued warning notices in relation to Regulations 13 and 17 of the Health and Social Care Act 2008 in relation to Safeguarding service users from abuse and improper treatment and Good Governance.

At this inspection we found that the practice had made improvements and had taken some of the appropriate steps required to ensure patients remained safe. Regulation 13 had been met in full. However as the legal requirements of the warning notice for Regulation 17 had not been met in full the Care Quality Commission has issued the practice with a requirement notice in which we require them to send us an action plan on how they will meet these requirements.

Governance arrangements

At the inspection in June 2017 we found that the practice had limited governance arrangements in place to support the delivery of their strategy. There was a lack of effective systems in place to monitor quality and make improvements and limited arrangements for managing risks.

At this inspection we found:-

- The practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe. Further work was required in regard to patient safety alerts, significant events, fire safety, management of legionella and quality improvement. Further evidence was required to demonstrate shared learning in regard to discussion and actions from significant events, complaints, NICE guidance and quality improvement.
- Meeting minutes needed to be more detailed. Since the inspection the practice had put in place a set agenda for future meetings. Minutes of meetings will be reviewed again at the next inspection.
- Safe systems were now in place for high risk medicines, cold chain, patient group directives, staff recruitment and training, policies and procedures.
- Effective systems were now in place to safeguard service users from abuse and improper treatment.
- At this inspection we still had concerns in regard to the leadership capacity and clinical oversight of the practice.

Leadership and culture

- At the inspection in June 2017 we found the overall leadership was not effective. Limited governance arrangements were in place to support the delivery of their strategy and there was a lack of clinical oversight to monitor quality, make improvements and manage risks.

At this inspection we found that the leadership and clinical oversight needed to be strengthened further as we found that the West Leicestershire Clinical Commissioning Group had taken a lead in supporting the improvements required and the lead GP still needed to demonstrate strong leadership in respect of safety and good governance.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure that systems and processes were established and operated effectively. The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.