Central Healthcare 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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Central Healthcare Centre on 2 October 2014. The practice was rated good overall with good ratings for every domain.

A comprehensive inspection was carried out on the 31 May 2017. The practice was rated as inadequate overall, and inadequate for providing safe, responsive and well led services. The practice was rated as requires improvement for providing effective and caring services. As a result of the findings on the day of the inspection, the practice was issued with a warning notice on 28 July 2017 for regulation 17 (good governance). The practice was placed into special measures for six months The full inspection reports on the October 2014 and May 2017 inspections can be found by selecting the 'all reports' link for Central Healthcare Centre on our website at www.cqc.org.uk.

This inspection was to check on improvements detailed in the warning notice issued on 28 July 2017, following the inspection on 31 May 2017. This report only covers our findings in relation to those requirements.

Our key findings from this inspection were as follows:

- There was an effective system in place to support patients who take medicines that require monitoring.
- A process had been established to review and act on Medicines & Healthcare products Regulatory Agency (MHRA) alerts.
- There was an effective system in place for the management and coding of clinical letters.
- There was an overarching governance system in place which gave management an overview of the performance of the nursing team.

In addition the provider should:

- The provider should continue to monitor the newly implemented systems and processes to ensure improvements to quality and safety are made and monitored. For example, the management and monitoring of safe prescribing.

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?

Our focused inspection on 18 October 2017 found that:

- Patients who required monitoring had been reviewed and extra phlebotomy clinics had been offered to address the increase in workload due to the high number of patients requiring blood tests. The GPs risk assessed those patients who did not attend appointments for medicines reviews and a spreadsheet to monitor the progress and status of reviews was kept up to date.
- There was a lead GP and lead administrative staff member who had responsibility for actioning patient safety alerts. The practice now kept a log of alerts and there was a clear system in place for the management and monitoring of these alerts.
- The practice had employed additional staff to manage the backlog of clinical coding and these members of staff had undergone workflow optimisation training. There was no longer a backlog of letters and there was a system and process in place to ensure this did not happen again.

This report should be read in conjunction with the full inspection report published on 9 August 2017.

Are services well-led?

Our focused inspection on 18 October 2017 found that:

- The management team had redefined the structure and roles within the practice. The nursing team had regular monthly meetings with the lead GP for the nursing team. Each nurse had a named GP who completed regular supervision sessions and audits of clinical consultations and prescribing.

This report should be read in conjunction with the full inspection report published on 9 August 2017.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- The provider should continue to monitor the newly implemented systems and processes to ensure improvements to quality and safety are made and monitored. For example, the management and monitoring of safe prescribing.

Central Healthcare Centre

Detailed findings

Our inspection team

Our inspection team was led by:

This focused inspection was completed by a CQC inspector and a GP specialist adviser.

Background to Central Healthcare Centre

Central Healthcare Centre provides services to approximately 17,000 patients in residential area in Great Yarmouth. The practice has three GPs; one female and two males. There are also four female locum GPs at the practice. There is a practice manager and a finance manager on site. The practice employs six advanced nurse practitioners, one nurse practitioner, three practice nurses, one trainee practice nurse and a nurse manager. The practice also employs five health care assistants and two healthcare specialists. Other staff include a clinical pharmacist, 14 receptionists and an apprentice receptionist, six secretaries and six admin assistants. The practice holds a GMS contract with NHS England.

In June 2016 the Family Healthcare Centre, East Anglian Way, Gorleston relocated into the Central Surgery and renamed the two practices Central Healthcare Centre. The Central Healthcare Centre formally merged on 2 November 2016. This involved the practice taking on an extra 5,000 patients from a deprived area and a merger of both clinical and non-clinical staff.

The practice is open between 8am and 6.30pm Monday to Friday. The practice is closed between 12.30pm and 1.30pm on Tuesdays. Appointments can be booked up to three to four weeks in advance with GPs and nurses. Urgent appointments are available for people that need them, as well as telephone appointments. Online appointments are available to book up to one month in advance.

When the practice is closed patients are automatically diverted to the GP out of hour's service provided by Integrated Care 24. Patients can also access advice via the NHS 111 service.

We reviewed the most recent data available to us from Public Health England which showed the practice has a smaller number of patients aged 25 to 44 years old compared with the national average. It has a larger number of patients aged 60 to 84 compared to the national average. Income deprivation affecting children is 21%, which is lower than the CCG average of 25% and comparable to the national average of 20%. Income deprivation affecting older people is 19%, which is comparable to the CCG average of 17% and national average of 16%. The practice is rated in the fourth more deprived decile and 1.8% of the practice population is Asian, while 1.7% of patients are other non-white ethnic groups. Life expectancy for patients at the practice is 79 years for males and 83 years for females; this is comparable to the CCG and England expectancy which is 79 years and 83 years.

Why we carried out this inspection

We undertook a comprehensive inspection of Central Healthcare Centre on 31 May 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate overall and as inadequate for providing safe, responsive and well led services and requires improvement for effective and caring services. The practice was placed into special measures for

Detailed findings

a period of six months. We issued a warning notice on the 28 July 2017 to the provider in respect of good governance and informed them that they must become compliant with the law by 30 September 2017.

You can read our findings from our previous inspections by selecting the 'all reports' link for Central Healthcare Centre on our website at www.cqc.org.uk.

We undertook a focussed inspection of Central Healthcare Centre on 18 October 2017 to check that the practice now met the legal requirements, as set out in the warning notice.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including a GP, a nurse and practice management staff.
- Reviewed practice documentation in relation to medicines which require monitoring, safety alerts, which included Medicines & Healthcare products Regulatory Agency (MHRA) alerts and the system for clinical coding.
- Reviewed the updated policies relating to management of medicines which require monitoring, MHRA alerts and coding.
- Reviewed a sample of the personal care or treatment records of patients.

Are services safe?

Our findings

At our previous inspection on 31 May 2017 we found that systems and processes were not in place to assess, monitor, and improve the quality and safety of the service.

- There was no effective system in place to deal with patient safety alerts. The alerts were sent to all GPs, but there was no system in place to monitor the actions taken in response to the alert. We looked at three safety alerts and reviewed patient records affected by these. Appropriate actions had been taken for some patients, such as medicine changes and discussions about medicines. However some patients had not had documented action taken relating to the alert.
- The practice had a medicine review system in place to support patients who take medicines that require monitoring. However, data demonstrated this system was not always effective. We found that some patients with long term conditions such as thyroid disorder or cardiovascular disease were not being monitored in line with current good practice guidelines. For example 199 with a thyroid disorder had not had a thyroid function test within the last 13 months, and 69 patients prescribed diuretics had not had the appropriate monitoring within the last 13 months.
- On the day of our inspection on 31 May 2017, the practice told us that approximately 10,000 clinical letters had not been coded. The practice reported that all letters had been reviewed by a clinician when they were received.

Our focused inspection on 18 October 2017 found that:

Safe track record and learning

- A process had been established to review and act on patient safety alerts which included Medicines & Healthcare products Regulatory Agency (MHRA) alerts. Patient safety alerts were logged, shared, initial necessary searches were completed and the changes effected. There was a new effective policy in place for the management of these alerts. This policy had been read and signed by the appropriate staff members.
- The practice had a spreadsheet to record all parts of the process of managing safety alerts. We saw that patient safety alerts were shared with relevant staff and these staff members signed to say they had received and actioned the alert. The practice also held a paper trail of these alerts.
- We found that patients affected by safety alerts we viewed were being reviewed. For example, we ran a search relating to female patients of child bearing age on sodium valproate. We found patients affected by this alert had either had a medicine review or had been booked in to see a GP.

Overview of safety systems and processes

- The practice had implemented a new policy for the management of patients on medicines that require monitoring. This had been signed by the appropriate staff members. There was also a lead GP for prescribing.
- There was a new system in place to manage patients on medicines that require monitoring. These patients were followed up by a dedicated administration clerk who invited patients for relevant testing. Where patients did not attend, two letters were sent explaining the importance of testing. This was followed up by a GP, where appropriate, with a phone call. For any patient who declined or did not attend, a risk assessment was completed on the appropriateness of prescribing the medicine. This information was clearly documented.
- The practice had also run additional phlebotomy clinics to help with the increase in workload due to the high number of patients requiring blood tests.
- We ran searches on patients with a thyroid disorder that had not had a thyroid function test in the past 13 months and found 51 patients affected (reduced from 199). There was clear evidence of these patients being followed up by the practice and invited for testing. The practice previously had 69 patients prescribed diuretics that had not had the appropriate monitoring within the last 13 months. This had reduced to 29 and the practice could evidence follow up of these patients and were in discussions with the local hospital around sharing information relating to blood monitoring

Monitoring risks to patients

Are services safe?

- We found a new policy in place for the coding of clinical letters which had been signed by the relevant staff. There was no longer a backlog of clinical letters and these were now managed daily by the administration team.
- The practice had employed additional staff and provided training to clear the initial backlog. The GPs each ran an audit of the letters coded and random sampled 100 letters each. They provided feedback to the administration staff on the outcome of the audit. They found in total 6% of letters coded had a minor error, there were no major errors and there were no trends in errors.

Are services well-led?

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

Our findings

At our previous inspection on 31 May 2017 we found that systems and processes were not in place to assess, monitor, and improve the quality and safety of the service.

- The practice did not demonstrate overarching clinical or non-clinical governance or leadership. Although there was an informal open door policy, we found there was limited clinical oversight of the nursing staff as the GPs held one teaching session every fortnight. There was no one to one clinical supervision on a regular basis for the nursing staff.

Our focused inspection on 18 October 2017 found that:

Governance arrangements

- The practice had reviewed the management structure and given staff defined roles. Staff commented positively on this and stated this gave them more ownership of their roles. Protected time was given for the management staff to meet on a weekly basis to discuss any issues within the practice.
- The practice had also developed a service development group. This was a monthly meeting attended by patients from the patient participation group and a member of staff from each department in the practice. The purpose of this was to inform everyone of changes within the practice and to also gain and act on feedback from the group.
- The practice had completed an anonymised staff survey to gain feedback. They had a management meeting to discuss findings and formulated an action plan, which included a more structured meeting format and protected time to complete allocated roles. This was due to be fed back to staff in a planned meeting in November.
- The nursing staff each had a named GP who offered support and supervision. The GPs completed audits of the clinical consultations and prescribing carried out by the nurses and provided regular feedback. There was clear documentation of these audits and the feedback. The nursing staff reported they felt more supported by this formalised structure.