The Grange

Quality Report

The Grange 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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was the fifth inspection that we have carried out at The Grange. We carried out an announced comprehensive inspection at The Grange on 6 June 2016. The practice was rated inadequate overall, inadequate for providing safe, effective, and well led services, and requires improvement for providing responsive and caring services. As a result of the findings on the day of the inspection, the practice was issued with a warning notice on 18 July 2016 for regulation 17 (good governance). The practice was placed into special measures for six months.

On 2 September 2016 we carried out a second inspection visit in response to information of concern about the provider. The inspection on 2 September 2016 focused on

Summary of findings

the safe and well led key questions. We found the systems and processes for managing pathology and X-ray results and dealing with repeat prescriptions were not adequate.

A third inspection was carried out on 4 November 2016, to check on improvements detailed in the warning notice issued on 18 July 2016, following the inspection on 6 June 2016. We found that the practice had reviewed their systems and strengthened their quality monitoring but could not demonstrate this was effective. A further warning notice was issued on the 22 November 2016 as appropriate systems were still not in place to assess, monitor, mitigate risks and improve the quality of the service.

A comprehensive inspection was carried out on the 28 February 2017, following the period of special measures and to check on improvements detailed in the warning notice issued on the 22 November 2016, following the inspection on the 4 November 2016. The practice was rated as requires improvement overall. The full inspection reports on the June 2016, September 2016, November 2016 and February 2017 inspections can be found by selecting the 'all reports' link for The Grange on our website at www.cqc.org.uk.

This inspection was to check on improvements detailed in the warning notice issued on 8 March 2017, following the inspection on 28 February 2017. This report only covers our findings in relation to those requirements.

Our key findings from this inspection were as follows:

- An effective system for the monitoring and review of high risk medicines was in place.
- A process had been established to review and act on Medicines & Healthcare products Regulatory Agency (MHRA) alerts.
- There was an effective failsafe system in place for cervical cytology samples.

The areas where the provider should make improvement are:

- Consider the need to improve the clarity of roles and responsibilities in relation to managing patient safety alerts.

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?

At the last inspection on 18 February 2017 we found that:

- A process had been introduced to ensure that patient safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts, were handled appropriately. We identified areas where clinicians were not prescribing in accordance with current evidence based guidance and specifically where the risks of such prescribing had been highlighted by safety alerts.
- The medicines management policy had been updated recently but we found that it was not followed in practice. The system and process in place for handling repeat prescriptions for high risk medicines did not ensure that patients were monitored regularly and that test results were checked before medicines were prescribed.

Our focused inspection on 29 August 2017 found that:

- A process had been established to review and act on Medicines & Healthcare products Regulatory Agency (MHRA) alerts which included those which had been adopted into evidence based guidance. A clinical pharmacist had recently been employed, who planned to take a lead role in managing patient safety alerts.
- The medicines management policy had been updated and was followed in practice. Effective systems and processes were in place for handling repeat prescriptions for high risk medicines. Records we viewed showed that patients were monitored regularly and results were reviewed before medicines were prescribed.

This report should be read in conjunction with the full inspection report published on 5 May 2017.

Are services effective?

At the last inspection on 18 February 2017 we found that:

- There was not an effective failsafe system in place for cervical cytology samples.

Our focused inspection on 29 August 2017 found that:

- An effective failsafe system was in place for cervical cytology samples.

This report should be read in conjunction with the full inspection report published on 5 May 2017.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Consider the need to improve the clarity of roles and responsibilities in relation to managing patient safety alerts.

The Grange

Detailed findings

Our inspection team

Our inspection team was led by:

This focused inspection was completed by a CQC inspector, a GP specialist adviser and a CQC Deputy Chief Inspector.

Background to The Grange

The Grange is an established GP practice that has operated in the area for many years. It serves approximately 2,900 registered patients and has a general medical services (GMS) contract with NHS Cambridgeshire and Peterborough CCG. It is located close to the centre of Peterborough in a residential area and is close to local bus routes. There is very limited designated parking for patients although patients and visitors can park on the nearby roads. The service is close to a small pharmacy.

According to information taken from Public Health England, the patient population has a slightly higher than average number of patients aged 0 to 39 years. When compared to practice average rates across England the practice has a lower than average number of patients aged 45 and over. The practice has a population group from diverse backgrounds and approximately 40% of their population are from a Pakistani background.

The principle GP is the registered manager, and is supported by locum GPs and advance nurse practitioners. The practice has not been successful in recruiting a second GP partner or salaried GP. The team includes two practice nurses, a health care assistant, three reception staff which includes a medical secretary and a practice management team. The GP also leads another larger practice based in the city. A number of staff, including the lead GP and practice management team are based at the other practice most of the time. Staff work at both practice locations at times to share resources.

The opening times are Monday to Friday from 9am to 6.30pm. Appointments are available with a GP or an advanced nurse practitioner generally from 9am to 11.30am and from 3pm to 5pm daily. Patients are able to book evening and weekend appointments with a GP or advanced nurse practitioner, as the practice had an arrangement with other local GP practices to provide this cover, through the Greater Peterborough Network. When the practice is closed patients receive care and support through the out of hour's service. Patients can access this by dialling the NHS 111 service or by calling the practice.

Why we carried out this inspection

We undertook a comprehensive inspection of The Grange on 6 June 2016 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, effective and well led services and requires improvement for caring and responsive services. The practice was placed into special measures for a period of six months. We issued a warning notice on the 18 July 2016 to the provider in respect of good governance and informed them that they must become compliant with the law by 9 September 2016.

On 2 September 2016 we carried out a second inspection visit in response to information of concern about the provider. The inspection on 2 September 2016 focused on the safe and well led domains. We found the systems and processes for managing pathology and X-ray results and dealing with repeat prescriptions were not adequate.

Detailed findings

We undertook a follow up inspection on 4 November 2016 to check that action had been taken to comply with the warning notice issued on the 18 July 2016. We issued a further warning notice to the provider in respect of good governance and informed them that they must become compliant with the law by 10 January 2017.

We undertook an announced comprehensive inspection on 28 February 2017 following the period of special measures, to ensure improvements had been made and to check that action had been taken to comply with the warning notice issued following the 4 November 2016 inspection. The practice was taken out of special measures and rated as requires improvement overall. However, we issued a further warning notice to the provider in respect of good governance and informed them that they must become compliant with the law by 8 June 2017. You can read our findings from our previous inspections by selecting the 'all reports' link for The Grange on our website at www.cqc.org.uk. We undertook a focussed inspection of The Grange on 29 August 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, a clinical pharmacist and practice management staff.
- Reviewed practice documentation in relation to high risk medicines, safety alerts, which included Medicines & Healthcare products Regulatory Agency (MHRA) alerts and the failsafe system for cervical screening.
- Reviewed the updated medicines management policy for recalling patients prescribed medicines that required specific monitoring, and carried out data searches to see evidence of how this had been actioned.
- Reviewed a sample of the personal care or treatment records of patients.

Are services safe?

Our findings

At our previous inspection on 28 February 2017 we found that systems and processes were not in place to assess, monitor, and improve the quality and safety of the service.

- A process had been introduced to ensure that patient safety alerts including Medicines and Healthcare products Regulatory Agency alerts, were handled appropriately. We identified areas where clinicians were not prescribing in accordance with current best practice and specifically where the risks of such prescribing had been highlighted by safety alerts which had been adopted into evidence based guidance.
- The medicines management policy had been updated recently but we found that it was not followed in practice. The system and process in place for handling repeat prescriptions for high risk medicines did not ensure that patients were monitored regularly and that test results were checked before medicines were prescribed.

Our focused inspection on 29 August 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 and initial necessary searches were completed and the changes effected. Monthly searches were also completed to ensure that patients were identified for any safety alerts which had been adopted into evidence based guidance.
- The practice had a spreadsheet to record the complete process of managing safety alerts. We found some gaps in the recording for some of the alerts, for example staff who were involved and actions agreed. We saw that patient safety alerts were shared with relevant staff by email and discussed at the weekly peer review and clinical supervision meeting.
- We found one safety alert which had been identified, but the practice were not able to evidence that a search had been undertaken to identify which patients may be affected. We spoke with the practice management team about this and they confirmed on the same day as the inspection, that no patients were affected. They added this alert to their monthly search list. The practice had recently employed a clinical pharmacist, who planned to take a lead role in managing patient safety alerts.

Overview of safety systems and processes

- The medicines management policy had been updated and was followed in practice. Effective systems and processes were in place for handling repeat prescriptions for high risk medicines. We looked at four high risk medicines and reviewed 17 patients who were prescribed these medicines. Records we viewed showed that patients were monitored regularly and results were reviewed before medicines were prescribed.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 28 February 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 not an effective failsafe system in place for cervical cytology samples.

Our focused inspection on 29 August 2017 found that:

Supporting patients to live healthier lives

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme. The practice nurses kept a written record of patients who had a cervical screening test and recorded when results were received. Monthly computer searches were undertaken to identify any patients who had a test and who had not received a result. Processes were in place to follow up any patients who were identified.