Cambs GP Network Limited

Inspection 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 location	Not inspected
Are services safe?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

At our previous inspection we rated the service as good overall and good for providing effective, caring, responsive and well-led services. We rated the service as requires improvement for providing safe services.

We carried out an announced focused inspection at Cambs GP Network Limited on 16 November 2021 to follow up on breaches of regulations and areas where the provider 'should' improve identified at our previous inspection. We found the required improvements had been made and the practice is now rated as good for providing safe services.

Cambs GP Network is a federation of GP practices in Cambridge, Ely, Royston, Milton, and surrounding villages. Cambs GP Network offer extended services in the evening and weekends for the local population.

Our key findings were:

- The provider had made improvements in respect of issues identified at our previous inspection.
- There were systems and processes in place for quarterly clinical audits of all high-risk medicines prescribed.
- The provider demonstrated they had clear systems to ensure learning outcomes from safety events were shared.
- The provider had improved their recruitment process and had clear oversight of staff who held zero-hour contracts.
- The provider had clear systems and process to ensure they had oversight of all premises from which they delivered services. They had safety risk assessments for all the premises used, processes to regularly review and ensure any actions identified were completed.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a second CQC Inspector.

Background to Cambs GP Network Limited

Cambs GP Network is a federation of GP practices in Cambridge, Ely, Royston, Milton, and the surrounding villages. Cambs GP Network is a private limited company with a social enterprise ethos.

Although member practices retain their individual identity and staff, the Cambs GP Network supports a number of health care hubs, typically large practices with good access, where extended services (both in terms of timing and scope) can be delivered as close to patients' homes as possible. Routine appointments for nursing procedures, monitoring and management of long-term conditions and assessment of new problems are available on weekday evenings and at weekends.

There was a registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Cambs GP Network is made up of a board of directors, a senior management team and 31 member practices.

Services are delivered from five practices at the time of inspection; St Mary's Surgery Ely, Comberton Surgery, Comberton, Nuffield Road Medical Centre, Cambridge, Royston Health Centre, Royston and Milton Surgery, Milton. Services are offered seven days a week, 365 days a year between 6pm and 10pm on weekdays and 8am and 2pm on weekends.

All appointments offered are for routine care, and can be with a GP, nurse, or healthcare assistant. All appointments are pre-booked via the patients' own GP practice or 111. The service does not offer emergency care or home visits.

As part of this inspection, we did not visit the sites where the provider delivers regulated activity.

How we inspected this service

Before the inspection, we reviewed information held by CQC on our internal systems.

During the inspection we spoke with the staff present including the chief executive officer and the clinical lead. We made observations of the facilities and service provision and reviewed documents, records and information held by the service.

Good

Are services safe?

At our last inspection we rated the practice as requires improvement for providing safe services because;

The provider did not have complete oversight of all building and safety risk assessments for all the premises used to deliver services. In addition to this, where a risk assessment had been completed, the provider did not have oversight of the progress of the actions required.

•We found the system in place for prescribing high-risk medicines did not ensure every patient had been appropriately monitored.

•The provider did not evidence that learning outcomes from safety events and complaints were shared across the whole staff team.

•The provider did not have oversight of references for zero-hour contract staff.

• The provider could further develop the existing process for quality improvement to monitor and improve the quality of care offered to patients.

• The system for reviewing competency of staff employed needed to be strengthened.

At this inspection we rated safe as Good because:

We found improvements had been made, embedded, monitored and sustained. There was oversight of completed risk assessments and actions required of the premises used to deliver regulated activity. All high-risk medicines were audited regularly, and findings shared with staff. There was clear management oversight of zero-hour contract held by staff. The process for sharing safety events had been improved with the introduction of a monthly newsletter to all clinical staff.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. We reviewed three personnel files all of which contained evidence that the appropriate checks had been undertaken. The provider told us they had external support through HR advisors to ensure documentation was correct and up to date.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There was an effective induction system for staff tailored to their role and including the relevant policies and procedures. The provider told us they were able to assure themselves of staff competencies through regular audits of clinical staff consultations and prescribing of high-risk medicines. Where any concerns were seen, the clinical director spoke with the staff member involved to ensure they were aware of the service policy in respect of prescribing. Appraisals were conducted to identify any training needs and staff had easy access to the clinical leaders to address any concerns they may have. The provider told us training was monitored closely and had adopted a tracking system which would alert staff when training was due, the system used also prevented shift access to those staff with expired training, this ensured the safety of patients.

Safe and appropriate use of medicines

Good

Are services safe?

The service had reliable systems for appropriate and safe handling of medicines.

- The service carried out regular audits in respect of high-risk medicines prescribed to ensure prescribing was in line with their policy and in line with best practice guidelines. The provider showed evidence of regular clinical audits that included reviewing the consultations of all clinicians prescribing high risk medicines including those for chronic pain. These regular audits showed positive change over the last 12 months. These audits were shared with individual clinicians and where the service identified prescribing and shared through a monthly newsletter produced by the provider. This newsletter contains current information such as new safety alerts, and updated guidelines. For example, in the newsletter dated November 2021, information regarding chronic obstructive pulmonary disease was given. Links to relevant sites for further information were provided.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. The provider had oversight of practice level risk assessments and had systems in place to track upcoming actions required, the tracker was reviewed every six months with monthly audits carried out to prevent any outliers. The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. Each site was regularly visited by a team leader or member of the management team.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There were clear systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service. For example, there was an allocated section in each newsletter for recent learning events which was shared with all staff. The provider told us there were monthly board meetings, monthly clinical governance meetings and biannual members meetings where learning was shared. For example, we saw in the newsletter for reception staff dated November 2021 the summary of the event which involved in the wrong patient being seen for a minor procedure and the learning outcomes which reminded staff to check the patient's identity using at least two criteria such as date of birth and name.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information, and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.

The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team.