# The Grange

## Quality Report

The Grange Medical Centre
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Date of inspection visit: 28 February 2017
Date of publication: 05/05/2017

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 | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Requires improvement |
| Are services well-led? | Requires improvement |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

This was the fourth 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 and 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. An inspection at another practice had identified that patient safety was being put at risk. Both practices shared a number of policies and procedures and several members of staff. The inspection on 2 September 2016 focused on the safe and well led domains. We found that areas of unsafe practice identified at the other practice, had ceased at The Grange. However, we found the safety and leadership of systems 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, 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.

The full inspection reports on the June 2016, September 2016 and November 2016 inspections can be found by selecting the 'all reports' link for The Grange on our website at www.cqc.org.uk.

# Summary of findings

This inspection was undertaken following the period of special measures and included a follow up of the warning notice issued on 22 November 2016. It was an announced comprehensive inspection on 28 February 2017. Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- During part of the special measures period the principal GP had been unable to provide clinical services. Throughout the special measures period, the practice had received management support from the Royal College of General Practitioners team which consisted of GP and practice management support.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses and there was evidence of learning and communication with staff.
- The arrangements for managing medicines needed to be fully embedded to keep patients safe. The process 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. The practice was not following a system to recall patients on high risk medicines as stated in their policy.
- The practice had systems and process in place to record and action safety alerts. However some patients who may be affected by Medicines and Healthcare products Regulatory Agency (MHRA) alerts issued some years ago, had not been reviewed.
- Risks to patients and staff which included fire, general risks and health and safety had been assessed and identified actions undertaken.
- Appropriate recruitment and induction checks had been completed for locum staff. A system was in place for recording and monitoring that mandatory training had been completed.
- On the day of the inspection the practice had not been successful in recruiting further GP partners or salaried GPs. They had engaged locum GPs and advance nurse practitioners who provided sessions on a regular basis. They told us they were in discussion with staff in relation to joining the team, but on the day of the inspection the staff had not signed any contracts. The systems to provide clinical supervision for clinical staff needed to be improved.
- 2015/16 Data showed patient outcomes were low compared to the national average, however 2016/17 unverified data showed significant improvements. Although some clinical audits had been carried out, there was limited evidence that audits were driving improvements in patient outcomes. Following the inspection, the practice informed us that they consider regular QOF reviews as part of their clinical audit process. Unverified data for 2016/2017 showed an improvement in their performance.
- The practice previously had a failsafe system in place for checking cervical cytology outcomes for patients; however this had not been completed since 2 September 2016.
- A staff member had taken a lead role as a carer's champion and the support and information available to carers had significantly improved. The practice had identified 56 carers (just under 2% of the practice list) compared to 15 at the inspection in June 2016.
- The appointment system was working well and patients told us they received timely care when they needed it.
- The practice had an active patient participation group (PPG) which included on line membership and members met with the practice on a regular basis. The PPG gave examples of where the practice had responded to patient feedback and made improvements and where the PPG had directly undertaken improvements.
- Some information was displayed in the practice which had been translated into a number of languages used by patients.
- Patients were informed that there was a complaints process, however further information was not easily available to patients and it was not available in other languages used by registered patients. Information on the complaints system was not up to date on the website.
- Governance systems had improved but the practice needed additional time to review, strengthen, and embed their new process to ensure that the improvements could be sustained over time.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

# Summary of findings

- Ensure systems and processes are in place to assess, monitor and improve the quality and safety of the service, including for example MHRA alerts which remain relevant, high risk medicines and cervical cytology.

In addition the provider should:

- Ensure that checks are undertaken and documented to provide assurance of the quality of the work undertaken by locum staff and improve arrangements for clinical supervision.
- Ensure that the patient information leaflet on complaints is easily available to patients and that complaints information on the practice's website is up to date.
- Continue to work on translating information into languages used by patients at the practice.
- Ensure that all staff know how to find practice policies and procedures.

This service was placed in special measures in September 2016. I am taking this service out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had established a process to ensure Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were responded to appropriately. However some patients who may be affected by MHRA alerts issued some years ago, had not been reviewed.
- The arrangements for managing medicines needed to be fully embedded to keep patients safe. The process 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. They were not following a system to recall patients on high risk medicines as stated in their policy.
- The practice had defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Health and safety risks to patients were assessed and well managed.

**Are services effective?**

**Requires improvement**

The practice is rated as requires improvement for providing effective services.

- Data from the 2015/16 Quality and Outcomes Framework (QOF) showed a mixed performance for patient outcomes for the clinical areas. Four were slightly above, four were in line, four were below and six were significantly below the Clinical Commissioning Group (CCG) and England averages. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance had improved in all clinical areas.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

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- Although some clinical audits had been carried out, there was limited evidence that clinical audits were driving improvements in patient outcomes. Following the inspection, the practice informed us that they consider regular QOF reviews as part of their clinic audit process. Unverified data for 2016/2017 showed an improvement in their performance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff. The arrangements for clinical supervision of locum GPs and advanced nurse practitioners needed to be improved.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. Patients said they were treated with compassion, dignity and respect, were listened to and were involved in decisions about their care and treatment.
- The practice had a carers' champion who took a lead on identifying and supporting carers within the practice. The practice had identified 56 patients as carers (just under 2% of the practice list). There was a notice board in the practice which was specifically aimed at identifying carers and providing advice, information and support to them. We saw that some information had been written in key languages used by registered patients, for example support for carers, information on the 111 service and complaints.
- Patients were able to access community activities such as coffee mornings, a befriender group, a walking to fitness group and educational sessions, which were held at a nearby GP practice.
- Data from the national GP patient survey showed patients rated the practice similar to or below national average for several aspects of care. For example patients rated their GP consultations lower than average scores overall and rated contacts with a nurse or receptionist as similar to national average scores. The patient participation group patient survey, undertaken in October 2016 showed similar results and an action plan was in place to improve these areas.
- Improvements had been made as some information had been translated into other languages used by patients at the practice.

# Summary of findings

**Are services responsive to people's needs?**

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Patients were 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.
- The majority of patients we received comments cards from and spoke with said they found it easy to make an appointment. Urgent appointments were available the same day and there was a process in place to ensure patients who needed to see a GP urgently were contacted.
- The practice was well equipped to treat patients and meet their needs.
- Some information was displayed at the practice which had been translated into a number of languages used by patients at the practice. This included information for carers, the 111 service, and signposting to the complaints process.
- A patient information leaflet on the complaints process was available at the practice, although this was not easily available to patients. This was written in English and had not been translated into other languages used by patients at the practice. Information in the complaints leaflet was easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff to improve the service provided. Complaints information was not up to date on the practice website. Since the inspection, the practice has informed us that they have taken action to address this concern.

**Are services well-led?**

Requires improvement

The practice is rated as requires improvement for providing well led services.

- The practice had a clear vision in place to 'help our patients to be healthy in mind, body and community (in their relationships with their family, workplace and neighbourhood.)' Staff were clear about the vision and their responsibilities in relation to it.
- There was a leadership structure and although staff felt supported by management, supervision could be improved.
- The practice had started having regular meetings and these were recorded appropriately.

# Summary of findings

- The practice had a number of policies and procedures to govern activity, however these were not always followed in practice, for example the medicines management policy. Not all staff were able to find specific policies when asked.
- The failsafe system for cervical samples had stopped in September 2016; this was noted during the inspection and had not been identified by the practice.
- The clinical and management team had regular meetings to manage the performance of the practice in relation to the quality and outcome framework. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance had improved across all the QOF clinical indicators.
- The practice sought feedback from staff and patients, which it acted on.
- There was a focus on improvement as the practice was working with staff from the Royal College of GPs which included a GP and practice management support.
- Governance systems had improved, but the practice needed additional time to review, strengthen, and embed their new process to ensure that these improvements could be sustained over time.

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

### Older people

**Requires improvement**

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• The practice offered proactive, personalised care to meet the needs of the older people in its population. Telephone requests were accepted for repeat prescriptions.

• The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

• GPs and nursing staff provided home visits to patients living in the two nursing and residential homes covered by the practice.

• Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were significantly below local and national averages. 2016/17 unverified data provided on the day of inspection showed that improvements had been made in these areas.

### People with long term conditions

**Requires improvement**

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• Nursing staff had lead roles in chronic disease management. A diabetes specialist nurse provided support to patients at the practice with complex needs.

• The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that performance for diabetes related indicators was 80%, which was below the local average of 90% and national average of 89%. Exception reporting for diabetes related indicators was 17% which was above the local average of 13% and the national average of 12% (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). 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was 74%.

# Summary of findings

• Longer appointments and home visits were available when needed.

• Patients with long term conditions were being recalled to check their health and medicines needs were being met. The practice was establishing a recall system for patients, based on their month of birth from April 2017.

**Families, children and young people**

**Requires improvement**

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• There were systems in place to identify and follow up children living in disadvantaged circumstances and who may be at risk.

• Immunisation rates were high for all standard childhood immunisations.

• The practice offered a range of contraception services and chlamydia screening.

• Appointments were available outside of school hours and the premises were suitable for children and babies.

• We saw evidence of joint working with midwives, health visitors, and social services professionals.

• Staff knew how to recognise signs of abuse in children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**Working age people (including those recently retired and students)**

**Requires improvement**

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

• The practice used the Electronic Prescription Service which meant that patients could collect their medicines directly from the pharmacy without obtaining a paper prescription first.

• Patients were 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.

# Summary of findings

• The practice was proactive in offering online services as well as health promotion and screening that reflects the needs for this age group.

• The practice's uptake for the cervical screening programme was 63% which was below the local average of 72% and the national average of 73%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed current performance was at 74%.

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• The practice had 17 adult patients on the learning disabilities register and all had received a health check in the previous year.

• Longer appointments were offered to patients who needed them which included patients with a learning disability.

• The practice worked with other health care professionals in the case management of vulnerable patients.

• The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

• Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Requires improvement

The practice is rated as requires improvement for safe, effective, responsive and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

• 54% of patients experiencing poor mental health had a comprehensive care plan, which was below the CCG average of 76% and the national average of 78%.

• The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

• The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

# Summary of findings

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|---|---|
| • Staff had a good understanding of how to support patients with mental health needs. They planned to become a dementia friendly practice and to further improve their care of this group of patients. | |

# Summary of findings

## What people who use the service say

The national GP patient survey results were published on 7 July 2016. 321 survey forms were distributed and 103 were returned. This represented a 32% response rate, compared with the national response rate of 38%. The results showed the practice was performing below the CCG average and in line with or below the national averages in relation to access and overall experience of the practice. This is the same data set as used in our June 2016 report.

• 65% of patients found it easy to get through to this practice by phone compared to the CCG average of 75% and the national average of 73%.

• 76% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 79% and the national average of 76%.

• 71% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.

• 63% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards, ten of which were positive about the care received and ease of getting an appointment. Many patients commented positively on the helpfulness of the staff. One patient reported that appointment times tend to overrun.

We spoke with eight patients or their representative during the inspection. All of the patients said they were satisfied with the care they received and thought all staff were approachable, committed and caring. They reported being able to get an appointment easily. We spoke with a representative from one nursing home and one residential home where residents were registered at the practice. The feedback included positive comments about how the practice ensured patients privacy and dignity and how they supported patients and their family during end of life care. We spoke with seven members of the patient participation group who reported that the practice offered excellent services, with a personal touch due to the smaller number of registered patients. Some patients expressed a preference for a consistent GP, whereas other patients felt that continuity of care was good despite the use of locum staff.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure systems and processes are in place to assess, monitor and improve the quality and safety of the service, including for example MHRA alerts which remain relevant, high risk medicines and cervical cytology.

**Action the service SHOULD take to improve**

- Ensure that checks are undertaken and documented to provide assurance of the quality of the work undertaken by locum staff and improve arrangements for clinical supervision.
- Ensure that the patient information leaflet on complaints is easily available to patients and that complaints information on the practice's website is up to date.
- Continue to work on translating information into languages used by patients at the practice.
- Ensure that all staff know how to find practice policies and procedures.

# The Grange

**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, a practice nurse specialist adviser, an inspector and a Pharmacist Specialist.

## 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 private 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 manager. The GP also leads another larger practice based in the city. A number of staff, including the lead GP, practice manager, and lead receptionist 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 Fridays from 9am to 6.30pm. Appointments are available with a GP or an advanced nurse practitioner generally from 9-11.30am and 3-5pm daily. Patients were 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. An inspection at another practice had identified that patient safety was being put at risk. Both practices shared a number of policies and procedures and several members of staff. The inspection on 2 September 2016

focused on the safe and well led domains. We found that areas of unsafe practice identified at the other practice, had ceased at The Grange. However, we found the safety and leadership of systems for managing pathology and X-ray results and dealing with repeat prescriptions were not adequate.

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. 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 further announced comprehensive inspection of The Grange on 28 February 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

## 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 on 28 February 2017. During our visit we:

- Spoke with a range of staff, including GPs, nursing staff, administration and reception staff and practice managers. We spoke with eight patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.
- Reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with a representative from one nursing and one residential home where residents were registered at the practice.

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

• Is it safe?

• 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.

Requires improvement

# Are services safe?

## Our findings

At our previous inspection on 6 June 2016, we rated the practice as inadequate for providing safe services as:

- The arrangements for ensuring that employed staff had appropriate qualifications, skills and experience to fulfil their role were not adequate.
- There was no easy access to an oxygen mask for use with children in an emergency situation and regular checks of all emergency clinical items were not documented.
- Equipment used for measuring blood glucose levels was not maintained to ensure it was suitable for use
- The temperature of the medicine fridges was not adequately monitored to ensure that medicines were stored at safe temperatures and were fit for use
- Procedures were not in place to identify, support and review patients with safeguarding needs.
- Effective systems were not in place for issuing repeat prescriptions particularly for patients receiving high risk medicines.
- There was no system in place to assess environmental risks. The risks of legionella and fire in the building had not been assessed and adequate control measures had not been implemented.

We issued a warning notice in respect of some of these issues and found some improvement when we undertook a follow up inspection of the service on 4 November 2016. A further warning notice was issued following the inspection on 4 November 2016 as

- The practice had not ensured that all patients receiving repeat medicines had been appropriately reviewed to ensure the safe and proper management of medicines.
- Although improvements had been made to the management of environmental risks, the recommended actions to mitigate and reduce the risks had not been completed.

When we undertook a follow up inspection on 28 February 2017, these arrangements had improved, but not sufficiently. The practice is now rated as requires improvement for providing safe services.

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed incident reports and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, controlled drugs were no longer prescribed on repeat prescription.
- The practice had carried out an analysis of the 17 significant events noted on the 2016 to 2017 incident log, in order to identify trends.

We reviewed patient safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts, and saw that a process had been introduced to ensure that these were handled appropriately. However, 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 some years ago. For example four patients were prescribed a high dose simvastatin and amlodipine, (a combination of medicines which puts them at increased risk of side effects); with no record for two patients, to show that the risk had been assessed or discussed with the patient. Following our inspection the practice sent information which showed that they had now reviewed these patients. We reviewed the records of two female patients of child bearing age who were prescribed a medicine (sodium valproate) which should not be used in pregnancy. There was no record to show that the patient had reviewed and advised of the risk or given advice about contraception. We brought these to the attention of the GP who said they would review the patients.

### Overview of safety systems and processes

The practice had some clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were available to all staff. The policies clearly

outlined who to contact for further guidance if staff had concerns about a patient's welfare. Safeguarding information was available in each room for staff to refer to easily. There was a lead GP for safeguarding. There was evidence of discussion regarding safeguarding concerns in meetings. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level three.

- Notices were displayed in the practice which advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The health care assistant was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw the latest audit which had been completed in January 2017. There was evidence that previous action had been taken to address any improvements identified, although no action had yet been undertaken from the latest audit. There were hand washing signs next to all sinks and alcohol hand gel was available for use. The practice used disposable curtains which were changed every six months. The practice had guidance in place for cleaning up body fluids. Body fluid spillage kits were available in the practice. Records were kept of the Hepatitis B immunity status of clinical staff. Clinical waste was stored and disposed of in line with guidance.
- There were a range of options for requesting repeat prescriptions, including online, in person or by phone, and the practice used the Electronic Prescription Service which meant that patients could collect their medicines directly from the pharmacy without obtaining a paper prescription first. Blank prescription forms were securely stored and there were systems in place to monitor their use. Records showed medicine refrigerator temperature checks were carried out to ensure medicines and vaccines requiring refrigeration were stored at appropriate temperatures. A GP bag for locums was kept securely and contained a suitable range of medicines and consumables which were all in date.
- The arrangements for managing medicines at the practice needed to be fully embedded to keep patients safe. The medicines management policy had been updated recently but we found that it was not followed in practice. For example the process 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. The high risk medicines that we reviewed were methotrexate, lithium and warfarin. We checked a sample of patient records and saw that, although there had been a recent improvement and most had current test results recorded, there had been gaps in monitoring over the last few months and prescriptions had been issued without the required checks being made. Following our inspection the practice carried out further checks and confirmed that the tests were up to date.
- The practice carried out audits, with the support of the local CCG medicines management team, to review prescribing, but there was limited evidence to demonstrate that the results had been used to improve prescribing practice. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. A general risk assessment had been undertaken and identified actions completed in order to reduce or eliminate the risks. The practice had an up to date fire risk assessment and identified actions which included for example, emergency light testing had been completed and

documented. There was evidence of a completed fire drill. All the electrical equipment had been checked to ensure the equipment was safe to use. This was next due in January 2018 and the practice had recorded this on their governance overview action log. Clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place such as control of substances hazardous to health, asbestos and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The actions identified from these had been completed or monitoring was in place and documented.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.
- The practice told us that recruitment was a challenge. They had not been successful in recruiting salaried GPs, GP Partners or nurses, although they did have two regular locum GPs and one regular locum advanced nurse practitioner. They told us they were in discussion with staff in relation to joining the team on a permanent basis, but on the day of the inspection the staff had not signed any contracts. We saw that the practice had made significant efforts to recruit new staff; they had advertised in the national and local areas and had been successful in gaining support from NHS recruitment including the making of a video.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or damage to the premises. The plan included contact numbers for key staff and suppliers.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

At our previous inspection on 6 June 2016, we rated the practice as inadequate for providing effective services as

- There was no system to ensure that staff had completed training appropriate to their role including chaperoning, safeguarding adults and children and infection control.
- The recruitment policy did not include checks for all staff (including locum staff) and there was no evidence that induction procedures had been completed.
- Governance arrangements were inadequate as staff were not informed about changes in national guidelines, performance against quality measures such as QOF were not monitored and clinical and other internal service audits were not undertaken or completed to ensure that quality and safety was maintained.

We issued a warning notice in respect of some of these issues and found some improvement when we undertook a follow up inspection of the service on 4 November 2016. A further warning notice was issued following the inspection on 4 November 2016 as

- There was no systematic process to recall patients with long term conditions or those who required health checks. There was no overall written plan to prioritise patients with conditions where the practice had consistently performed below local and national average scores in the quality and outcomes framework.

These arrangements had improved when we undertook a comprehensive inspection on 28 February 2017. The provider is now rated as requires improvement for providing effective services.

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Local deep vein thrombosis guidelines had been discussed at a practice meeting.

The practice reviewed data from the Clinical Commissioning Group on a regular basis to compare themselves with other practices for issues such as the prescribing of antibiotics, referral rates and attendance at the accident and emergency department. As a result of higher than average accident and emergency department attendance, the practice had started coding these and discussed patients at practice meetings.

### 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). The most recent published results (2015/2016) showed the practice scored 73% of the total number of points available. This was 22% below the CCG average and national average. The overall clinical exception reporting rate was 16% which was 5% above the CCG and 6% above the national average (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 exception rate had increased from 2014/2015, when the practice had an overall exception reporting rate that was similar to the CCG and National averages at 9%.

Data from 2015/16 showed:

- Performance for diabetes related indicators was 80% this was 10% below the CCG and national average. The prevalence of diabetes was 7% which was above the CCG average of 6% comparable to the national average. The exception reporting rate was 17%, which was above the CCG (13%) and national (12%) exception reporting rates. The performance for 2014/15 was 71%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 74%.
- Performance for asthma related indicators was 100% which was 3% above the CCG and national average. The prevalence of asthma was 6% which was in line with the CCG average and national average. The exception reporting rate for asthma was 25%, which was above the CCG (8%) and national (7%) exception reporting rates. The performance for 2014/15 was 89%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 100%.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- Performance for hypertension related indicators was 60% which was 38% below the CCG and national average. The prevalence of hypertension in the patient population was 9%, which is lower than the CCG average of 13% and the national average of 14%. The exception reporting rate was 6%, which was higher than the CCG average of 5% and national average of 4%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 87%.
- Performance for heart failure indicators was 35%, which was 63% below the CCG average and 64% below the national average. The prevalence of heart failure was 0.38%, compared with 0.61% for the CCG and 0.75% nationally. The exception reporting rate was 6%, which was higher than the CCG average of 5% and national average of 4%. The performance for 2014/15 was 31%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 34%. However there was a system issue in relation to the data which meant performance was not showing accurately.
- Performance for mental health related indicators was 44%. This was 50% below the CCG and 49% below the national average. The prevalence of mental health was 1% and was comparable to the CGC and national average. The exception reporting rate was 15% which was lower than the CCG average of 13% and national average of 11%. The performance for 2014/15 was 42%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 83%.
- Performance for dementia related indicators was 74% which was 24% below the CCG average and 23% below the national average. The prevalence of dementia was 0.45%, compared with 0.66% for the CCG and 0.75% nationally. The exception reporting rate was 7% which was lower than the CCG average of 14% and national average of 13%. The performance for 2014/15 was 77%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 100%.

Having viewed unverified data for 2016/2017, we have been able to identify improvements had been made by the practice across all clinical indicators. The practice had a QOF monitoring spreadsheet and recall system based on when patients were due QOF reviews. The practice was planning to undertake a recall system based on patients month of birth from April 2017.

Although some clinical audits had been carried out, there was limited evidence that audits were driving improvements in patient outcomes.

- We looked at four single cycle audits, which included epilepsy, confidentiality, telephone answering times and controlled drugs. Three of these had not identified any learning or actions. The audit for controlled drugs identified that patients should be removed from having these on repeat prescription when they were next seen by a clinician. This had been shared at the locum meeting.
- The practice had completed one two cycle audit on inadequate smears. This showed that they had achieved no inadequate smears.
- Following the inspection, the practice informed us that they considered regular QOF reviews as part of their clinical audit processes. Unverified data for 2016/2017 showed improvements in their performance.

### Effective staffing

- The practice had an induction programme for all newly appointed staff including GP and nurse locums. This covered such topics as health and safety, safeguarding, infection control, fire safety, and confidentiality.
- Training deemed mandatory by the practice was available and included for example, moving and handling, safeguarding, infection control, equality and diversity, and fire safety awareness.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources. The practice had audited the performance of staff who undertook cervical smears in order to ensure their technique was appropriate.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to training to meet their learning needs and to cover the scope of their work. We reviewed three staff files and saw that appraisals and a personal development plan were in place for staff as appropriate. A probationary review had been undertaken for a new member of staff.
- The practice is reliant on locum GPs and advance nurse practitioners to provide appointments for patients. The practice did not undertake any medical records audit of the work of the advanced nurse practitioners. We were told that an informal record audit had been completed of the work of the locums but this had not been documented. The practice had recently established a weekly peer review and clinical supervision meeting. The system for clinical supervision for clinical staff needed to be improved.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. All medical correspondence, including pathology results was reviewed by a GP.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. A midwife held a clinic at the practice.

We reviewed the minutes of a number of meetings where the practice worked with other professionals, including health visitors. Multi-disciplinary meetings took place by telephone to discuss, review and plan ongoing care and support patients who were vulnerable. Patients with palliative care needs were reviewed at four to six weekly meetings. The practice also held safeguarding meetings. The practice planned to incorporate these meetings into their recently established weekly 'peer review and clinical supervision' (PRACS) meetings, which would then have a different focus each week.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance, which included The Mental Capacity Act (2005). Mental Capacity Act (2005) training had been undertaken by the majority of staff at the practice. Staff we spoke with in care homes confirmed that the GPs involved family appropriately in care decisions. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. The practice had completed a simple audit to check that consent was being sought and recorded appropriately.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients with drug dependency needs, those receiving end of life care, and carers. Patients were signposted to the relevant service. Patients were supported to attend educational coffee mornings which were held at a nearby practice. The practice had a self-testing blood pressure machine in the waiting area for patients to use.

The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding five years was 72%, which was below the CCG average of 82% and national average of 81%. The exception rate was 5% which is lower than the CCG average of 9% and the national average of 7%. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance was currently at 74%. A failsafe system had been in place to ensure results were received for all samples sent for the cervical screening programme. However this had not been completed since 2 September 2016 and the practice had not been recording this in any other way. Following our inspection the practice sent information which showed that they had now reviewed these patients and had arranged further intervention as appropriate. A new failsafe system was proposed but this needed to be agreed, implemented and embedded.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Patients aged 60-69 screened for bowel cancer in the last 30 months was 53% with a CCG and England average of 58%. Females aged 50-70 screened for breast cancer in the last 36 months was 68% with a CCG average of 75% and an England average of 73%.

Childhood immunisation rates for the vaccinations given to under two year olds were above national averages and ranged from 90% to 98%. This gave the practice a score of 9.5, which compared with a national average score of 9.1.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Immunisation rates for the measles, mumps and rubella vaccination, dose 1 and 2 was 98% and 88% respectively. This was in line or higher than the CCG rate of 93% and 88% and national rate of 94% and 88%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40 to 74, both of which were undertaken by a health care assistant. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

At our previous inspection on 6 June 2016, we rated the practice as requires improvement for providing caring services as data from the national GP patient survey showed patients rated the practice similar to or below national average for several aspects of care. For example patients rated their GP consultations lower than average scores overall and rated contacts with a nurse or receptionist as similar to national average scores. Written information was available in English from the practice although information in key languages used by registered patients was not available. Systems used to identify patients with caring responsibilities were not effective and relevant information about support systems accessible to carers was not easily available.

We found that improvements had been made when we undertook a follow up inspection on 28 February 2017. The practice is rated as good for providing caring services.

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. A notice was displayed which informed patients of this.

Patients told us they were satisfied with the care provided by the practice and staff were helpful, caring and treated them with dignity and respect. Patients' comments from the comments cards aligned with these views.

Results from the national GP patient survey published July 2016 showed the practice was below average for its satisfaction scores on consultations with GPs and nurses. The practice achieved a 32% response rate to the survey compared to a national response rate of 38%. This is the same data set used in our June 2016 report. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CGG) and national average of 89%.
- 77% of patients said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 77% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 95% of patients said they had confidence and trust in the last nurse they saw or spoke to compared to the CCG and national average of 97%.

Feedback from patients in the GP patient survey about other staff was above average scores. For example:

- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The PPG had completed a patient survey in October 2016 which looked at similar areas to the National GP patient survey. For example, in relation to the question 'Clinician putting you at your ease,' 14 patients responded positively and 10 responded less positively. An action plan had been developed and agreed with the practice to improve the positive responses. One action was to continue the training meetings and locum meetings which included discussion around patient complaints.

### Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received showed that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. The views of patients were also positive and aligned with these views.

Results from the national GP patient survey showed results were in line with and below the local and national averages

Good

# Are services caring?

for how patients responded to questions about their involvement in planning and making decisions about their care and treatment by the GP. This is the same data set used in our June 2016 report. For example:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.

In relation to feedback for nurses, this was in line with and above the local and national averages.

- 92% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG and national average of 90%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care, which was the same as the CCG and national average.

The October 2016 PPG patient survey responses for 'Did you fully understand the diagnosis or explanation for our condition' was positively answered by 14 patients and six patients responded less positively. The action plan highlighted that this would be address in the training meetings and locum meetings which included discussion around patient complaints.

The practice provided facilities to help patients to be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- The practice was aware that Pakistani patients formed the biggest cultural group within the practice. Some information had been translated into different languages used by patients at the practice.
- Longer appointments were given to patients who required additional time to communicate clearly.

### Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. This included for example, carer's information and support, dementia, mental health and bereavement support. Information about support groups was also available on the practice website and this included local contact numbers for Cruse (bereavement care) and drug advice services. We saw that some information had been written in key languages used by registered patients. For example information on the 111 service and support for carers.

The practice had a carers' champion who took a lead on identifying and supporting carers within the practice. The practice had identified 56 patients as carers (approximately 2% of the practice list). There was a notice board in the practice which was specifically aimed at identifying carers and providing advice, information and support to them. Written information was available to direct carers to the various avenues of support available to them. There was no specific information available to carers on the website.

Patients were able to access community activities such as coffee mornings, a befriender group, a walking to fitness group and educational sessions, which were held at a nearby GP practice.

Staff told us that if families had suffered bereavement, they sent the family a card. If the family contacted the practice they would signpost them to sources of bereavement support.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

At our previous inspection on 6 June 2016, we rated the practice as requires improvement for providing responsive services as key service information was not available in alternative languages to suit the practice population and information about how to complain was not clearly accessible and the practice website required updating.

These arrangements had slightly improved when we undertook a follow up inspection on 28 February 2017. The practice is still rated as requires improvement for providing responsive services.

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice offered a variety of services to patients in addition to chronic disease management. This included for example chlamydia screening, phlebotomy, travel vaccinations available on the NHS and influenza vaccination clinics. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met people's needs. For example, a midwife held a regular clinic at the practice and educational coffee mornings were open to patients registered at the practice. The practice worked closely with Aspire, a service supporting adults with substance misuse issues. Clinics were held at the practice on a regular basis. Patients could be referred to a counselling service, improving access to psychological therapies.

The practice had 17 adult patients on the learning disabilities register and all had received a health check in the previous year. The practice offered longer appointments for patients who needed this, which included patients with a learning disability.

There were disabled facilities which included parking and an accessible toilet. An electronic check-in screen was available in a range of languages to meet patient needs. Translation services were also available. Photos with the name and role of some of the staff were displayed at the entrance to the practice to help inform patients.

### Access to the service

The practice was open from 9am to 6.30pm on Monday to Friday, with appointments available with a GP or an advanced nurse practitioner generally from 9-11.30am and 3-5pm daily. Patients were 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. Telephone appointments were also available for patients if required. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. A GP triaged all requests for a home visit. Same day appointments were available for children and those patients with medical needs that required same day consultation.

Appointments could be booked in person, by telephone or online. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were available for people that needed them, by telephone consultation or a face to face consultation. Patients could book their appointment online if they had registered to do so. The practice offered online repeat prescription ordering and access to the patient's own medical record.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was slightly lower when compared to local and national averages.

- 67% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 76%.
- 65% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and the national average of 73%.

We received 11 comments cards and patients did not report difficulty in getting an appointment. We spoke with eight patients during our inspection, whose views aligned with this. The practice assured us that all patients who say they have an urgent need to see a GP were assessed and given an appointment the same day if clinically necessary. The practice had a system in place to assess whether a home visit was clinically necessary.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. Its complaints' policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information was displayed in the waiting room and was written in a range of languages used by patients at the practice, to inform them that there was a complaints system. The practice had a patient information leaflet on complaints, although this was not readily available for patients. Information on complaints was on the practice's website, although this was not up to date. Since the inspection the practice have told us that they have taken action to address this concern.

The practice had recorded four complaints, both written and verbal since March 2016. These were logged onto a spreadsheet, with learning identified. We looked at documentation relating to three complaints received in 2016 and found that they had been investigated and responded to in a timely and empathetic manner. Complaints were shared with some staff to encourage learning and development.

# Are services well-led?

Requires improvement

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

## Our findings

At our previous inspection on 6 June 2016, we rated the practice as inadequate for providing well-led services as

- Systems to monitor infection control practice so that identified improvements can be made in a timely manner were not in place.
- Governance arrangements were inadequate as staff were not informed about changes in national guidelines, performance against quality measures such as QOF were not monitored and clinical and other internal service audits were not undertaken or completed to ensure that quality and safety was maintained.
- Governance procedures did not help to identify risks and drive improvement.

We issued a warning notice in respect of these issues and found some improvement when we undertook a follow up inspection of the service on 4 November 2016. A further warning notice was issued following the inspection on 4 November 2016 as

- There was no systematic process to recall patients with long term conditions or those who required health checks. There was no overall written plan to prioritise patients with conditions where the practice had consistently performed below local and national average scores in the quality and outcomes framework.
- The practice had not ensured that all patients receiving repeat medicines had been appropriately reviewed to ensure the safe and proper management of medicines.
- Although improvements had been made to the management of environmental risks, the recommended actions to mitigate and reduce the risks had not been completed.

These arrangements had improved when we undertook a follow up inspection on 28 February 2017. The practice is now rated as requires improvement for being well-led.

### Vision and strategy

The practice had a clear vision in place to 'help our patients to be healthy in mind, body and community (in their relationships with their family, workplace and neighbourhood.)' The practice management team we spoke with shared this vision and told us that they had been involved in working out the strategy to achieve this since the last inspection. The practice staff told us that they were working hard to achieve the improvements.

Practice staff we spoke with were committed to providing a quality service and felt that there had been a greater emphasis on improving the service since the previous inspections in June, September, and November 2016. We recognised that the practice had met some unforeseen and difficult challenges whilst addressing the required improvements identified in our reports from June, September, and November 2016. The practice had made significant improvements to ensure that patients were kept safe but there were further improvements required.

### Governance Arrangements

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Governance systems and processes had improved but the practice needed additional time to review, strengthen, and embed their new process to ensure that the improvements could be sustained over time. For example, a system was in place for responding to MHRA alerts; however this did not include alerts issued some years ago, which remain relevant to patients.
- We saw that practice protocols and policies were in place and had been updated to reflect the change in clinical leads, although not all staff were able to find these on the computer.
- The medicines management policy had recently been updated but was not being followed in practice as they did not have a system in place to recall patients on high risk medicines, as stated in their policy.
- The clinical and management team had regular meetings to manage the performance of the practice in relation to the quality and outcome framework. 2016/17 unverified data provided on the day of inspection, which did not include excepted patients, showed performance had improved across all the QOF clinical indicators.
- The failsafe system for cervical samples had stopped in September 2016; this was noted during the inspection and had not been identified by the practice.
- Clinical audits were used but there was limited evidence that audits were driving improvements in patient outcomes.

# Are services well-led?

Requires improvement

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

- We saw that the practice had implemented systems to ensure that appropriate clinicians saw all test results and dealt with incoming medical correspondence.
- Arrangements for identifying, recording and managing health and safety risks to staff and patients had improved.
- Some of the changes that have been recently implemented can only be assessed once the new methodology has been put into practice, then the appropriateness, workability and sustainability of the new systems and processes can be determined.

### Leadership and culture

There was a leadership structure with a newly formed management team in post, which included GP and practice management support from the Royal College of GPs. There were named members of both clinical and administration staff in lead roles and practice staff we spoke with were clear about their own roles and responsibilities.

The leadership at the practice had responded to the findings of our previous inspections and some improvements had been achieved. They had engaged staff and members of the patient participation group in order to address some of the issues raised. For example, members of the PPG had undertaken work to address some of the health and safety risks which included fixing the drains and moving cabinets.

The practice had engaged locum doctors and advanced nurse practitioners to provide some continuity of care and they were actively seeking permanent GPs and advance nurse practitioners to join the team. Staff told us they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

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

The practice encouraged and valued feedback from patients, the public and staff. They had an effective face to face Patient Participation Group (PPG) with 12 to 15 patients and approximately 40 patients were part of a virtual PPG, who corresponded mainly by email. The PPG had completed a patient survey in October 2016 which looked at similar areas to the National GP patient survey. An action plan had been developed and agreed with the practice and there was evidence of some improvements. For example, the telephone answering system now informed patients they were in a queue, rather than the previous engaged tone. The PPG also reported that the time taken to answer the telephone had reduced.

The practice manager shared with us the plans they had to engage with the wider community. The practice had a programme of events planned which included talks on Powers of Attorney, and Falls Prevention (identified by public health as a concern in the area). This community work had helped patients who may be socially isolated and had in some instances given patients' confidence to undertake voluntary work.

The practice had also gathered feedback from staff through staff meetings, appraisals, and informal discussion. Practice staff told us that they felt able to give feedback, discuss any concerns and make suggestions. They felt there had been positive changes made in the previous months following the introduction of the new management team.

### Continuous improvement

The practice was working with a GP and practice management staff from the Royal College of GPs to order to improve the service that they provided to patients. The practice planned to become a dementia friendly practice and to further improve their care of this group of patients. They told us that they planned to further improve medicines management and had applied for funding to engage a clinical pharmacist and to train staff to become prescribing clerks.

This section is primarily information for the provider

# Enforcement actions

## 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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Good Governance. How you are failing to comply with this regulation:**<br>• Systems and processes must be in place to assess, monitor and improve the quality and safety of the service.<br>• 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.<br>• 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 some years ago. The governance process for reviewing patients who may be affected by historic MHRA alerts was not effective.<br>• There was not an effective failsafe system in place for cervical cytology samples. |