

Care Quality Commission

Inspection Evidence Table

Lakeside Healthcare at Rushden (1-6017886221)

Inspection date: 6 June 2019

Date of data download: 09 June 2019

Overall rating: Inadequate

Safe Rating: Inadequate

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Explanation of any answers and additional evidence: At the inspection on 29 th November 2018 we found that the practice did not hold records to demonstrate that staff vaccinations were maintained in line with current Public Health England (PHE) guidance. At this inspection we found that the practice now had a log of all staff, and most staff, with the exception of three GPs out of 11 clinical staff , had immunisation records within their staff file.	

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	No
There was a documented approach to the management of test results and this was managed in a timely manner.	No

Explanation of any answers and additional evidence:

See medicines management section.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection on 29 November 2018 we found patients in receipt of warfarin who required regular blood testing had their tests done by a third-party healthcare provider, commissioned by the clinical commissioning group. This system did not provide the practice with patients' INR result or the date when their next INR test was due. We acknowledged that this situation was at least in part, as a result of the commissioning arrangements for blood tests between the clinical commissioning group and a third-party provider. The practice was served a warning notice in relation to the Health and Social Care Act 2008 - Regulation 17 – Good Governance. They submitted an action plan to tell the Care Quality Commission how they would become compliant with the regulation.</p> <p>At this inspection we reviewed the action plan and found that the practice had made improvements to the process in which patients on Warfarin received their appropriate monitoring and clinical review prior to the prescribing of medicines. We found they were now compliant in relation to the monitoring and prescribing of Warfarin.</p> <p>At the inspection on 29 November 2018 we also found that 43 patients prescribed ACE inhibitors, a medicine used to treat hypertension and congestive heart failure, had not had the appropriate blood tests in the last 24 months. The practice was served a warning notice in relation to the Health and Social Care Act 2008 - Regulation 17 – Good Governance. They submitted an action plan to tell the Care Quality Commission how they would they become compliant with the regulation.</p> <p>At this inspection we reviewed the action plan and found that the practice had made improvements to the system they had in place for the monitoring process for patients on ACE inhibitors. We found that all the patients who we had previously found to have not had blood monitoring in the last 24 months had been reviewed and received the appropriate blood tests. However, we found at this inspection that this system was still not effective as we found there was 111 patients who were not managed appropriately as they had not received monitoring in the last 12 months.</p> <p>We also checked the system in place for the management of patients on medicines used to treat high blood pressure. We were told by the lead GP that this was the next priority for monitoring and recalls. We found that 315 patients were being prescribed these medicines on the day of the inspection and the system was not effective as there were 13 patients with no monitoring in the last two years.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things

went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded since the inspection on 29 November 2018	21
Number of events that required action:	Unable to ascertain as a number of forms not available.
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection on 29 November 2018 we found that staff were encouraged to raise any areas of concern relating to safety. However, we found that events had not been well documented in the past, nor was there always evidence of them being discussed at staff meetings to encourage and promote learning. More recent events had been better documented and actions taken as a result were clear.</p> <ul style="list-style-type: none"> At this inspection we found that the practice did not have an effective system in place to learn and make improvements when things went wrong. We decided to focus on significant event analyses (SEAs) logged since the last inspection on 29 November 2018. We asked to see five SEAs but the practice manager could not produce the SEA forms or the investigation for any of the five SEAs. We looked at meeting minutes and found the minutes did not reflect the detail of the discussion or learning and actions identified as a result. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection we found the systems for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were actioned appropriately not embedded or effective within the practice. Examples of alerts that had not been actioned included: -</p> <p>A safety alert in regard to an anti-thyroid medicine from February 2019 had not been received into the practice and added to the safety alert log. There were two drug safety updates which related to this medicine. i) can increase the risk of birth defects if taken by pregnant women in the first three months or at high doses. ii). Increased risk of acute pancreatitis. The lead GP did an immediate search to identify patients on this medicine. The search generated 69 patients but it was not clear whether this was an accurate picture or not. All 69 patients' records would need a full review.</p> <p>A safety alert in regard to a specific opioid analgesic from January 2019 was found in practice alert</p>	

folder but on the safety alert log it stated no further action. We asked if a patient search had been carried out to identify any patients at risk. The practice manager was unable to confirm that this had taken place. A search carried out on the day showed that no patients were currently on this opiate medication.

A safety alert in regard to a diuretic medicine from 14 November 2018 was found in the safety alert folder. We asked if any searches had been done for patients on this medication for high blood pressure as there was an accumulative risk of developing certain types of skin cancer. The practice had not carried out a patient search to identify patients on this medicine to enable them to alert the patients of this increased risk.

At the time of our inspection we also found that there was no system in place to review older patient safety alerts to ensure no new patients were affected (for example placed on medication after an alert has been issued or were new to the area).

We looked at meeting minutes in relation to MHRA and patient safety alerts. We found the minutes said they were discussed but no information on the discussion that took place or actions to take forward. Meeting minutes annotated that clinicians were aware and no further action required

Population Groups

People with long-term conditions

Population group rating: Requires Improvement

At the inspection on 29 November 2018 we rated the population group, people with long term conditions, within the effective domain, as requires improvement.

At this inspection we found that patients' health was not always monitored in a timely manner to ensure medicines were being used safely and followed up on appropriately and we have therefore the rating remains as requires improvement.

Findings

- At the inspection in November 2018 we found that patients in this group were not having their healthcare needs met in a manner that ensured as far as practical their treatment was safe. The system in place for medication and long term conditions reviews was not effective. Repeat prescribing in the absence of blood monitoring for patients who were prescribed some high risk medicines was not effective.
- At this inspection we found that the practice had made improvements for patients who had prescriptions for warfarin and regular monitoring was now in place. We also found that improvements had also been made for patients on ACE inhibitors who had not received monitoring in the last 24 months. However, there were 111 patients who had not had monitoring in the last 12 months.
- At this inspection we found the system in place for medicines reviews was not effective.
- At this inspection we found that the practice did not have an effective system in place for the review of patients with long term conditions to ensure all patients were reviewed in a timely manner.

Well-led

Rating: Inadequate

Leadership capacity and capability

There was compassionate, inclusive but not always effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: At the comprehensive inspection in November 2018, we rated the practice as requires improvement for providing well-led services as we found that arrangements to improve the quality and safety of services provided required improvements in oversight and monitoring of governance arrangements. We issued a warning notice in relation to Regulation 17 of the Health and Social Care Act 2008 in relation to the governance arrangements in place for monitoring of patients on high risk medicines such as Warfarin as well as ACE inhibitors. At this inspection we found that the practice had made improvements and had taken the appropriate steps required to ensure patients remained safe. However, at our most recent inspection we found further concerns so we have issued a further warning notice in relation to Regulation 17 of the Health and Social Care Act 2008. This is in relation to the governance arrangements for a further high risk medicine, medication reviews and recalls for patients with long term conditions, significant events, patient safety alerts, monitoring of locum staff, complaints. Since the inspection the practice had sent in an action plan of the improvements that will be put in place following the concerns found at this most recent inspection.	

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

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Culture

The practice had a culture which did not always drive high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	No
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection there was not a system in place to address concerns about locum agency staff. We looked at meeting minutes dated 18 December 2018 and found under significant events that there was a paragraph where concerns were raised in relation to the consultations provided by a locum nurse practitioner during November 2018. Consultation notes were reviewed by a permanent member of staff in the first instance. Concerns were to be shared with the locum nurse practitioner via the agency once a full investigation had taken place. We looked at the significant event log but could not find where a significant event had been raised. We asked to see the SEA form but one was not completed and there was no evidence of investigation having been taken place. We asked the lead GP to review the patient records of those who attended the practice on 5th and 12 November 2018. On the initial review concerns were found on patient consultations. Further work was required to review all the records and complete the significant event investigation.</p>	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2018 we found an induction programme for new staff was in place which included the completion of the Care Certificate for Health Care Assistants employed since April 2015. However, the health care assistant employed at Lakeside Healthcare at Rushden had not completed the course.</p>	

- At this inspection we spoke with the health care assistant and found she had started the Care Certificate on 15 May 2019 and had completed a number of modules. She did not currently have an assessor or allocated hours in which to complete the course.

At the inspection in November 2018 we found that the practice only had 72 patients identified as carers which was 0.6% of the patient list.

- At this inspection we were told that the practice had made improvements to the way they identified carers. They had improved the carers register and now had 128 carers registered which was 1.15% of the practice population. Carers pop-up clinics were now held in the practice where patients' carers and relatives could attend and meet with practice staff for support and signposting to other organisations.

At the inspection in November 2018 we found that the practice did not hold additional GP extended hours during weekdays.

- At this inspection we found that the practice could now offer extended access for evening and weekend appointments via the East Northants Hub. Appointments were booked via the practice. The extended hours access appointments were provided by GPs, Practice Nurses, Paediatric Nurses and other clinicians both inside and outside of core General Practice opening hours in East Northants. Opening times were: 6.30pm to 8pm Monday to Friday. 8am to 12 midday on Saturdays and 8am to 12 midday on Bank Holidays. All appointments were carried out at Harborough Field Surgery, 160 Newton Road, Rushden. NN10 0GP

At the inspection in November 2018 we found that staff were encouraged to raise any areas of concern relating to safety. However, we found that significant events had not been well documented in the past, nor was there always evidence of them being discussed at staff meetings to encourage and promote learning. More recent events had been better documented and actions taken as a result were clear.

- At this inspection we found that the practice still did not have an effective system in place to learn and make improvements when things went wrong. We looked at meeting minutes and found the minutes did not reflect the detail of the discussion or learning and actions identified as a result.

At the inspection in November 2018 we found that the practice did not have an effective complaints system in place as they had 40 complaints recorded since January 2018 but only had one example available for us to view to assess how it had been dealt with.

- At this inspection we looked at the complaints log. We saw that the practice had received 12 complaints since the last inspection. We looked at four complaints in detail and the practice's responses. The complaints policy was to acknowledge complaints within three days but we saw no evidence of this. We looked at the responses and found that not all the concerns raised had been responded to. We looked at meeting minutes and found it said complaints were discussed but there was no information on the discussion that took place, or the learning or actions to take forward. There was a poster in the reception/waiting area advising patients to speak to reception if they wanted to make a complaint. There were no complaints forms available in the reception area.

We also found:-

Systems for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were actioned appropriately were not embedded or effective within the practice. We also found that there was no system in place for ongoing reviews of patient's subject to patient safety alerts. We found you were not reviewing old searches and did not have a system to carry out searches to see if any new patients were affected (for example placed on medication after an alert has been issued). We looked at meeting minutes in relation to MHRA and patient safety alerts. We found the minutes said they were discussed but no information on the discussion that took place or actions to take forward. Meeting minutes annotated that clinicians were aware and no further action required.

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	No
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial*
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<p>At the inspection in November 2018 we found there was little oversight of the high exception reporting in QOF clinical indicators. Senior staff appeared to be unaware of the issue and could offer no explanation other than they may be due to IT changes part way through the year, although this could not be evidenced.</p> <p>At this inspection we found that the practice did not have an effective system in place for the review of patients with long term conditions to ensure all patients were reviewed in a timely manner. Since the inspection the practice recognised that further work was required but they had reviewed the exception reporting data and told us that overall exception reporting had reduced from 19% in 2018 to 15% in 2019.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
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Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	yes
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2018 prescribers of high risk medicines were not always in possession of accurate and reliable information about patients that enabled them to make safe, considered judgements.</p> <ul style="list-style-type: none"> • At this inspection we found the system in place for medicines reviews was not effective. We found there was not a clear system in place to ensure all patients who received medicines were reviewed in a timely manner and received regular monitoring in accordance with national guidance. • We looked at the QOF data for 2018/19 which was unverified. The practice had total points 544.6 out of 545. We were unable to look at exception reporting as this data was unavailable so we were not able to ensure that the information the practice used was accurate, valid, reliable and timely in relation to long term conditions such as diabetes, mental health, cardiovascular disease, and chronic obstructive airways disease. All had significantly higher rates of exception reporting in comparison to local and national averages. Since the inspection the practice had reviewed the exception reporting data and told us that overall exception reporting had reduced from 19% in 2018 to 15% in 2019. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.