

# Driving improvement

Case studies from 10 GP practices



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## Our purpose

**The Care Quality Commission is the independent regulator of health and adult social care in England.**

We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

## Our values

**Excellence** – being a high-performing organisation

**Caring** – treating everyone with dignity and respect

**Integrity** – doing the right thing

**Teamwork** – learning from each other to be the best we can



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# Foreword



Professor Steve Field  
Chief Inspector of  
General Practice

Engaging with general practices during inspections gives us valuable insight into their experiences. Feedback shows that although our inspection reports highlight the areas of concern and risk that need to improve, practices want to know more about how to actually improve from a rating of requires improvement or inadequate.

Each GP practice and its patient list is unique, so there is no 'one size fits all' way to improve. But, by talking to those practices that have made significant improvements, we can share their experiences so that others can recognise familiar problems and learn what others did to overcome them.

The overwhelming majority of general practices in England are providing good or outstanding care for their patients, despite the widening gap between the demand from a growing and ageing population with more complex medical needs and the capacity of general practice to meet those needs, which CQC has previously reported on.

The pressure on general practice is a nationwide issue, so what is it that drives improvement for some and not for others?

To help shine some light on this, we have put this collection of case studies together as a source of information to help general practices improve the quality of care they provide for their patients. These examples represent only a handful of practices that have successfully improved their quality – and therefore their rating – but we know there are many more working tirelessly to improve. We have seen hundreds of practices throughout the country working passionately to improve the quality of their care – not just for their patients but for their local communities.

The case studies show that a good or outstanding GP practice needs to work as a team – including its clinical, administrative and managerial staff – with a shared vision, values and commitment to improving. This also means working as a multidisciplinary model, recognising the value of nursing teams in taking some of the clinical workload off GPs.

But they can't do it on their own – they should not hesitate in asking for support locally or nationally, as well as from other practices that are good or outstanding. We know that professional isolation is a common root cause for a practice receiving a poor rating. By tapping into networks available to them, practices are able to learn from others and share their own experiences.

We know that good leadership is critical to improvement and moving forward: GPs provide the clinical leadership, but the practice manager is a key player in enabling them to focus and ensure the effective running of the practice. All the experiences in the case studies support this.

One of the first steps for improving from a poor rating is accepting when change is needed. We know that being placed in special measures can be distressing for individuals, but the experience of practices shows that once they step back and look at the findings of the inspection report 'from the outside', they can see that things needed to change.

I would like to thank the staff at the practices and other organisations that gave their time to talk to us to help to encourage others to improve. The most striking common factor in all cases was the incredible amount of hard work to drive improvement, and we are grateful for their insight and enthusiasm.

**Professor Steve Field CBE FRCP FFPH FRCGP**  
**Chief Inspector of General Practice**

**“We know that professional isolation is a common root cause for a practice receiving a poor rating. By tapping into networks available to them, practices are able to learn from others and share their own experiences.”**

**Professor Steve Field**



# The practices that we interviewed

“Maybe I had focused too much on front line and left holes in the overall management of practice. It’s all very well doing clever stuff, but you have to get the basics right as well.”

Dr Julian Brown,  
Litcham Health Centre

We selected 10 practices throughout the country that had each made significant improvements from their initial inspection to their most recent, and whose overall rating had improved.

Nine practices were originally rated as inadequate and placed into special measures; all these improved to an overall rating of good on their last inspection. One practice improved from a rating of requires improvement to outstanding.

## Changes to overall ratings

Practice	From	To
Peartree Surgery, Welwyn Garden City, Hertfordshire	Inadequate	Good
Orchard Surgery, St Ives, Cambridgeshire	Inadequate	Good
Metro Interchange Surgery, Gateshead, Tyne and Wear	Inadequate	Good
Litcham Health Centre, Kings Lynn, Norfolk	Requires improvement	Outstanding
St Mary’s Surgery, Walsall, West Midlands	Inadequate	Good
OHP Falcon Medical Centre, Sutton Coldfield, West Midlands	Inadequate	Good
Dr Krishnan (Kent Elms Health Centre), Leigh-on-Sea, Essex	Inadequate	Good
RAF Scampton Medical Centre, Lincoln	Inadequate	Good
Conway PMS, Plumstead, London,	Inadequate	Good
Victoria Park Medical Centre, Bridgwater, Somerset	Inadequate	Good

The case studies include one practice that serves military personnel. CQC carries out independent inspections of Defence Medical Services under invitation from the Surgeon General. Although there is no statutory requirement for these services to be registered with CQC, the inspections are used to report on the current standards of care and to drive improvements. Although not a typical practice, it shared common issues with others.

We interviewed a range of people at each practice, including GPs, practice managers, practice nurses, receptionists, administrative staff, patients and external stakeholders such as local medical committees and clinical commissioning groups.

In the conversations at each practice, we asked similar questions of different people to get a picture of their experiences, including:

- What was your reaction to the initial inspection report and rating?
- How did you view the practice before this rating?
- How did you approach improvement?
- [For more junior staff] How were you involved in the steps taken to bring about improvement?
- What support did you receive?
- What were the obstacles to improvement? How did you overcome them?
- Did the inspection report help you improve?
- How did you involve staff/public and patient representative groups?
- Did CQC help you to improve in any other way?
- Is there anything more that CQC could have done to help you to improve?
- What improvements have you made?
- Looking back on the improvement journey, is there anything you would do differently?
- What are you doing to ensure improvements are sustainable?
- What's next on your improvement journey?





## Key themes

**“If something was to happen, we didn’t have a safety net...what I took away was that we needed to be doing all the stuff behind the scenes a lot better.”**

**Dr Panagamuwa,  
St Mary’s Surgery**

Along the journey of improvement, all the practices that we interviewed faced similar challenges and shared some common experiences.

### Reaction to the report

All the featured practices expressed shock or disappointment, or both, on receiving a critical report and low rating. Commonly, this was because they believed that the care they had been providing to their patients was good, and patients seemed satisfied.

But that initial reaction was soon replaced with an understanding that the practice did indeed have serious problems, often based on a lack of clear policies and procedures that should mitigate risks to patients. As the practice manager at Peartree Surgery put it: “When patients think about general practice they think about the clinical care, the doctors and nurses, but the operational structure and business foundation underneath has to be set up to allow that to thrive and work well.”

At Litcham Health Centre, Dr Julian Brown noted that “we were pretty good on outcomes for patients, but the report did highlight flaws in our processes and identified some failings, so we did a deep dive...and realised we needed to strengthen our management”.

In the same way, Dr Panagamuwa at St Mary’s Surgery had also thought the practice was running reasonably well until he saw important areas for improvement highlighted by the report, such as the lack of emergency drugs. “If something was to happen, we didn’t have a safety net...what I took away was that we needed to be doing all the stuff behind the scenes a lot better.”

For most, the report became the basis of an action plan for improvement.

## Providing assurance

After digesting their inspection reports, practices recognised the need to put robust policies and processes in place so that they could assure themselves that risks to patients were mitigated. In some cases, practices may already have had policies in place, so their priority was to ensure that these were implemented properly, which meant that staff knew about them, understood them and followed them.

At Litcham, the joint Practice Managers, Tony Bailey and Marta Haskiewicz, spent a great deal of time updating policies and procedures. Now that these are in place, they have established systems to make sure they are reviewed. They also met with everyone at the practice to introduce the policies.

For Stacey Wyatt at St Mary's Surgery, having the right policies in place allows her to be more strategic. "With our processes improved, I have more ability to look ahead."

As well as reducing risks, improved systems also enable practices to provide a better service for people using the surgery. For example, the new way of handling annual reviews for people with chronic diseases at Metro Interchange Surgery ensures that people are called in for appointments.

Across the practices we spoke to, there were other areas where implementing the right policies helped to improve services for patients. For example, ensuring that significant events were recorded properly and learned from; handling complaints properly; following up blood test results effectively; handling alerts and notifications better, leading to quicker patient reviews; and reviewing patients' medicines appropriately.

## Leadership

In a number of the case studies, we can see how hard-working GPs – sometimes in surgeries affected by vacancies – have not been able to find time to effectively manage the practice on top of their clinical responsibilities. Couple this with the absence of a practice manager, or a practice manager who doesn't have the appropriate skills or experience to lead the practice team, and failure beckons.

What these inspiring stories of improvement show is that a good practice manager working in tandem with a senior GP can deliver change.

At Victoria Park Medical Centre, Dr Catherine Lewis had been left as the only GP following the departure of two partners. "I had to put a lot of faith in assurances I had been given that everything was as it should be. Because of the clinical demands of the job, I couldn't verify that everything was correct". After the report, help arrived from the local medical committee in the form of an experienced practice manager. Litcham Health Centre brought in two new practice managers to drive the improvement process.

Jenny Walsh, who provided support from the Royal College of General Practitioners (RCGP) to Dr Krishnan's Surgery said "the majority of the issues that needed to be addressed were down to management and leadership inexperience".

## Staffing and training

Many of CQC's reports highlighted problems relating to staffing. These covered a range of issues including shortage of staff, people not being clear about their roles, training not being taken up or delivered, staff not having appraisals and poor recruitment procedures, which included lack of DBS checks.

**"We knew things were not where we wanted them to be. But we felt like we were doing a good job under the circumstances and doing the best for our patients."**

**Dr Tom Gillham,  
Peartree Surgery**

**“It all boils down to teamwork, structure and clear responsibilities. We all support each other – we are one big team.”**

Tricia Hart  
Dr Krishnan’s Surgery

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**“CQC lit a fire under us. I want to continually improve.”**

Dr Panagamuwa,  
St Mary’s Surgery

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The practice managers at Litcham Health Centre developed a list of mandatory training and created a matrix to show what training staff needed to do and to map progress.

Stacey Wyatt, Practice Manager at St Mary’s Surgery reported that the training she had for her role in HR helped her: “I see things differently now and am better equipped to manage the organisation.”

Offering more training opportunities also brings clear benefits to patients. At Conway Surgery, training in dementia awareness for staff resulted in improved diagnosis rates.

The services at a number of the practices we spoke to had been adversely affected by staff shortages, with existing staff struggling to fill gaps. Inspection reports highlighted the importance of filling vacancies, which Metro Interchange Surgery addressed by employing two additional members of staff, working as apprentices.

Engaging staff in decisions that affect the practice is also important. As Chief Receptionist at St Mary’s says, “Management and GPs are open to our suggestions. If they think something is a good idea, they’ll run with it. Staff do feel more engaged.”

## **Teamwork and communications**

Better teamwork leads to better care for patients. Lack of clarity about roles and lack of information about what different teams in the practice are doing were issues that were noted in early inspections of our featured practices, and putting this right was a priority.

More regular practice and clinical meetings, where minutes are recorded, are features of a number of the improvement stories.

At Orchard Surgery, we heard how interaction between GPs and nurses is better. Practice Nurse Gail Rogers told us, “I now know what’s going on; I know who is on the ‘at risk’ register and needs looking out for.”

Tricia Hart at Dr Krishnan’s Surgery introduced protocols to connect all staff and make more use of task management software. As well as regular meetings for different groups of staff there are monthly practice meetings for all staff. “It all boils down to teamwork”, says Tricia, “teamwork and structure and clear responsibilities. We all support each other – we are one big team.”

At RAF Scampton, everyone is involved in regular meetings, whatever their rank.

St Mary’s Practice Manager Stacey Wyatt says, “Everyone in the practice is part of the team – we involve everyone.”

## **Involving patients and the local community**

A number of our practices have reaped the benefits of working more closely with patients and the wider community. For example, patient groups at Peartree were helpful in redesigning aspects of the service. Patients also carried out a survey and, said Practice Manager James Brookman, “asked us difficult questions, which we were obliged to answer.”

Acting on feedback from its own survey of patients, St Mary’s introduced early morning and evening appointments, and Dr Krishnan’s Surgery held a Patient Survey week in conjunction with the Patient Participation Group to encourage feedback and suggestions for improvement.

At Conway Medical Centre, Dr Perera sees the practice making much more use of the patient voice in how the practice is run in future, working more closely

with the Patient Participation Group and involving them in decisions from a patient's perspective.

## Support

Almost all the featured practices received some form of external support to help them make the necessary improvements. This proved invaluable, particularly for smaller practices where staff were already stretched. For some practices the support came from the RCGP; one had support from NHS England's Vulnerable Practice Scheme and others employed external consultants. Local stakeholders such as the clinical commissioning group (CCG) and the local medical committee also helped some practices.

Tricia Hart, Practice Manager at Dr Krishnan's Surgery says, "The RCGP gave very good support and advice – they look for where they think you have gaps, the CCG helped us with infection control and Public Health England also offered advice."

St Mary's engaged an external consultant, with Dr Panagamuwa noting that the 'initial hump' to get over is a lot of work and having guidance from an external consultant was invaluable: "I don't think we would have been able to do that ourselves."

A key message is that it is hard for smaller practices to deliver and sustain improvement. A number of our practices spoke about the way forward being to work in partnership with or merge with larger practices. Some of the improvements for patients of OHP Falcon Medical Centre have been made possible by the fact that Ley Hill, who took over the practice, is part of a group of six merged practices and so can offer a wider range of services.

## Moving forward

There is a common sense of pride in achieving an improved rating, with an ambition and determination to improve further. At St Mary's Surgery, Dr Panagamuwa says that, "CQC lit a fire under us. I want to continually improve". Even with a rating of outstanding, practice manager Tony Bailey points out, "You are never finished. We now have a structure and know where we are going... although our staffing is fairly stable, we need to start planning for retirements."

## Support for practices from the Royal College of General Practitioners

The RCGP ran the Peer Support Programme for Practices in Special Measures from 2014 to 2017. To date, of the 138 practices that took part, 80% have been successfully supported to exit special measures. Support is through a multidisciplinary team of advisers acting as 'critical friends' and providing practical and emotional support during the challenging journey out of special measures. The advisers aim to stabilise practices as quickly as possible, work with them to establish and address the root causes of their difficulties, and embed long-term change. The common themes that need addressing include issues with clinical leadership, practice management and professional isolation.

The RCGP now offers a Practice Support Service to support any practice that feels it is struggling with the current pressures facing general practice. The aim is to provide diagnostic assessments and targeted support to practices before they get into serious difficulty. Further information can be obtained from [practicesupport@rcgp.org.uk](mailto:practicesupport@rcgp.org.uk). Practices that now find themselves in special measures can also obtain advice and support from this service.



# Peartree Surgery

Welwyn Garden City, Hertfordshire

July 2017

Rated as good

October 2016

Rated as inadequate

The Peartree Surgery is part of the Peartree Group Practice, which has two other sites in Welwyn Garden City and serves around 21,000 patients.

It serves an area that has been ranked as having quite a high level of deprivation from the recent tables of the most deprived areas in Hertfordshire.

CQC first inspected Peartree Surgery in October 2016. The practice was rated as inadequate overall and placed into special measures for six months. The inspection report noted a need to implement formal governance arrangements and systems to assess and monitor risks and the quality of the service, including processes for safe prescribing of medicines and managing clinical records.

Following an inspection to make sure that the practice had met the requirements, a further comprehensive re-inspection in July 2017 found significant improvements, including an open and transparent approach to patient safety and clearly embedded systems to minimise risks, particularly for patients prescribed high-risk drugs. As a result, the practice was rated overall as good.

## Reaction to the initial rating

Dr Tom Gillham is a Partner at Peartree Surgery: “We knew we were stretched and something was likely to give.”

At the time of the initial inspection, some key members of staff were absent from the team: two senior partners had retired, one GP was on maternity leave and another senior partner was on long-term sick leave.

At first there was disbelief and denial among practice staff to the findings of the report. “We were shocked about the rating, so our immediate reaction was to challenge the decision; however we soon realised that our energies should go into making improvements” says Tom.

“After a short period of consideration everyone agreed that it was actually a fair reflection and there were major issues that resulted in the inadequate rating, which were accurate.

“We knew things were not where we wanted them to be. But we felt like we were doing a good job under the circumstances and doing the best for our patients.”

Senior Partner, Dr Alastair McGhee, believes they were delivering “adequate and safe care, if not the five star service” they would have liked to.

Staff had not previously identified the elements that contributed to the initial rating of inadequate as areas for concern. Tom Gillham says that “GPs were flat out doing clinical work” and that the practice manager appeared to have everything else in hand. “We didn’t think we were the sort of CQC problem practice, but clearly we were. Basically, the things that most practices are aware of, we weren’t.”

He explains, “The manager hadn’t been really up to the task, or didn’t understand the magnitude of what was happening. We weren’t even aware that we didn’t have an audit on high-risk drugs until after the report.”

Once the findings had landed, a period of reflection enabled staff to see that there was a lack of clear leadership. They decided to recruit an external consultant to assess the report and help to make improvements.

Senior Partner Dr Alastair McGhee was the registered manager at the initial inspection. “Often you can be wrapped up in the moment. We’re a big practice, it’s a busy place, it’s never quiet here.

“As a training practice we’ve always considered ourselves to be absolutely OK. I was hoping that we would be alright on inspection day. It’s not to say that we weren’t doing it, or weren’t doing it properly or cutting corners, but we were not able to produce the evidence of this on the day.”

He says, “It was an enormously difficult day when we heard the outcome. We were not expecting special measures. I’m not questioning CQC’s judgement in any way or the validity of the decision making, but it was a shock. If you can’t produce the evidence it is reasonable that they want to draw attention to that.”

## Approach to improvement

According to Tom Gillham, “High-risk drug monitoring was a problem area. We were in the local paper and contacted them to give them a measured response and to lessen the impact of losing patients. The article stated ‘Peartree is not safe’, and that was my main concern from a clinical perspective – that we hadn’t robust enough checks in place for medications.”

James Brookman, now permanent Managing Partner, was brought in initially as a consultant as he had previously managed a practice of a similar size, which had a positive outcome from its CQC inspection. James says, “The first area to tackle was audit and protocol.”

James was particularly interested in the need to make organisational change. “When patients think about general practice they think about the clinical care, the doctors and nurses, but the operational structure and business foundation underneath has to be set up to allow that to thrive and work well.”

The practice held consultancy meetings with the theme of ‘everyone really needs to knuckle down and embrace significant change’. As James puts it, “This isn’t tactical change, this is whole business change. You can’t place plasters over these holes. Your whole mindset needs to change.”

**“When patients think about general practice they think about the clinical care, the doctors and nurses, but the operational structure and business foundation underneath has to be set up to allow that to thrive and work well.”**

James Brookman,  
Managing Partner



The practice created new lead roles and formed a 'CQC task force' comprising three skilled members of staff to work with James to tackle the problems uncovered in the report and improve. These were GP Partner Carrie Keen, Deputy Manager Amy Elliot, and Head Nurse, Sandra Craig.

With CQC scheduled to re-inspect in July, and James only starting in April, there was not much time. "Many would think that amount of work in four months was insurmountable. But everyone worked so hard it was incredible, evenings, weekends – it was a real team effort", says James.

## Leadership and accountability

Key to turning the practice around was identifying the need for clear and effective leadership and outside help from a consultant. Managing Partner James says, "The Practice needed someone telling GPs 'if you do Y it will achieve X'. But you need someone doing that as GPs don't typically have the time. Someone has to be orchestrating that and digging deep into what needs to be in place."

Senior Partner Dr Alastair McGhee says of James, "Someone has to give direction. James gave us a strategy; we were really patient-centred but at the end of the day to be safe, effective and responsive we also had to have a strategy of careful policies and procedures, which have to be adhered to.

"We've had the benefit of James and his leadership, and he has steered us with an appropriate firm rein. Having had the second report, we were delighted because it was what we have always aspired to."

## Embedding a different culture

"We have complete foundation change: audits and protocols are in place, there is a whole new appointment system, and a new way of managing people, recruiting and training. Staff structure, development and appraisal is all in place for the long term", says James.

Although the new policies and procedures did increase workload temporarily, they are now more manageable.

Patients are seen quickly and the burden on GPs is now manageable in a way it wasn't before. Initiatives such as a patient triage system and robust HR procedures, appraisals and staff development opportunities have helped to achieve this.

Head Nurse, Sandra Craig, worked extra days initially to review clinical guidance and procedures and make sure policies were up to date and evidence-based. Policy documents are now complete and James and Sandra are embedding a culture of using them effectively, reviewing and updating when appropriate, and for this to become second nature for all staff.

Sandra says she is "instilling good habits and challenging old ones."

Alastair McGhee, says "We now have pop-ups in terms of [prescribing] high-risk drugs, which remind us where we need to do something before going ahead to the next step."

James has helped to lay 'solid foundations', ensuring that they continuously review the working practices and making sure that this culture trickles down to all staff.

Patient groups were also helpful in redesigning aspects of the service. They carried out a survey about accessibility and customer service levels. James says, "That information was used to change how we work. They asked us difficult questions, which we were obliged to answer."

## Views on CQC and external help

Dr Tom Gillham says, “The CCG said publicly that it would be involved in assisting failing surgeries; the help never materialised.”

He continues, “CQC were supportive; they gave us advice and told us the things we needed to address, such as issues covered in Nigel Sparrow’s top tips etc.”

He adds, “The same team came back again and we really appreciated that. They sensed we would turn it around and wanted to share in our success.”

Speaking about the inspection team, James Brookman says, “They were available to speak with to offer help and clarification on failure points, so we could make sure we were tackling the right areas and prioritising change. The inspection manager wasn’t ambiguous at any time.”

CQC’s inspection report was a catalyst for change. Without it, Peartree Surgery may have declined further and there was a real fear that the practice would close. The inspection team gave Peartree an understanding of where and why they had failed on certain criteria.

“Actually we were given direction on where we had gone wrong, what evidence we needed to produce and we worked tirelessly to make the improvements and make them robust,” says Alastair McGhee.

## Sustaining and developing

CQC’s inspection was the beginning of huge changes to the way Peartree now operates and has left a ‘legacy’. “This improvement is only the start,” says James Brookman, “we want to build on this, build something special and become outstanding.” But he continues, “CQC doesn’t appear to make it clear what it takes to achieve outstanding. However, I am confident we will always be good – we know what it takes to achieve this and maintain it. Although we aren’t clear on what outstanding might look like to a CQC inspector, we aspire to achieve outstanding service for our patients and to create projects with the wider community.”

**“This improvement is only the start. We want to build on this, build something special and become outstanding.”**

**James Brookman,  
Managing Partner**

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# Orchard Surgery

St Ives, Cambridgeshire

July 2017

Rated as good

November 2016

Rated as inadequate

Orchard Surgery serves around 4,200 patients in the small town of St Ives, Cambridgeshire. The team comprises three GPs, three practice nurses and two dispensary staff, supported by eight administrative staff.

CQC first inspected Orchard Surgery in November 2016, which resulted in a rating of inadequate overall and the practice being put into special measures for six months. The inspection report noted a need to improve systems to record significant events and complaints and to carry out sufficient risk assessments for fire and infection control and prevention.

The practice was inspected again to make sure that it had made the required improvements, and this was then followed by a comprehensive inspection in July 2017, which noted that there was effective leadership capacity to deliver all improvements, including the systems to assess, monitor and mitigate risks to patients. The significant improvement resulted in the practice being rated as good overall and good for all five key questions and population groups.

## Reaction to the initial rating

Two of the GP Partners, Dr Renate Marsh and Dr Germaine Tong, were shocked by the rating. "I was out of the country when the first report was published and was scared we were going to be closed down," says Dr Tong, but Dr Marsh recognised the findings in the report, "Some things at the practice were slightly archaic; there was some resistance to change."

From a patient point of view, the rating also came as a surprise. Gary Clarke a patient and PPG member had no reason to doubt the quality of care at the practice, "I assumed that the rating must have been due to administrative issues that weren't obvious to patients."

But it was no surprise to Gail Rogers, who was a Practice Nurse at the time, as she felt there was little collaboration between members of the team, and individuals worked in their own way. For example, she realised that the practice needed an infection control nurse, and when she was given this responsibility she had to identify and arrange her own training. She also explains that there were very few policies and protocols in place.

Preparing for the inspection made the practice aware of gaps and they did make some improvements beforehand, so it was then demoralising to get the rating.

## Approach to improvement

Dr Tong's first step was to talk to the CQC inspector. She hadn't realised that they could discuss the findings in the report with CQC, and found her very supportive. The report set out what the practice had to do to firstly meet the regulations, and then to improve further. "When I read the report and spoke to the inspector, my feeling was 'this is do-able'."

The practice formed a small team of two GPs, two admin staff, two nurses and the practice manager, led by Dr Tong. They looked at all the issues that needed attention, came up with ideas and pushed through improvements. Their priority was to meet the two regulations that had been breached – this had to be done within three months. There was then another three months before the practice was re-inspected to see what other progress had been made.

## Teamwork and communication

Effective teamwork enabled good communication and people worked together. Everyone involved in the improvements comments how the team was supportive – their ideas and opinions were valued and considered. The improvement team showed huge commitment and worked very hard, and was large enough to push through changes.

"The culture has changed and communication is much better", says Practice Dispenser Alison Kitchen-Jarvis. "New staff have joined, bringing different ideas. The practice is now open to ideas and decision-making is very transparent. Teamwork is key to improvement. Management is motivated to improve and they want to hear from us."

The two GPs supported the group and their leadership was appreciated. Dr Tong notes a change in the whole culture, "Improved communication and wider involvement of the whole team has benefitted patients – they are getting better care."

The practice also engages more positively with patients and has set up a patient participation group (PPG). PPG member, Gary Clarke says "It seems promising, with 15 or so people at the first meeting, and is chaired by a GP."

## Improvements

Many improvements at Orchard Surgery are immediately obvious to patients: there is more information on the website, including online forms; more engagement with the new PPG; and notices in the waiting room are clearer and up-to-date. There are also new clinics, for example for asthma, and nurses triage patients more often.

Behind the scenes, safety and risks are managed appropriately, including upgraded storage for medicines and implementing fire safety measures. The practice has also embedded effective management practices: minutes are taken of all meetings and record-keeping is thorough so there is evidence to support patient care and promote learning.



**"The culture has changed and communication is much better. Management is motivated to improve and they want to hear from us."**

Alison Kitchen-Jarvis,  
Practice Dispenser

**“I now know what’s going on; I know who is on the ‘at risk’ register and needs looking out for.”**

**Gail Rogers,  
Practice Nurse**

For staff, the improvements include developing consistent training and starting appraisals, with development goals. The staff feel more aware of the direction the surgery is heading.

The practice manager left three months after the first report, so an acting practice manager was appointed. Then, in November, new manager Rachel Lovelidge started, and is encouraging collaborative working and embedding the improvements. She is, in turn, supported by other local practice managers. “We are in a much better place now. There have been lots of improvements and staff have noticed the difference. Before things were not documented so there was a lack of evidence.”

Reception procedures had previously been inconsistent and handovers between staff were not always effective. Now, with proper procedures, they are working consistently to the right standard. Receptionist, Joanne Waller, is relatively new, having joined after the first inspection. “People were still a bit panicky and down-hearted when I came. But, she adds, “they gave me excellent training and it’s much clearer what we all have to do.” For example, the GP to GP registration system is now online and much more efficient and receptionists have clearer guidance to help distinguish between urgent and non-urgent appointments. They now feel able to make suggestions to improve the practice, such as managing appointments for flu jabs.

Dr Tong comments, “The practice is now more integrated and we’re making better use of the different roles.”

Interaction between GPs and nurses is better. Practice Nurse Gail says, “I now know what’s going on; I know who is on the ‘at risk’ register and needs looking out for.” She has been able to take action to help protect these patients.

Patients have noticed a difference. Gary Clarke feels the practice is far more engaging. “When I had a test result letter I was called in, had the text clearly explained and discussed next steps. I think before I would have just been sent the letter.”

## **Support**

Orchard Surgery used the RCGP package of support for practices in special measures and found this very helpful. Dr Marsh comments, “Before they arrived we thought that we’d done most of the work, but they helped us do so much more. They had templates to follow, checked progress, and had action lists. They gave very concise, precise guidance.” Dr Tong adds, “The RCGP were very helpful and responsive to our queries. They jollied us along and brought to light what we didn’t know.”

The practice was also well-supported by the local medical committee (LMC) and clinical commissioning group (CCG). The new PPG was also involved and made good suggestions.

The CQC report gave a good starting point for improvement by identifying issues clearly and helping to focus their thoughts. “Even after the first inspection there was a positive message and the inspector was very supportive throughout the improvement process.” says practice nurse Gail.

Practice Dispenser Alison used advice and support from the **Dispensing Doctors Association**, as she feels their information and training is “the best way of keeping up-to-date with good practice.”

## Obstacles to improvement

Although there was a great deal of enthusiasm and commitment for change, people acknowledged it was stressful and there are still some issues. Not everyone was keen to change and the challenge now is to keep the impetus to improve.

The six-month timescale for improvement was very tight. “We felt vulnerable while in special measures”, says Dr Marsh, “it would have been good if RCGP had got involved sooner, as it took a while to get the support organised and funding agreed.”

Practice Nurse Gail thinks more guidance from CQC beforehand would have helped to prepare for inspection and show what good care looks like. Practice Manager Rachel also feels there could be protocols and models for others to follow. “Lots of practices must be trying to work the same things out and repeating mistakes.”

Receptionist Joanne thinks that more manpower would have helped, as “GPs were pulled off clinical work to manage improvement work.”

## Reflections

Some members of staff felt that being rated as inadequate was a blessing as they needed structures to support good quality care. “It was an emotional and intense experience, yet wonderful when you feel you’ve made an improvement... with hindsight, I wished we’d started earlier; at the time of the inspection we had identified some training but hadn’t started it,” says Gail.

The commitment from staff to improve bonded the team and gave a huge amount of job satisfaction. Alison says, “It has been a lot of hard work but fantastic – the second CQC report was lovely.”

And practice manager Rachel says, “The team worked incredibly hard to make the difference. They have learned so much. All GP partners are now much more involved in running the practice.”

As Dr Marsh puts it, “We knew we needed to change, this gave us the impetus.”

Dr Tong adds, “People were used to how it had been and we didn’t know what we didn’t know. It shouldn’t have continued. Now, we’re achieving our goals.”

## Moving forward

There are still issues to address. As Dr Marsh says, “we’re still not where we want to be”. Possible improvements include longer opening hours, enabling nurses to handle more appointments and making further improvements to processes such as ordering medicines.

Orchard Surgery finds it hard to offer a full range of services at the scale of the existing practice, and knows that people like to come to their own surgery. For example, when they tried to encourage patients to use a local stop smoking service it was unsuccessful. Yet, when they started to run exactly the same service in the surgery, the take-up rate improved. A significant development in the pipeline is to merge with two other local practices. This would mean they could share services, possibly physiotherapy, between the three practices. Dr Tong describes their vision: “We need to find out what patients’ needs are and try to meet them.”

**“The RCGP were very helpful and responsive to our queries. They jollied us along and brought to light what we didn’t know.”**

**Dr Germaine Tong,  
GP Partner**



A photograph showing a woman with dark, wavy hair, wearing a black top, holding a clear plastic nebulizer cup to the mouth of a young girl with brown hair and a pink clip. The girl is wearing a pink shirt. They are sitting on a light-colored sofa. The background is a plain, light-colored wall.

# Metro Interchange Surgery

Gateshead, Tyne and Wear

September 2015

Rated as good

January 2015

Rated as inadequate

**Dr Syed Masroor Imam's surgery, also known as Metro Interchange Surgery, provides services to around 3,600 patients from one location in Gateshead.**

Dr Imam is the main partner and the practice also employs two long-term locum GPs who work three full days a week to support Dr Imam. The practice is part of NHS Newcastle Gateshead Clinical Commissioning Group (CCG). The area where the practice is located has a higher level of economic deprivation than the average across practices in England and is in the second highest band of deprivation.

CQC first inspected Metro Interchange Surgery in January 2015. The practice was rated as inadequate and placed into special measures. The main issues were with processes to ensure safety such as having insufficient assurance to demonstrate that people received effective care and treatment. A comprehensive re-inspection in September 2015 found significant improvements, including improved staffing arrangements, audit of infection control and training staff. Inspectors rated the practice as good in each of the five key questions and good overall.

## Reaction to the initial rating

All practice staff admitted to feeling shocked and upset when they found out their service was being placed into special measures. They all agreed that although they knew they were doing the correct procedures, they needed a new process to show evidence of this.

"The first inspection was a shock for all of us and we were devastated. We were proud of the patient care we delivered but the inspection showed that our documentation needed improving and that was a disappointment to the team", says Practice Manager Carole Crawford. "Before the rating we thought we were doing OK, we're a small team and one that always works hard so we were quite deflated."

Her view was echoed by the single GP at the practice, Dr Imam. "Like the rest of the team we were all devastated. We thought we were doing fine as we always had positive feedback from our patients so it was a shock. Once we got over this shock we did what we had to do.

"Our main problem was documentation of things and the general running of the practice."

Practice Nurse Denise Blair admitted to feeling shocked and upset when she saw the report. "At first I was gutted and angry as we work hard to provide good care here. We're a small unit who are all close and have worked together for years because we all like working together. We knew we weren't perfect and there's always room for improvement but we weren't expecting this rating as we were happy and the patients were happy."

But Denise acknowledges "Although it was a big blow to us, we needed to get it all sorted so that's what we did."

## Approach to improvement

The first thing the team did was to get together and look at all the findings in the report in detail to see where they needed to make changes.

"Most of the work has been about improving our documentation, systems and the general running of the practice," says Dr Imam, "We've now followed policy much more rigorously including areas like infection control."

Practice Manager, Carole took an effective approach to analyse what needed doing straight away. "We knew we had to make these changes and we did this as a team. I became a lot more confident as a person knowing that we were now doing things properly and I had control over the action plan and how we were going to tackle each area. This was a massive learning curve."

Practice Nurse Denise Blair says all members of staff had their say initially. "It was a case of us all sitting down and putting our heads together to approach the improvements that were needed. We tried our very best to work through everything and this eventually paid off. We wanted to prove CQC wrong when they next visited, as we knew we had a good practice."

Following the initial report, the practice team was proactive in making the required improvements. They developed arrangements for infection prevention and control, which involved completing an infection control audit, making sure staff undertook all appropriate training and updating the infection control policy so it was in line with current guidance.

The inspection had highlighted some important areas for improvement; the report highlighted that the reception area was understaffed so the practice reviewed staffing arrangements immediately following the feedback. They employed two additional members of staff as apprentices, each working 30 hours a week. "This worked really well as we provided their training and they're still with us now. It had a really positive impact on the reception team," adds Carole.

Practice Secretary Lorraine O'Connell, made immediate changes to the signage at the practice. "I put up new signs in reception for where post was meant to go and instructions regarding hand washing, which weren't fully correct before."

As Carole puts it, "We took everything on board that CQC told us and it has now paid off."

**"It was a case of us all sitting down and putting our heads together to approach the improvements that were needed. We tried our very best to work through everything and this eventually paid off. We wanted to prove CQC wrong when they next visited, as we knew we had a good practice."**

**Denise Blair, Practice Nurse**

**“NHS England colleagues visited us and pushed us in the direction we needed to go. They were a big input towards us improving.”**

**Denise Blair, Practice Nurse**

## **Year of care approach**

As part of the NHS Long Term Conditions Year of Care programme, the practice began to generate letters and search lists for patients according to their month of birth to get them to come in for annual reviews. These lists are then passed to the practice secretary who flags on the system any patients who have not responded to letters. She also keeps track of the patients who are attending appointments for blood tests so the practice can monitor their attendance and DNA (did not attend) rates.

The new way of handling annual reviews for people with chronic diseases has resulted in extremely positive feedback from patients. “Patients absolutely love this new system as it is based around their birthday, so they know when to receive a letter from us to come in. It’s made a huge difference to us and them. Now they’re seen for everything all at once, for example diabetes, COPD or hypertension, and they find this much better than before.” Denise Blair, Practice Nurse

## **Teamwork and communications**

The practice now has a much more effective level of teamwork, which includes regular meetings and daily catch-ups.

Carole Crawford believes CQC’s report brought the practice together as a team as they needed to work together to form their action plan. “The report had a massive impact on us all... We now hold monthly meetings for all staff whereas before it was a bit more staggered and less organised. We also address any issues on a daily basis when we can as we’re a small, close-knit team.”

Denise Blair agrees, “We have much more regular meetings now and pass relevant information onto each other daily. We’re a lot more organised now as a team thanks to Carole.”

Lorraine O’Connell echoes the views on the importance of communications and teamwork “Everybody rallied round and we all worked really well as a team to sort out the problems.”

CQC’s second inspection report noted that staff were confident in raising concerns and suggesting improvements.

## **Improvements**

The practice was grateful for the external support from NHS England. “NHS England colleagues visited us and pushed us in the direction we needed to go. They were a big input towards us improving”, says Denise.

Regional NHS England representatives issued the practice with an additional action plan which listed how they could work to drive improvements following CQC’s feedback. The team all commented that this was helpful towards reaching their goals and that they quickly became aligned with what needed doing.

All members of staff worked towards implementing changes as part of the NHS Long Term Conditions Year of Care Programme, which was endorsed by the Royal College of General Practitioners (RCGP). The Year of Care approach to care and support planning aimed to improve the outcomes and experiences of people with a long-term condition by providing patient-centred care and support for people to self-manage.

Denise also notes a significant improvement in her role as a nurse as a result of the practice following the Year of Care policy. “I now do yearly reviews for patients with chronic diseases, which are much less haphazard than they were. Patients are now on a register and are sent letters when they’re due to visit, it’s a lot more organised now and better for patients. I think that organisation is what we lacked before and it’s made a huge difference.”

Lorraine O’Connell leads on managing proactive communication with patients and is responsible for ensuring that the reception team contacts patients who haven’t responded to letters.

## **Views on CQC**

Carole Crawford says that the report and rating were hard to accept at first, but that “it did put everything into perspective and highlighted the reasons we needed to improve and where. The things CQC picked up were things we were doing, but we just needed the documentation and evidence to prove these.”

During CQC’s second inspection, Denise Blair was more positive, “We noticed a big difference when the second team came to visit us and their approach was good and much more supportive. We felt much more comfortable and inspectors brought out the best in us.”

Dr Imam says “CQC did help us by pointing out what our weaknesses were so we could work on these so, in hindsight, it was very helpful for us after the initial shock.”

## Obstacles to improvement

Denise Blair feels that her main obstacle was getting over the mind-set that it was going to be a lot of hard work to get to where they needed to be after being placed into special measures. “We didn’t like what had been said and assumed it would be a long, hard slog to get where we needed to be but we got on with it positively and did it.”

## Sustaining and developing

The practice is determined to sustain the improvements and it now works with other local practices to support them before a CQC inspection. Carole Crawford notes, “We work with other practices in the locality to give advice and support them through the inspection process and we’ve found this to be really positive and helpful for both sides.

“We will continue as we have been to ensure the correct processes are in place, policies are updated and everything is as it should be. For example, we’re currently ensuring our data protection policies are all correct.”

All practice colleagues know that they must not stand still following their good rating and must strive for continual improvement. “The important thing for us is to maintain those regular meetings, keeping up to date with new policies, implementing new changes and keeping on top of everything,” says Denise.

“For example, before we would pass a colleague in the corridor for a quick catch-up but now we have proper regular meetings where everyone can air any opinions or concerns of the day. This goes right from the reception team to the nursing team and up to GPs. We’re so much more efficient now and will continue to be our best.”

Lorraine O’Connell believes the new way of working and positive communication is key to sustaining improvements. “Carole and I have a daily morning meeting to check what’s going on throughout the practice and what we can do to rectify an area that isn’t working, for example we recently reviewed our e-referral system.”

Dr Imam is confident and ambitious for the practice. “Communication is now much better and we don’t believe in just improving things and then stopping still – we must follow improvements through and constantly review what we do so we can be our very best for patients.”

**“We work with other practices in the locality to give advice and support them through the inspection process and we’ve found this to be really positive and helpful for both sides.”**

**Carole Crawford,  
Practice Manager**

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# Litcham Health Centre

Litcham, Kings Lynn, Norfolk

November 2016

Rated as outstanding

February 2015

Rated as requires improvement

Litcham Health Centre provides services for approximately 3,500 patients in a rural area with a mixed level of deprivation. The practice population has a larger percentage of adults aged over 55 compared with the national average.

Following an inspection in February 2015, the practice was rated as requires improvement overall. The inspection report noted a number of positive aspects; for example, the practice understood the needs of local people and offered services to meet these, and it had worked to ensure that it identified and met the health needs of patients who did not regularly attend the practice.

However, there were some important areas that needed to improve to ensure that patients were safe. For example, the practice needed to improve how it reported significant events, assessed risks to patients, staff and visitors, and also improve measures for infection control and prevention.

A re-inspection in November 2016 found significant improvements and some examples of outstanding practice, such as a specialist community support team and an innovative system to monitor patient outcomes. As a result, the practice was rated overall as outstanding.

## Reaction to the initial rating

“Getting a rating of requires improvement did bother me,” says Senior Partner Dr Julian Brown. “It demoralised the team and undermined some trust in my clinical leadership. The team felt I was doing something wrong with the set-up in the surgery.

“At the time, we were not a poorly performing surgery – we were pretty good on outcomes for patients. But the report did highlight flaws in our processes and identified some failings, so we did a deep dive on our infrastructure in the surgery and realised we needed to strengthen our management.

“So although I was irritated at the time, there were some definite weaknesses. While you must always look at clinical outcomes, the infrastructure and the operational governance are also important. It made us address those things.”

Senior receptionist June Burton was also disappointed with the rating. “I had worked here for 11 years and thought patients were treated really well. I read the report at home, and once you see the report, you realise it was right. We did have management problems; the practice manager had left and we didn’t have a replacement so people were filling in but not keeping up with all the things that needed to be done. Inspectors picked up on this.”

## Approach to improvement

Dr Brown says he responded to the report on two fronts: addressing the inadequacies around governance and taking steps “to be the best practice we can be clinically.

“We had a very stable staff and low staff turnover, which meant a lot of our staff hadn’t had all the best practice criteria when first employed.”

He recognised that operational governance did need attention. “There was lack of structure in the way we managed our processes, certainly in terms of staff accreditation etc.

“The problem with a small surgery like this, with someone like me who focuses on the clinical side, you need to have someone who focuses on the blind spots. And we’ve now got that. Maybe I had focused too much on front line and left holes in the overall management of practice. It’s all very well doing clever stuff, but you have to get the basics right as well.”

Dr Brown had recognised that the practice had some operational weaknesses within the surgery and a surgery management advisor came in one day a week to help. But after the report he says, “I realised that what we really needed to do was increase the infrastructure here rather than have outsiders keep coming in.”

To overhaul the governance and management of the practice, two practice managers, Tony Bailey and Marta Haskiewicz, were brought in.

Tony and Marta joined the practice a few months after the practice was rated as requires improvement, and both understood the urgency of making improvements quickly as a follow-up inspection was expected in the near future.

They used CQC’s reports as a starting point for what Marta called “a massive plan to work on.”

For Tony, the starting point was to address the key issues of policies and procedures, training and the building environment.

Dr Brown focused on the clinical side, bringing in an admissions avoidance team to increase support for vulnerable patients – although he points out this was not directly as a result of the report, “but I did want us as a surgery to be as excellent as we could in terms of our clinical implementation.”

## Improvements

Tony and Marta developed a list of mandatory training and created a matrix to show what training staff needed to do and to map progress. It included expiry dates for all the training. Marta says they “pushed people to make sure they completed training” and encouraged this by giving people extra paid time to do it. “Mostly it was e-learning but some courses, such as first aid, basic life support, safeguarding, and infection control, were delivered face-to-face in-house.” The matrix helps them keep track of progress. “It needs constant monitoring”, says Marta.

**“While you must always look at clinical outcomes, the infrastructure and the operational governance are also important. It made us address those things.”**

**“It’s all very well doing clever stuff, but you have to get the basics right as well.”**

**Dr Julian Brown,  
Senior Partner**

## Avoiding admissions to hospital

On the clinical front, Dr Brown is proud of the practice's population management process – not something that he says is routinely done in general practice. "When the inspectors came they said they hadn't seen it done elsewhere.

"We have an admissions avoidance room staffed by healthcare assistants. Whiteboards list our priority patients and are updated monthly to identify any key calls to action. Each week we use the Eclipse system to identify our 'at risk' patients. One of the healthcare assistants does a daily upload to the system to get new alerts. The system runs over 2,000 algorithms against our patients each day. Calls to action are identified by the team."

A specialist community support team ensures that housebound patients and patients who are unable to attend the surgery can be appropriately assessed. The team enables support in the community by using both the clinical system and the whiteboards in the office to keep up to date with changes in the care for patients. This reduced admissions to hospital through A&E and inappropriate hospital referrals. The practice's rate of emergency admissions was one of the lowest in the region.

"Updating policies and procedures was a nightmare. The problem is that there is no guidance. There isn't a specific list of policies you must have. We visited another surgery that had an enormous amount of policies and picked the ones we thought were most important. We read them and reviewed them to make sure they were up to date. It was a difficult job to do."

Tony says they are still adding to these, "but we think we have a manageable list now." To keep on top of the subject, Marta explains that on the front of every policy they put the date it was last reviewed and check all the links. "The policies cover every aspect of our activity", she says.

Marta and Tony had meetings with every department to introduce the policies and tell staff where they could find the information they needed.

The problems with the building also needed good organisation to resolve. "The building was outdated, but there were no quick fixes. We needed to plan, get people in and work around the day-to-day functions of the surgery," says Tony.

Installing new computers and much-needed new phone lines added complexity to the task but, says Marta, "the improvements were really needed – reception hadn't been updated in 30 years. Carpets were awful." They took the opportunity to design a proper storage room for documentation and a small staff room. The refurbishment work included installing electronic doors which, says senior receptionist June Burton, "helps people in wheelchairs."

Infection control was another area that needed to be addressed. The practice's cleaner, Donna Lucas, took responsibility. All documents relating to Control of Substances Hazardous to Health (COSHH) were checked, as well as all chemicals, equipment, and cleaning equipment.

They replaced chairs that had been split, brought in new toys and changed the entire section, "out with soft toys, in with wooden and plastic", says Tony. "We understood there was a valid reason for this. Being new to this, if we hadn't had the report to work through, we wouldn't have known."

There is now a log for significant events, which are acted on straight away and discussed at a weekly practice meeting. The process for handling complaints has improved, as the practice acknowledges them straight away and deals with them promptly or directs them to NHS England through the major complaints procedure. "We give patients the option of going to NHS England if the issue is significant. We try to explain and offer different routes", says Tony.

CQC inspectors also picked up on the issue of recruitment practices as another area that needed to improve. There is now a recognised recruitment policy, which involves advertising jobs properly, interviewing and following up references using the practice's own bespoke template, and DBS checks. Everything is now recorded.

According to Receptionist June Burton, the changes have made the practice "much more smooth running – and that makes reception's job much easier."

Another innovative system is the Patient Passport system. Patients have a smartcard that links to the data held on the practice's system. Scanned at reception when a patient arrives, the Patient Passport alerts staff if any outstanding tests are due or if additional clinical input is needed. The Patient Passports are directly linked with local hospital data and allow the extended healthcare team to access the patient's key medical information outside of the practice.

"I make big savings by keeping people out of hospital", says Dr Brown. "We have created a vulnerable patient support network, dramatically reduced the admission rates for our patients and dramatically improved our ability to keep people safe. That's what excites me."

The practice holds a weekly meeting to review patients who have been admitted to hospital. “We do a deep dive into their records to see why they went into hospital”, says Julian. “There is always something that could be done better. It’s all about discussing these issues transparently in a non-threatening environment. I think we do have a non-threatening environment for discussing mistakes.”

## Teamwork and communications

The practice managers worked on improving communication between teams in the practice, addressing issues with rotas, and roles and responsibilities in the practice dispensary, and creating a new website, which involved patients through the Patient Participation Group.

## Views on CQC

Tony and Marta say CQC’s reports gave them the ‘blueprint’ for their improvement action plan. They also looked at reports from other practices to see if they needed to address problems that had been highlighted elsewhere.

Dr Brown found a big difference between the first and second inspections, particularly as the most recent inspection focused more on the positive work being done. “CQC can either support clinicians and get them in tune with what it is trying to do, or it can ostracise them”, he says, suggesting that the positive approach was more likely to facilitate improvement.

## Obstacles to improvement

The practice had no external support to help it improve. For Dr Brown, one of the biggest obstacles was finance: they needed to spend about £30,000 to improve the infrastructure.

For Practice Managers, Tony Bailey and Marta Haskiewicz, it was the sheer amount of work that had to be done in a short time. They would have appreciated external support.

## Sustaining and developing

Tony is clear that there’s no sitting back even with a rating of outstanding. “You are never finished. We now have a structure and know where we are going. We review everything annually to make sure we stay on track and although our staffing is fairly stable, we need to start planning for retirements.”

For Dr Brown, the future is about continuing to develop the systems that ensure the best care, particularly for vulnerable patients.

## The value of healthcare assistants

On the day CQC spoke to Julian Brown, the practice nurse and healthcare assistants were due to visit 22 patients in the community. “We identified patients who need flu jabs and went through records to see what else they might need”, says Julian. “We found two or three things that had been missed. They’ll go through to be discussed as significant events so we can learn from them.

“Of all the improvements, I am most proud of the healthcare assistants and the difference they have made in terms of interactions with patients and attention to detail. The difference they have made is astonishing. I think what we’ve done is identify a niche, using healthcare assistants in a way that’s different to the rest of primary care and I think we’ve identified a really elegant solution to reduce workloads and improve outcomes for very little outlay.”



# St Mary's Surgery

Bloxwich, Walsall, West Midlands

December 2016

Rated as good

February 2016

Rated as inadequate

St Mary's Surgery serves patients in an area ranked as one of the highest deprived in England. It shares a health and social care centre with five other GP practices and has a registered patient list size of approximately 2,700 patients.

CQC first inspected St Mary's Surgery in February 2016. The practice was rated as inadequate overall and placed into special measures. The report noted a need for processes for health and safety risk assessments, the use of clinical audit to improve patient outcomes, and reviewing and acting on patient safety alerts. A comprehensive re-inspection in December 2016 found significant improvements, including a programme of audits that were driving improvement in patient outcomes, and staff understanding and fulfilling their responsibilities to raise concerns and report incidents and near misses. As a result, CQC rated the practice as good overall.

## Reaction to the initial rating

"The first inspection was a shock for all of us. We were proud of the patient care we delivered but the inspection showed that our documentation was not the best and that was a disappointment to the team", says Practice Manager Stacey Wyatt. "Before the rating, we didn't think we were too bad; we thought we were a good team; we thought we were doing okay. On the positive side, the report said we were good at caring and that our patients were happy."

Her view was echoed by Senior Partner Dr Panagamuwa, "When the report came out I was surprised we were in special measures because all the indicators I was getting on a day-to-day basis were positive. So this was a surprise as to how bad we were doing when we felt we were not negligent in any of our practice and the practice was running reasonably well."

But he acknowledges that the inspectors had highlighted some vitally important areas for improvement. “For example, the lack of emergency drugs. That’s an immediate red flag – if you can’t treat meningitis if it turns up, you are failing as a practice. That was a blind spot – I’d assumed someone else was doing it. The inspection was a kick up the backside to get things done.”

Dr Mangala Wijetunge works part-time for the practice. “When I looked at the report I understood the issues. We were doing a lot of things right but there were gaps in communication and people doing things in their own way – doing their best, but not as a team. We needed to do things as a team and communicate with each other more.”

Dr Uzma Ahmad is Medical Secretary at Walsall Local Medical Committee. “We had full faith in the clinical leadership of the St Mary’s practice. We believed that they were doing the right things, but the CQC report highlighted that they needed to ensure that systems were followed and adhered to more vigorously to enable them to demonstrate their performance.”

## Approach to improvement

Stacey Wyatt says when the practice received the report and rating she “looked at other reports from practices from similar areas that had been rated as good and talked to other practice managers in the building.” She also looked at CQC’s website, particularly the information and tips in ‘Nigel’s Surgery’.

“Most of the work has been about improving our systems. We needed to tidy up our processes and have proof and document everything, including our internal meetings” says Stacey.

Dr Panagamuwa says the report identified important areas that needed to be addressed: “If something was to happen we didn’t have a safety net; there’s no process for checking whether those gaps are being filled. That was an eye opener. What I took away was that we need to be doing all the stuff behind the scenes a lot better.”

CQC’s inspection report noted that although the practice had carried out some audits, inspectors saw no evidence of how these were driving improvement. Following the report, the practice engaged a consultant “with a lot of managerial nous”. Dr Panagamuwa says, “We asked how we could show evidence what we did and she said ‘you have no evidence, this is all very scant, only hearsay and conjecture rather than documentation’ – she meant we had no audit trails.”

The ‘initial hump’ to get over is a lot of work and having guidance to do that from an external consultant was invaluable. “I don’t think we would have been able to do that ourselves” says Dr Panagamuwa.

He also went to a seminar with a practice in Kidderminster that had been rated as outstanding, which was organised by the Federation (the Walsall Alliance). This practice talked about how it was given a rating of outstanding, and there was a lot of practical guidance.

Dr Mangala also works at another practice, which is rated as good in every area and says she discusses what that practice is doing with colleagues at St Mary’s to help it improve.

The practice has received help from NHS England’s Vulnerable Practice Programme. Although St Mary’s had been re-inspected before the scheme took effect, it is helping to embed and continue the improvements.

**“We had full faith in the clinical leadership of the St Mary’s practice. We believed that they were doing the right things, but the CQC report highlighted that they needed to ensure that systems were followed and adhered to more vigorously to enable them to demonstrate their performance.”**

**Dr Uzma Ahmad,  
Medical Secretary,  
Walsall Local Medical  
Committee**

**“Things were discussed before but there are now more in-depth discussions. Management and GPs are open to our suggestions. If they think something is a good idea we’ll run with it and try it. Staff do feel more engaged.”**

**Carol Richards,  
Chief Receptionist**

## **Teamwork and communications**

Another failing highlighted in the report was the lack of communication within the practice. This has improved greatly and there are now clinical meetings held every two weeks and a monthly practice meeting.

Dr Mangala says, “As GPs, we recognised we needed to communicate more – there hadn’t been a time when all three GPs sat down together. So we increased the number of meetings. This has helped in every respect: staff are more of a unit and everybody knows what we are doing and when to do things.

“We used to have monthly clinical meetings but sometimes they were not well-structured or minuted. Now they are much better structured. We discuss clinical incidents; we look at new alerts and significant events. Minutes are circulated by email and stored on the shared drive. It helps me do my job better.”

Chief Receptionist Carol Richards says that “things were discussed before but there are now more in-depth discussions. Management and GPs are open to our suggestions. If they think something is a good idea we’ll run with it and try it. Staff do feel more engaged.”

CQC’s second inspection report also noted that staff were confident in raising concerns and suggesting improvements.

Practice Manager, Stacey Wyatt says, “Everyone in the practice is part of the team – we have to involve everyone. We can’t improve by just doing things from the top. We had not been working well as a team across the practice. Now staff feel able to offer ideas on how to improve systems and on how things are managed.”

She explains, “One of the other things we did was to define roles so that everybody knew what their jobs were. It’s important that everybody in a small practice can multitask, but people need to be clear about their main roles.”

## **Vision and strategy**

The first inspection report noted the lack of a vision or strategy, with no plans for the sustainability or development of the practice.

“I didn’t have the time or knowledge to do these things”, says Dr Panagamuwa. “We never saw this as something we needed to address, so that led to the manager not having a lot of direction so she just got on and did the things that she needed to do rather than delegate some things to an admin role to have more time for forward planning.”

With the help of the consultant, the practice wrote a business plan to show where it wanted to be in five years’ time. Combined with the extra support from NHS England and the Vulnerable Practice Scheme, Dr Panagamuwa says they are now “looking at financial planning, ambition and direction. We’ll have spreadsheets of our cash flow projections, succession planning for our nurse and senior partner and a staff development plan.”

The lack of a strategy had resulted in “a very shaky staff foundation, a naïve clinical governance foundation, and a lack of knowledge about how to shore these things up. I guess this is what CQC has introduced: you can’t just be doing what you are doing – things are changing and risks are occurring so make sure processes are being shored up.”

## Improvements

Practice Manager Stacey Wyatt says the practice started by addressing the main issues from the report. “We developed a better system for alerts. Every alert goes on a spreadsheet; for example, if it’s an alert that relates to a particular medicine, the system searches for all the patients that have that drug. This generates a notification to the GP to consider what follow up action may be necessary.”

Alerts are then reviewed at the next practice meeting and when actions have been signed off the practice manager notes this on the spreadsheet.

Nurse Practitioner Carol Dwyer commented that the new system means that “others in the team are now more aware of the importance of alerts”. She also notes that having more clinical meetings to discuss patient issues has improved her ability to do her job well. She says this has led to the GPs being more approachable and generally to improved teamwork.

And with more robust processes in place across the practice, everyone, as Chief Receptionist Carol Richards puts it “is singing from the same hymn sheet”. The changes mean that “now we know exactly how we need to document things and what needs to be documented. It does make sense. Now we can teach new receptionists the way that it is expected to be done, which does make our lives easier as everyone knows what they need to do.”

The practice also improved the way that it identifies patients who are carers – the inspection report had identified this as an area to address. At the time of the first inspection, the practice had only identified four carers; but after carrying out a full review of patient records, by the time of the second report that number had risen to 18.

The first CQC report pointed to the need to strengthen recruitment practices. Stacey Wyatt says the practice has improved its induction processes for new staff and makes sure that it follows up and records all references and DBS checks.

CQC also noted the lack of a patient participation group (PPG). Stacey says the practice has been taking steps to re-establish its PPG with more patient involvement and better communication with patients. Acting on feedback from its own survey of patients following the first CQC report, the practice started to offer early morning and evening appointments.

Other important improvements included better reporting and learning from incidents. CQC’s latest report noted that if things go wrong with care and treatment, patients are informed of the incident, receive reasonable support and a written apology and are told about any actions to improve processes to prevent the same thing happening again. Significant events are discussed at the monthly practice meetings and there are systems to ensure these are reported to the National Reporting and Learning System if appropriate.

The practice has introduced a programme of audits that are helping to drive improvements for patients. For example, an audit of patients on a medication to lower cholesterol identified 12 who required a review. All 12 were seen and their medicines updated accordingly.



**“One of the other things we did was to define roles so that everybody knew what their jobs were. It’s important that everybody in a small practice can multitask, but people need to be clear about their main roles.”**

**Stacey Wyatt,  
Practice Manager**



According to Stacey Wyatt “the practice does feel different now we are more streamlined. The changes have helped me as a manager. I have had more training including CIPD HR, which has really helped. I see things differently now and am better equipped to manage the organisation. If the staff are happy in their roles it reflects well on patient care. With our processes improved, I have more ability to look ahead, for example, looking at the NHS General Practice Forward View.” She also has more time to engage with others outside the practice, through regular meetings with the other practice managers in the building.

Dr Panagamuwa also notes the impact on the practice manager, “I think the manager is a lot happier because she has direction. I am now much happier with the time carved out for managerial interactions. Having that time allows me to know what other people are thinking.”

## Views on CQC

Dr Panagamuwa feels that, overall, “the inspection and rating was very useful and did galvanise us to move forward and gave us a structure to work towards.”

He says, “When you are in a small practice you never get feedback to say ‘this is wrong’ until it’s too late. The inspection is useful as a risk exercise. It covers a lot of things we can mitigate for. It didn’t come across as showing that, as a practice, we were failing our patients.”

Stacey Wyatt says “The inspection report did identify weaknesses – things that you can’t always see from the inside. Our inspector has been supportive and always available to answer questions.”

## Obstacles to improvement

As a small practice, the main obstacle to improvement at St Mary’s was its staffing. Dr Panagamuwa points to the turnover in nursing and reception staff, leaving gaps and some uncertainty as to responsibilities. “Our senior manager had retired, our senior nurse had retired and the senior doctor was starting to wind things down.”

He says staff had lacked direction from partners – something that has now been addressed. Staffing is now more stable, with people clear about their roles.

Dr Uzma Ahmad, Medical Secretary at Walsall LMC says, “The practice contacted the LMC soon after the initial CQC report was shared. It was clear the practice was keen to engage and improve in order to meet the standards. LMC provided support throughout that process and signposted it to resources to help make the changes.”

More external support would also have been welcome, but Dr Panagamuwa recognises that other parts of the local system, particularly the CCG and acute trust, have also been struggling. He would have liked more support with handling the media reaction to the first report: “I was worried about the media backlash. We’d seen the stories about a neighbouring practice rated requires improvement.”

The CCG helped the practice to access the Vulnerable Practice Scheme and is now organising more workshops for local GPs. These, says Dr Panagamuwa are helping him to “make the day-to-day more efficient and be more managerially savvy – do some things myself, delegate some, train people up to do some.”

## Sustaining and developing

The practice is determined to sustain the improvements and is aiming to be outstanding. “CQC lit a fire under us. I want to continually improve”, says Dr Panagamuwa, “our aim is to be outstanding, but we may not yet have the staff to do all the things I’d like to do. I’d like to work on a bigger scale, have more GPs with leads for different areas.”

Richard Jarman, an associate advisor with Primary Care Commissioning Community Interest Company, has been working with the practice through the Vulnerable Practice Scheme. He is confident that St Mary’s can keep improving. “Having got over the shock of special measures, I think they can sustain the improvements. They are very conscious that they need to think about how they change to meet the challenges of the future. The GPs also now understand the importance of enabling the practice manager to have a more strategic role.”

LMC Medical Secretary Dr Uzma Ahmad congratulated the whole team of the practice for the improvement, with “particular praise due to Dr Panagamuwa, whose hard work and leadership delivered improvement within a short period of time. We believe it was the whole team approach and willingness to engage and improve that have made St. Mary’s an exemplary practice providing high quality care to its patients”.

Dr Panagamuwa is confident and ambitious for the practice. “Now that we know what good looks like, we should be able to sustain it. But I have the knowledge of what outstanding would be. If we could work collaboratively across the six practices in this building we could be amazing.”

**“Now that we know what good looks like, we should be able to sustain it. But I have the knowledge of what outstanding would be. If we could work collaboratively across the six practices in this building we could be amazing.”**

**Dr Panagamuwa,  
Senior Partner**

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# Falcon Medical Centre

(Now OHP-Falcon Medical Centre)  
Sutton Coldfield, West Midlands

October 2017

Rated as good

January 2016

Rated as inadequate

## The Medical Centre is in a deprived area within a predominantly affluent area.

It is the only area in Sutton Coldfield that is within the 20% most deprived areas nationally. The practice itself serves approximately 2,000 registered patients. Falcon Medical Centre merged with Ley Hill Surgery and is now a member of Our Health Partnership (OHP), involving approximately 40 practices providing care for 340,000 registered patients across the West Midlands.

CQC inspected Falcon Medical Centre in January 2016. This resulted in an overall rating of inadequate and being placed into special measures. Inspectors found a risk of harm for patients because systems and processes at the practice were not implemented well enough to keep them safe. For example, the practice didn't adequately manage risks relating to staffing, infection control, the premises, equipment and unforeseen events to ensure that it could take appropriate mitigating action.

In October 2017, CQC inspected Falcon and recognised Ley Hill's work to improve the practice, which was reflected in an overall rating of good and a rating of outstanding for being well-led. The report noted evidence of strong leadership, with staff identifying the needs of the practice population and establishing links within the local community to help address health inequalities, and working with other health and social care professionals to safeguard some of the practices most vulnerable patients.

## Reaction to the initial rating

The only current member of staff who was at Falcon at the time of CQC's inspection in January 2016 is Senior Receptionist Debbie Nixon. While she says she was upset to see the report, she wasn't surprised as, along with other staff, she had concerns – and shared these with CQC's inspector on the day.

"Staff had complained and staff morale was low. We felt patients were at risk".

The local clinical commissioning group (CCG) had inspected the practice and also had concerns about its ability to deliver actions needed to improve. The GP

that was running the practice resigned, so other local practices were invited to put themselves forward as caretakers while the CCG considered options. Nearby Ley Hill Surgery, rated as good, was selected as caretaker and was subsequently awarded the contract to run services at Falcon.

Dr Rahul Dubb, GP Partner at Ley Hill says “It was sad to see that just three miles down the road there was such a stark difference in the levels of health care being provided. We were excited by the opportunity to transform health care here for Falcon patients.”

## Approach to improvement

“We recognised that we needed to use the same ‘belt and braces’ approach in Falcon as we do in Ley Hill Surgery. We also recognised the specific different needs of the Falcon population in particular in relation to mental health, sexual health and drugs and alcohol support needs.”

But Dr Dubb says there was a vast amount of work and dedication needed to achieve the improvements that led to Falcon’s leap from inadequate to good.

Improvement was a team approach, “addressing the hearts and minds of all involved”. The decision to take on Falcon – first in a caretaking role and then as the contract holder – was taken by Ley Hill’s GP partners but the plans were then discussed with all the Ley Hill staff.

“We identified core groups of staff who would need to work across the two sites, and offered our assistant manager the opportunity to be upskilled and take on the role of practice manager at Falcon”.

CQC’s report was the basis for the improvement work but, says Dr Dubb, “we found things were even worse than the report. And the only member of staff left was one receptionist.”

He set up a risk register to set out and monitor improvements. This was a week-by-week plan that covered activity under four main headings: premises, clinical, infection control, and reception.

From January 2017, when the Ley Hill team took over the GMS contract for Falcon, Dr Dubb says it was encouraging to “visualise the progress seeing the red colours on the risk register turn to greens. It was a powerful tool to share with staff. We used it for driving continuous improvement. It allowed us to be methodical and focus attention where it was most needed, on the clinical and safety issues”.

Nurse Coordinator Annie McLaughlin had the job of addressing some of the most immediate safety issues. “It was an exciting challenge. I had been at Ley Hill for some years. I felt sorry for the Falcon patients and wanted to give them better healthcare.

“I went to have a look at the place, then stripped it – we got rid of the old equipment and restocked supplies. It was almost doing a mirror image of what we had at Ley Hill, but on a smaller scale. It was a nice building and good to put a bit of love into it!”

Assistant Manager Nicki Frost, who became Practice Manager at Falcon, says “it was a brilliant opportunity for me and allowed me to gain experience of being a practice manager. I found the challenge exciting and I really wanted to make a difference.

“My approach was first to see how they did things and then try to bring them up to our standards at Ley Hill.”

The local health system also played a part in the approach to improvement. Dr Dubb says the CCG was very supportive, especially the guidance he received from the quality team. “The CCG took headaches to do with the premises away

**“It was encouraging to visualise the progress seeing the red colours on the risk register turn to greens. It was a powerful tool to share with staff. We used it for driving continuous improvement. It allowed us to be methodical and focus attention where it was most needed, on the clinical and safety issues”**

**Dr Rahul Dubb,  
GP Partner,  
Ley Hill Surgery**

**“The CCG took headaches to do with the premises away from us and provided a support pharmacist to help us sort out the problems with prescriptions that had been highlighted in the CQC report.”**

**Dr Rahul Dubb,  
GP Partner,  
Ley Hill Surgery**

from us and provided a support pharmacist to help us sort out the problems with prescriptions that had been highlighted in the CQC report.”

Ravy Gabrria-Nivas, Senior Primary Care Quality Manager at Birmingham CrossCity CCG, says “the CCG was proactive and engaged. We had regular meetings to go through the CQC report. The practice engaged with us and with the LMC

“What impressed us about Ley Hill was its local knowledge of the community and the patients. The practice also had a good skill mix and the leadership was clear about what they wanted to achieve. The plans were practical and sustainable.”

## **Improvements**

CQC’s inspection report was clear about the need for rapid improvement. “After the CQC report, we had to make improvements because things were not safe”, says Nicki Frost. “For example, one of the receptionists used to carry out urine dipsticks; record keeping wasn’t up to date and people were not being called in for reviews as they should.”

Dr Dubb highlights the difference in the affluence of the practice areas. “The population needs at Falcon are unique in the area. We recognised there were needs that we were not used to, so our risk register included services we wanted to introduce such as for sexual health, addiction and mental health”.

New additional services included regular clinics run by mental health charity Mind, who referred patients to counselling or advice about benefits, and access to Ley Hill’s trained substance misuse prescriber. As a result of the subsequent merger with four other practices to form Sutton Coldfield Group Practice (SCGP), Falcon patients can now take advantage of minor surgery in these practices. Staff have also organised an education session on sexual health at a local school.

Community matrons employed by the group as a whole have also worked with Falcon patients to provide more support to people at home, which helps to reduce the number of unplanned hospital admissions. The group of practices also employs semi-retired district nurses who, along with palliative care nurses, now provide services to Falcon patients as well.

The Falcon practice introduced new clinics and a staff rota meant that patients would know which GPs were on duty on which day, made possible by the particular skill mix of the GPs. Patients were also able to see a female GP, something they weren’t able to do previously.

For Falcon’s Practice Manager Nicki Frost, improvements centred on getting the right systems set up. Mainly this meant introducing policies from Ley Hill. “The toughest thing was not having systems in place, for example on how you deal with the death of a patient. You only found out that some things were not in place when you needed them.”

For patients, the improvements were noticeable. “I wasn’t happy with the previous GP at Falcon. The surgery was dirty and unpleasant. A lot of people complained,” says Kenneth Preston, a patient at the Falcon practice, “but the new practice is fantastic. The place is more joyful. I can’t fault it. They call me in if they need to see me – I can’t praise them enough. I feel I am getting better care.”

And Nurse Coordinator Annie McLaughlin sees how everyday courtesy has an impact on patients who were not used to it, “one patient said to me ‘the GP shook my hand’ – it meant a lot to that chap.”.

## **Teamwork and communications**

For Annie, teamwork has been the key to the success in taking over and improving Falcon. “Because we are such a close knit team it was quite a smooth process – we have worked together so long and know each other so well. It was all about



teamwork. We went in on days off, for example to clean the surgery – including GPs. We support each other, help each other. We’ve always had a strong team and GPs have always supported the nurses.”

Good internal communications at Ley Hill have been rolled out across both sites, with regular clinical meetings, discussions about audits and opportunities to share learning.

Dr Dubb stresses the importance of teamwork to driving improvements, “there’s teamwork within the practice, but also with patients, with OHP, the LMC, CCG and CQC.”

He says the practice also has more engagement with the patient participation group. “Previously there was very little engagement with the PPG. We’ve now had three meetings with the chair and incorporated Falcon into a larger, combined PPG with Ley Hill – but it’s a work in progress.”

A lot of effort went into telling the local population about changes at the Falcon practice – and keeping people informed. According to Annie McLaughlin, “we regularly communicate why we are doing things – we need to explain our goals. It all starts the minute a patient comes through the door so we have to involve the whole team.”

## Views on CQC

The practice and the CCG viewed CQC’s first report as helpful, as it identified priorities for improvements. And Dr Dubb says that “the atmosphere generated on the day of the [second] inspection was good as inspectors said they could see the improvements. The vibe on the day was supportive and encouraging.”

He was also pleased that CQC allowed the practice to carry out its own patient survey after the inspection as CQC’s inspection team used results from a previous survey, which were mainly based on people’s experience of the previous provider. The practice’s own survey revealed much greater patient satisfaction.

## Obstacles to improvement

The main obstacle to improvement was the short timescale allowed to demonstrate and embed improvements. But Dr Dubb welcomed CQC’s decision to postpone the follow-up inspection as inspectors recognised that it was too soon after being taken over by Ley Hill, so they would not have been able to see the impact of the work.

Operationally, there were issues with the lease of the building, which the CCG helped to resolve. For Nicki Frost, the tough issues were in setting up contracts for new telephone lines, developing the website and activating online patient access.

## Sustaining and developing

Everyone involved with the practice is confident that the improvements at Falcon can be sustained and continued.

Dr Dubb is Chair in the Sutton Coldfield Group Practice, which is a merger of six practices, and therefore brings more opportunities to improve the services offered to the whole patient population.

Falcon has gone from being a small, struggling practice to one that can now draw on different levels of support – from Ley Hill, from Sutton Coldfield Group Practice and from Our Health Partnership.

Dr Dubb is looking to the future by aiming to develop the staff mix further. He is thinking ahead to mitigate issues such as the decline in the number of GPs for example, by making more use of advanced nurse practitioners and pharmacists.

**“The toughest thing was not having systems in place, for example on how you deal with the death of a patient. You only found out that some things were not in place when you needed them.”**

**Nicki Frost,**  
Falcon Practice Manager

## Prioritising prescription problems

Prescriptions were a key issue. Under the previous provider, receptionists had the authority to issue repeat prescriptions without referring to the GP. According to Dr Dubb, this meant that some patients were not getting annual medication reviews.

The practice carried out audits to identify the affected patients and implemented systems to ensure that these patients were monitored appropriately. The CCG’s pharmacy team supported the practice to ensure that its prescribing was in line with best practice guidelines.



# Dr Krishnan

Leigh on Sea, Essex

June 2017

Rated as good

January 2016

Rated as inadequate

## Dr Krishnan's practice provides services for almost 5,000 patients in Essex.

The demographic of patients at the practice is similar to the national average for younger people and children under four years, and for those of working age and recently retired, but the number of patients aged 85 and over is slightly higher than average.

There is also a higher level of economic deprivation than the average across practices in England.

When CQC inspected in January 2016, the practice was rated overall as inadequate and put into special measures. Inspectors highlighted a number of issues that needed to improve, including problems with infection control, issues around the management of medicines and recruitment procedures.

After a comprehensive inspection in June 2017, the practice was rated overall as good. The inspection report noted that the practice had assessed risks to patients and staff and was managing these properly, that medicines were appropriately stored and monitored and that recruitment processes had improved.

## Reaction to the initial rating

Dr S Krishnan is one of the partners at the practice; he says the report came as a surprise as it had been delayed at CQC so, although the practice was made aware of a number of concerns on the day of the inspection, the formal notice of the rating was not until some six months later.

"The practice immediately addressed a number of issues that inspectors raised on the day with us. Then, once we got our heads round the specifics of the report, from our perspective we knew what we had to address to get on with it."

Tricia Hart is now the Practice Manager, but at the time of the inspection she was a secretary at the practice, having started there as a receptionist. "There was

some surprise at the report, but at no time did I think patients were not being well cared for. It did affect morale but we were able to address some things straight away.”

Administrative Supervisor Esther Henderson joined the practice after the report was published. “It was a negative report, but everyone wanted to make it better.”

## Approach to improvement

Tricia was appointed as Practice Manager between the inspection and the publication of the report. She had been involved in the improvements carried out immediately after the inspection, including risk assessments and setting up reminders for essential checks such as making sure equipment was calibrated correctly. But on becoming Practice Manager she “went through the report with a fine-tooth comb and set up a spreadsheet that detailed every action that needed to be taken – it had a comment next to each entry and an outcome for myself.

“It helped me make sure everything was done by giving reminders and it was colour-coded with dates to show when something needed to be done.”

Admin supervisor Esther Henderson agrees that the key to improvement was “getting more organised, with structures put in place. I saw things could be streamlined, could be done quicker – for example, dealing with the post coming in so that it would be seen more quickly by doctors and staff to put in records.” Changes, she says, were tested, reviewed and then put into practice.

As a new practice manager, Tricia also found it easier to approach people and ask questions. “The RCGP gave very good support and advice – they look for where they think you have gaps, the CCG helped us with infection control and Public Health England also offered advice on issues such as NHS health checks and smoking cessation services.

“My view was that the more people we could get in to help us improve, the better. I got to know a lot of people and tapped into networks who could advise on who to ask.” Tricia also attends meetings for practice managers organised by the CCG, where she can listen to what others have done to improve, and she has signed up for training courses.

Support from the RCGP came from Jenny Walsh, Practice Management Adviser and Dr Kate Needham. Jenny says the majority of issues that needed to be addressed were down to management and leadership inexperience. “I worked with the practice on a turnaround plan based on the ‘musts’ and ‘shoulds’ in the CQC report. We looked at each issue and put in place a step-by-step plan, with accountabilities and deadline dates, for each item.

“Tricia quickly got a grip on what needed to be done and my role was to support her in a mentoring role, helping her to understand what was needed and how to go about it. Dr Needham worked with Dr Krishnan and the other GPs, for example, improving the approach to clinical audits.”

Jenny adds, “there was good support locally, too, from NHS England, the CCG and the Local Medical Committee.”

Cathy Pedder is from Essex Local Medical Committee. Tricia had contacted her when the practice received the inspection report, and they discussed it together. “I worked with Tricia to help ensure that improvements would be embedded, not just a box-ticking exercise.”

As a new practice manager, Tricia also found support from Emma Tindall and Andrea Bann from Southend CCG in applying to provide enhanced services and also setting up SMS text messaging to patients.

**“The RCGP gave very good support and advice – they look for where they think you have gaps, the CCG helped us with infection control and Public Health England also offered advice on issues such as NHS health checks and smoking cessation services.”**

**Tricia Hart,**  
Practice Manager

**“It’s good to empower staff: by having processes in place they feel they can handle things better, for example knowing when to refer patients elsewhere when that’s appropriate rather than waiting for an appointment.”**

**Dr Krishnan,  
Partner**

Dr Krishnan, too, was pleased to be able to look for support. “When we set about improvement, I was put in touch with the RCGP. They were really helpful in showing us not only how to do things, but showing us how to provide the evidence that we’d done them.” He thinks this is something that a lot of other practices need to be better at – demonstrating that they have effective systems that can stand up to rigorous examination, “things do need to be written down.”

## **Improvements**

From CQC’s report and feedback from the RCGP Dr Krishnan says, “We didn’t feel we had to change much in terms of the care for individual patients, but we did need to have clear written policies. For example, we were carrying out audits, but we didn’t have the evidence, so it was about having a plan for the year – a system and structure.”

Structure was important for Tricia Hart, too. “Improvements were made. We have a better structure and I think that helps us to work better as a team. Structure is the basis of good performance and makes sure we are all singing from the same hymn sheet.”

While Tricia led on the administrative improvements, Dr Krishnan took responsibility for clinical improvements. “Most clinical things are to do with leadership, for example, making sure there are policies to refer to matters such as how we action blood test results or deal with immunisations.”

On re-inspection, CQC inspectors saw that the practice had made a number of improvements, such as:

- ensuring there was sufficient and appropriate equipment to treat patients, including emergency equipment
- implementing a programme of clinical audit
- storing prescription pads securely and storing and monitoring medicines appropriately.

Tricia is responsible for sharing patient safety and medicine alerts among the clinical team and making sure they are consistently actioned. She says she found ‘Nigel’s surgery’ on CQC’s website helpful for safety information.

The practice had purchased a new fridge for storing medicines and staff were familiar with the cold chain policy, which enabled them to explain the process to take if the temperature of the fridge was out of range.

Practice Nurse Hannah Hargrave, who joined the practice after CQC’s first inspection, says her team is responsible for checking fridge temperatures daily and she is also responsible for infection control, vaccine checks and ordering stock.

Hannah’s arrival marked a change in the nursing team: where the practice previously had only one nurse, it now also has Hannah as nurse prescriber and a full-time healthcare assistant. Patients have also benefited from a change to the layout of the premises, which has created an extra room so the nurse and healthcare assistant can see patients at the same time.

Training has been strengthened to ensure that staff have appropriate training to their roles and there is a more robust induction programme for new staff, which involves a period of shadowing. Admin supervisor Esther Henderson created an introductory document for new staff and an online ‘bible’ that sets out all the key procedures and policies.

The practice also looks to patients and the public to inform improvement work. Staff encourage patients to use the NHS Friends and Family Test forms to feed back on their experience. They held a Patient Survey Week where members of the

Patient Participation Group encouraged patients to use the forms – and promote the PPG in the process.

Graham Longley is a patient at the practice and chair of the PPG, which, he says had always had good involvement with the practice. The PPG carries out surveys and engages directly with patients. Following patient feedback, the practice introduced early morning appointments one day a week. Graham comments that the changes introduced after CQC's report "have made sure the practice is doing what it should be doing."

Dr Krishnan says that he also is also "proactive in terms of NHS Choices – it's good to acknowledge feedback so I check it regularly."

The practice wants to build on working with external organisations to provide more benefits to patients. As part of this, Southend Carers Organisation is represented in the surgery every Monday and has also attended a practice meeting.

## Teamwork and communications

"It boils down to teamwork", says Tricia Hart, "teamwork and structure and clear responsibilities. We all support each other, we are one big team, including the doctors."

The practice introduced protocols to connect all staff and make more use of task management software. There is more emphasis on using online systems rather than paper.

As well as regular meetings for different groups of staff there are monthly practice meetings for all staff. These are recorded in minutes with clear actions allocated. Dr Krishnan joins the regular nurses meetings, and the practice manager attends QOF meetings.

Dr Krishnan and Tricia also have weekly meetings, which are formally recorded and used to update the action planning matrix.

"We are quite open", says Dr Krishnan, "everyone in the practice is present at practice meetings and I always encourage people to speak at meetings or raise issues in other ways with me or Tricia."

"It's good to empower staff: by having processes in place they feel they can handle things better, for example knowing when to refer patients elsewhere when that's appropriate rather than waiting for an appointment."

## Obstacles to improvement

Dr Krishnan says the most challenging thing was not being entirely sure what level to go to and what would be expected. "How far do we go? Is this enough?" This was particularly difficult for the practice as CQC's report was delayed so, while the practice responded to the initial feedback on the day of the inspection, it had to pursue its improvement work without the benefit of the detailed report.

He also notes that improvements need to be embedded and it takes time to make change and make it part of routine.

## Sustaining and developing

The practice is determined to keep improving. It encouraged feedback from external organisations, for example the CCG's medicines management team, and it has signed up to get clinical updates from NICE. Staff are constantly looking for opportunities to improve and develop, for example, the nursing team is looking at spirometry care, clinical skills and other ongoing training.

## Practice desk aid

The practice has a desk aid that all reception staff can use. This provides processes to follow for different circumstances. For example, it provides advice on how to handle calls requesting home visits, handling a call about the death of a patient at home, dealing with requests for repeat medicines that can't be issued before the review date, and provides action plans for stroke and heart attack.

This was put together by the practice itself so that staff were all following the same process and knew what to do in an emergency.



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# RAF Scampton Medical Centre

Lincolnshire

February 2018

Rated as good

May 2017

Rated as inadequate

RAF Scampton Medical Centre provides primary medical services and emergency care to a practice population of approximately 400 personnel, drawn from all three services in the UK Armed Forces.

CQC first inspected the medical centre in May 2017, leading to a rating of inadequate. A further comprehensive inspection in February 2018 found improvements and led to an overall rating of good.

## Priorities for improvement

Senior Medical Officer Squadron Leader Adrian Dawson joined the practice just as the first report was published. He'd had a full briefing from his senior officer based at regional HQ. "I felt things could be fixed", he says. "Some of the concerns were down to lack of awareness of process – things were being done but not in a way that could be demonstrated sufficiently to give CQC assurance.

"But we did need external support from the region. We couldn't fix the fact that we were a single-handed practice."

He says a big challenge was to build up the morale of staff: "I needed to be clear that this was a system failure not a personal failure."

For Practice Manager Sergeant Lorraine Barclay, the key things to address were infection control and getting the right frameworks and policies in place.

"The first thing I did was re-visit the Defence Medical Services Infection Control policy. Then I met with the contracts monitoring team and we created check lists for cleaners and for medics. I set up a recording system and arranged a deep clean of the medical centre."

## Recording and reporting

CQC's original report noted that there was a system in place for recording and reporting significant events. However, this appeared to be on an individual basis and events were not routinely discussed and analysed, with findings shared within the practice and more widely. "We already had the correct policies and procedures, so this was about following them and doing things right" says the Practice Manager.

The Senior Medical Officer says there were two aspects to putting this right. The first part of this was to develop a change in culture by "continually making the practice team aware that significant event and complaints information is important and emphasising learning and sharing – rather than looking at events in a punitive way."

The second part was to formalise an approach to recording and reporting. "Each month there's a slot on our healthcare governance meeting where events are discussed. Staff are also encouraged to discuss issues among themselves.

The Practice Manager now maintains and monitors a tracker of significant events that helps to support the analysis of emerging themes and trends. This is reviewed at healthcare governance meetings and at practice meetings.

## Roles, responsibilities and communication

Being clear about roles and responsibilities was another area that needed prompt attention. "We identified 18 areas for which there was no clear lead", says the Senior Medical Officer. "We now have a list showing designated leads and deputies, recognising that, in the military, personnel can often be moved around the organisation or onto other tasks for a while." Previously, staff had been unaware, for example, who the lead was on managing medicines, or who would deputise for the practice manager.

According to the Senior Medical Officer, in the past "staff had felt a little in the dark", so improving communications and, importantly, giving staff the assurance that they were being listened to were priorities.

Meetings are now held more regularly, with monthly practice and monthly governance meetings. "It is a small unit", says the Practice Manager, "so everyone is involved in the meetings, whatever their rank."

Staff told CQC inspectors that the leadership of the service had improved and that they now felt engaged supported, and valued by management.

**"We already had the correct policies and procedures, so this was about following them and doing things right."**

**Sergeant Lorraine Barclay,  
Practice Manager**

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**"Significant event and complaints information is important and emphasising learning and sharing – rather than looking at events in a punitive way."**

**Squadron Leader Adrian  
Dawson,  
Senior Medical Officer**

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# Conway PMS

Plumstead, London

**September 2017**

Rated as good

**December 2016**

Remained rated as inadequate

**February 2016**

Rated as inadequate

Conway PMS provides services from its main site, Conway Medical Centre, and also operates a branch site at Welling Medical Centre. The practice serves approximately 4,500 patients, and has a much higher than average proportion aged below four years and between 25 to 35 years.

After CQC inspected Conway PMS in February 2016 the practice was rated as inadequate overall and placed into special measures. A further inspection in December 2016 found insufficient improvement and the overall rating for the practice remained as inadequate.

Both inspections noted some positive areas. For example, the practice made improvements to the quality of care in response to complaints, and staff felt supported and valued by the practice's leaders. However, on both inspections there were a number of areas of concern around governance and leadership arrangements.

A third comprehensive inspection in September 2017 found significant improvements following changes to the management and leadership team, and the practice was subsequently rated overall as good.

## Reaction to the initial rating

Gemma Hepburn-Morris was the assistant practice manager at the time of the first inspection before taking up the permanent post as practice manager ahead of the third inspection.

"I have been a patient at Conway since I was eight years old, started as a receptionist and worked my way up. I therefore had an affinity with the practice that others didn't. It was disheartening to see the rating from CQC, and felt far too negative."

Practice Nurse Debbie Hines felt the report was “a kick in the teeth” and had a detrimental effect on staff morale.

Dr Ranil Perera is now a partner, but was a salaried GP at the practice before the second inspection. “I thought we were doing a good job in terms of improving access and serving the local community. What the inspection did was shine a light on the lack of clinical governance and oversight at the practice.

“It gave us a good overview of what we needed to do to improve. However, I did think that the second inspection report was more useful, as the first did not focus on the clinical governance side. This meant that we lost out on time by the time it came round to the second inspection and could have already rectified a number of things that we had to put right following the second inspection.”

## Approach to improvement

Discussing the practice’s approach to improvement, Dr Perera says the biggest change was setting aside time. “I increased the time I spent at the practice, and focused on things like mental health care plans and long-term conditions management. We stepped back and refocused, ensuring the robustness of our clinical governance processes.” With this renewed energy in looking at long-term conditions, the practice found that general performance against markers such as the Quality Outcomes Framework improved.

Taking over the role of practice manager a month before the third inspection was a daunting prospect for Gemma, but the change in personnel at the top allowed the practice to refocus. “We broke down everything that needed to be done, went through line by line, and checked and rechecked our policies and procedures with a fine-tooth comb.”

## Improvements

The changes to the management and leadership team allowed the practice to review where it was not performing well and make significant improvements.

After noticing poor rates of dementia diagnosis, the practice paid for administration staff and clinicians to have awareness training, with the result that diagnosis rates subsequently improved. This upskilling across the whole practice team ensured that all staff were able to play a part in the improvement journey.

There was evidence of quality improvement at the practice through clinical audits. One audit was aimed at ensuring that treatment of diabetic patients with symptoms of kidney disease was in line with current guidelines. The practice had previously identified this as an area of concern based on its assessment of data from the Quality Outcomes Framework.

In total, the practice was able to conduct two audits looking at cohorts of patients who had received the treatment and concluded that the data within the Quality Outcomes Framework was due to a low sample size and that the appropriate guidelines were being followed.

The practice spent more time on analysing significant events and lowered the threshold for recording these. Staff had to inform the practice manager about any incidents and record them on a form on the practice computer system. The form also helped staff to record notifiable incidents under the duty of candour. A particularly helpful source of information about this for the practice was ‘Nigel’s Surgery’ CQC’s website.

Access to consultations for patients became a priority too. “We knew this would be a key area to drive improvement across the practice. We increased



**“I increased the time I spent at the practice, and focused on things like mental health care plans and long-term conditions management. We stepped back and refocused, ensuring the robustness of our clinical governance processes.”**

**Dr Ranil Perera,  
Partner**

## Recognising the importance of external support and advice

As a new practice manager, Gemma sought out others in the same role within the local area. "We were not plugged into these networks previously and it was good to hear from my peers, and bounce ideas off them."

She enrolled on a training course from the Practice Managers Association. "It was really helpful, but my concern is that people might not know this resource is available to them, and that can be a barrier to improvement. We need to support each other more."

the number of phone consultations available to our patients, introduced a new appointment system and offered two 7pm openings." says Practice Manager, Gemma Hepburn-Morris.

The practice became far more proactive and also implemented in-house referrals; if the nurses need support for patients that are more difficult, they are able to refer to a GP as they now have appointments ready with the GPs at the practice.

## Support

Dr Perera sits on the governing body for the local clinical commissioning group, "they gave some us data so that we could demonstrate improvement and acted as a sounding board." It is through this engagement with other clinicians in the local area that Dr Perera was able to avoid the professional isolation that is often a root cause of problems for practices who are placed in special measures.

## View of CQC

People's perceptions of CQC vary across the three inspections. Dr Perera says "Our inspector for the third inspection was really good – she got the best out of us on the day, because of how she was. This is in contrast to the first and second inspections, where it felt CQC was out to get us."

Reflecting on her experience of CQC, Gemma echoes the words of Dr Perera. "The inspector for our third inspection was amazing. She was previously involved with the second inspection, but not the lead at the time. She has always been very helpful, made suggestions, as well as being very understanding."

Looking back on the first two inspections, she adds, "The way CQC approaches the situation could be seen as a little harsh. Practice managers are the centre of the surgery and CQC's approach is more likely to succeed by working with us. The big picture is that patients receive safe care – we both want the same thing."

When talking about the other members of the inspection team, Dr Perera also has positive words to say about CQC's GP specialist advisors, "it's very easy to be critical, but he was very supportive, constructive and knowledgeable."

## Teamwork and communications

Changes in the leadership at the practice also led to improvements across the organisation. Dr Perera says they "instigated clinical meetings using teleconferences to get around being based at two different sites. This meant we had to think creatively."

Practice nurse, Debbie Hines felt the move to monthly clinical meetings was a real positive for engendering the team spirit required to improve on the rating. "Before, these were ad hoc, but they became permanent and we used the time to look at issues such as clinical case studies or patient complaints, and discussed ideas on how we can manage them."

Communication improved across the whole practice. "Everyone is now in the loop; nobody can come to me and say they don't know what is going on. The communication is much improved, 100% better." says Gemma Hepburn-Morris. "Importantly our communication with patients is also much improved, as we explain why we are doing what we are doing so they are more in tune with us."

Communication outside of the practice also improved. When patients were referred or discharged from hospital, information was shared and meetings took place with other healthcare professionals where care plans were routinely reviewed and updated for patients with more complex needs.

## Obstacles to improvement

Reflecting on staff morale during her time as deputy, and then full-time practice manager, Gemma says that “things were rocky following the first two inspections; we lost two members of staff and had to go through a recruitment process.

“I cracked the whip a little bit and there was a little bit of rebellion, but we’re better now and much more balanced.”

For Dr Perera, it was a case of all focusing on the “day-to-day firefighting at the practice – you don’t necessarily put time aside to address the issues you can’t see, or the unknown unknowns.

“When coupled with patient demand, and concerns over jobs heading into the third inspection, things were not easy at the practice.”

## Sustaining and developing

Everyone at Conway PMS is mindful of the journey the practice has been on and they are driven to keep making improvements.

Dr Perera says his wish is to use patient voice more in how they run the practice. This will include working more closely with the patient participation group (PPG) and ensuring a more active presence for the PPG in decision making at the practice.

Looking to the future, Gemma says “We are very proud of what we have achieved, but we won’t be over-confident; the next time we are inspected, we will be outstanding. Because this is who I am.”

**“It was really helpful, but my concern is that people might not know this resource is available to them, and that can be a barrier to improvement. We need to support each other more.”**

**Gemma Hepburn-Morris,  
Practice Manager**

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# Victoria Park Medical Centre

Bridgwater, Somerset

November 2016

Rated as good

February 2016

Rated as inadequate

**Victoria Park Medical Centre occupies part of a purpose-built community development, which was built in the grounds of a local park.**

It serves a relatively young population of 4,600, some of whom live in one of the most deprived parts of Somerset.

The area has a poor public health profile and relatively high rates of obesity, smoking and drug and alcohol addictions.

When CQC inspected the practice in February 2016, it was rated as inadequate overall and placed into special measures (at this time the practice was known as Doctors Lewis, Hawkes and Dicks). Although staff knew how to raise concerns and report incidents and near misses, reviews and investigations were not thorough enough and there was no clear non-clinical leadership structure and formal governance arrangements.

A follow-up inspection in June 2016 found that the practice had met the urgent requirements, and this was followed by a further comprehensive inspection in November 2016, which found significant improvements and rated the practice as good in all five key questions and good overall. The report noted that risks to patients were assessed and well managed, staff had received training to deliver effective care and treatment, and that patients reported finding it easy to make an appointment with a named GP.

## Reaction to being rated inadequate

"I was devastated," admits Dr Catherine Lewis, now the sole partner. On the day of the inspection, the inspectors took her to one side and started to explain their findings about the management of the practice.

The CQC inspection could hardly have come at a worse time for the practice. Nine months earlier, one of the three partners had decided to leave. Initially, they had struggled to replace her, getting by with locums until a salaried doctor could start part-time later in the year. Then a second partner decided he was going to move abroad. At the same time, there had been ongoing discussions

DRIVING IMPROVEMENT – CASE STUDIES FROM 10 GP PRACTICES

with NHS England about the PMS contract that had cast doubts on the financial viability of the practice – and worried the staff.

“Within the space of a year, two of the partners had left, and I was on my own,” says Dr Lewis. “We were going through a very tough time, but I knew we were keeping things together from the perspective of what we were doing for the patients. I don’t think there were any difficulties clinically, but on the paperwork side I had to put a lot of faith in assurances I was given that everything was as it should be. Because of the clinical demands of the job I couldn’t verify that everything was correct.”

Dr Val Sprague, who had been working there as a locum for the last three months, was surprised by the rating – although she recognised that some of the admin protocols may have been out of date.

“I think Catherine had so much to cope with, there had been a lot of trust left with other people, and unfortunately things hadn’t been done. It’s very hard if you are the only GP here to keep an eye on every single thing going on. I can see how those things had happened – although I didn’t feel that anyone had come to harm.”

“When the report was released we were headlines in the Bridgwater local paper, we had a lot of letters of support from patients saying we can’t believe this, this can’t be right. We thought it was all so public – but actually the public don’t really know what it is all about – and we carried on giving really good clinical care because we do here.”

Although patients said they were treated with compassion, dignity and respect and were involved in decisions about their treatment, some did not find it easy to make an appointment because they could not always get through by phone.

Clinical risks to patients were well-managed, but the practice had no clear non-clinical leadership structure, and limited formal governance arrangements. Policies and procedures were overdue for review.

## Approach to improvement

Dr Catherine Lewis went through the first inspection report line by line, creating a spreadsheet to identify the issues and specific actions that could be taken in each case.

Her first call was to contact the local medical committee, who sent an experienced practice manager, initially to offer short-term support. Claire Gregory had visited the practice in the past as part of a team assessing practices for the old primary care trust. As the practice manager representative on the local medical committee, she was aware of Victoria Park, and she could see that the main problem was simply that of a busy GP who needed more help to manage the non-clinical side of the practice.

Claire says: “As soon as I got to know Catherine well, I knew there would be no problem. A lot of GPs leave it all to the practice manager and that can work well – depending on the manager. Cath is very switched on – she is directly involved and knows what is going on.”

## Staffing

Once Claire had agreed to come in to Victoria Park one day a week, her immediate priority was the staff (now 15 people in total including admin staff, GPs, nurses and healthcare assistants).

She says: “I realised that I was a new person – and an unknown. I needed to reassure them that they could come and talk about anything that worried them. My aim was to get them back on track, sort out the systems and processes so things were clearer for them... just make it as nice a place to work as it could be,



**“It was a question of tackling the ‘must-dos’ first before moving on to the things we would do in an ideal world. Really the priority was to sort out the CQC list, recognising that we couldn’t do everything at once. The CQC report gave me a steer as to what to look at first.”**

**Claire Gregory**  
Practice Manager

make sure they were content and that the things they needed to support them were in place.”

Harry Clarkson, who provides IT and admin support, found that the new manager made an enormous difference.

“As far as we’d been concerned, everything had seemed to be running relatively smoothly... but at that time my admin duties were never really that clear. It was only after the inspection that my role, everyone’s role, became much more defined, in the way you’d expect it to be. That made everyone’s job a lot easier, everyone knew what was expected – all of our training materials were reinforced to us.

“When we got the first inspection report we were knocked back on our feet, but we rallied quite quickly and things started getting fixed. We recognised the issues we had and started working on them in every area where we weren’t satisfactory. We bounced back really quickly.”

## **Policies and procedures**

It didn’t take long for Claire to identify where the gaps were. Although the policies may have been there it was not always obvious where to find them.

“I was a little concerned about things that were not in place: little things like I tried to establish what someone’s normal working pattern would be but I just couldn’t find it. They knew they worked 30 hours a week – but you just couldn’t find what they were expected to do on a day-to-day basis.

“I think that was something that was found on the inspection as well – people couldn’t find what they needed so you felt you couldn’t answer CQC’s questions. They were asking for proof of something but you felt you couldn’t lay your hands on it. I think some of this came to light later but it might have been out-of-date, or not reviewed.

“It was a question of tackling the ‘must-dos’ first before moving on to the things we would do in an ideal world. Really the priority was to sort out the CQC list, recognising that we couldn’t do everything at once. The CQC report gave me a steer as to what to look at first.”

## **Patient appointments**

The inspection had concluded that although patients said they were treated with dignity and respect they did not find it easy to see a doctor when they wanted.

Dr Steve Robson, a salaried GP, had noticed that it was not as easy for patients to get appointments as it had been at his previous practice.

“People were struggling to get appointments,” he says. “I remember there was a period where reception would turn up and there were only about five appointments available that day because everything had been pre-booked. There wasn’t much capacity to fit people in from the day’s stuff, which did cause a bit of chagrin – it meant us all having to do backflips to try to fit people in to be seen, and move things around.

“It always felt a bit stressful for the reception staff: Reception sometimes feel responsible for how patients flow through the surgery – when they turn up for work and there aren’t many appointments available, it makes them feel stressed. And the patients seem happier when they can see a doctor quickly.”

Claire Gregory says: “People used to moan about the phone system...especially when they’d been trying to get through at busy times and then phones were engaged. It was a very old system – we had so much negative feedback about it so we changed it. It’s not perfect now; there are only so many lines, but it puts people into a queueing system.”

## Significant events

In February the inspectors had found that while staff did raise concerns and report incidents, the reviews and investigations were not thorough enough. Patients did not always receive an apology.

Claire Gregory says: “There wasn’t a process in place. Now everyone knows to complete the significant event form (including reception and the nurses). If something happens, it’s now ingrained on everyone that, actually, we can learn from this, so let’s fill out an event form. They’re not frightened of doing it... I’ll get the form first because sometimes there are things that need acting on immediately and I’ll talk about it with the person concerned. But then as a learning point we will also talk about it at the staff meeting.”

## Views on CQC

Clare Gregory says, “I thought our inspector was brilliant; she was very supportive, she understood the difficulties and the complexities the practice was going through.

“The inspection team obviously had real concerns, although I’m glad they recognised that, clinically, the practice was really good and it was the managerial side that was the issue: they did fully recognise that.”

Dr Robson says, “I felt that the inspection report focused on some of the organisational aspects and some of the care planning that wasn’t good enough, including admin behind the scenes or things which we hadn’t really been doing up until the inspection, like significant event reflections and regular practice meetings looking at how we performed or managed complaints.”

## Sustaining and developing

Within 10 months of that initial inadequate rating Victoria Park Medical Centre had been turned round. Dr Catherine Lewis and her small team of part-time GPs could concentrate more on their patients – and CQC inspectors were able to rate the practice as good in all areas.

Dr Lewis says, “It wasn’t a bad thing for us in the long run. We were lucky in a lot of ways that our patients were incredibly supportive. After the piece in the paper about us having an inadequate inspection, they carried a piece with one of our patients the following week saying that we’d saved her life, and that got a lot more prominence in the paper. We got support from the community, and we didn’t lose patients either; we got a lot of letters of support.”

Claire Gregory is satisfied that the practice fully deserves its current good rating. “I’m now in the nice position where most of the things that needed doing have been sorted out. There is a small list of things we can to improve even more rather than the urgent list we had after the inspection.”

Dr Lewis says, “In hindsight, the inspection gave me the opportunity to sit down and review everything – to look at what the practice was about: are we actually viable, what do we need to do to be viable, what are the things we need to change, the key staff we need to have in place? It did give me a huge amount of momentum to make some progressive changes that were useful.

“If this hadn’t come to light I suspect that things would have carried on in much the same way. The staff morale was not very high at the time... without this inspection it would have been a lot more difficult to make the changes that were needed.”

On the surgery walls, signs spell out the practice ethos:

**“Victoria Park medical centre is a close knit team and responsible community partner providing safe, responsive patient-centred quality care while developing the team through further learning and encouraging community cohesion. Our mission is to provide the best possible care for our patients.”**

## How to contact us


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