Dr Richard Hattersley

Quality Report

Boscombe Manor Health Centre
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Bournemouth
Dorset
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused inspection of Dr Richard Hattersley on 31 May 2016 to assess whether the practice had made the improvements in providing care and services that were safe, effective and well-led. The practice was able to demonstrate that they had made some improvements. However, the practice was unable to demonstrate that they were fully meeting the standards. The practice remains rated as requires improvement for safe, effective and well-led services. The overall rating for the practice remains as requires improvement.

We had previously carried out an announced comprehensive inspection at Dr Richard Hattersley on 2 September 2015 when we rated the practice as requires improvement overall. The practice was rated as good for being caring and responsive and requires improvement for safe, effective and well-led. This was because blank prescriptions were not safely tracked by the practice. There were also gaps in the employment checks necessary for staff. We also found a lack of governance systems to adequately monitor patient outcomes and manage risks to patients and staff.Following our last inspection we asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time.

This report should be read in conjunction with the full inspection report.

Our key findings across the areas we inspected on 31 May 2016 were as follows:

- Risks to patients were assessed and well managed, with the exception of emergency procedures.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Data on patient outcomes was used to monitor the performance of the practice. However, the practice was performing below local and national averages.
- Governance arrangements were in place, however these were not consistently effective.

The areas where the provider must make an improvement are:

Summary of findings

- Ensure that governance systems operate effectively. For example, the practice must review the system in place for checking emergency equipment.
- Ensure that performance for patient outcomes relating to the Quality Outcomes Framework improves.
- Conduct a robust risk assessment to determine whether a defibrillator is necessary at the practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- There was a system in place for reporting and recording significant events, however this was not consistently robust.
- Risks to patients were assessed and well managed, with the exception of the management of emergencies. Some emergency equipment was out of date and the practice did not have a defibrillator or an adequate risk assessment to justify the rationale for not having one.

Are services effective?

Requires improvement

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

- The practice exception reporting for Quality and Outcomes Framework (QOF) indicators was higher than Clinical Commissioning Group and national averages. showed patient outcomes were at or above average compared to the national average.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff understood the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, but these were not consistently implemented.
- There were systems in place to monitor and improve quality and patient outcomes, but these had not demonstrated significant improvement.
- The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

- The practice had systems in place for notifiable safety incidents and shared this information with staff so appropriate action could be taken. However, we found that this was not always communicated to staff in a timely way.
- Clinical meetings between GPs took place weekly, however these were not documented. Information about the practice was not consistently shared with staff.
- Risks to patients were not consistently well-managed. The systems at the practice were not effective enough to consistently protect patients. We found that emergency equipment was checked regularly, however oxygen masks were found to be out of date.

The practice sought feedback from staff and patients, which it acted upon.

Dr Richard Hattersley

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was lead by a CQC lead inspector. The team also included a practice manager specialist advisor.

Background to Dr Richard Hattersley

Dr Richard Hattersley, known locally as Boscombe Manor Health Centre, is based in Boscombe, a suburb of Bournemouth, Dorset. It has been at its present location since 1996, and operates out of a converted Victorian era building.

The practice is part of Dorset Clinical Commissioning Group and has an NHS general medical services contract to provide health services to approximately 3,000 patients. The practice is open from 8.00am to 6.30pm from Monday to Friday and between 7.30am and 6.30pm on Mondays and Thursdays. The practice has opted out of providing out-of-hours services to their own patients and refers them to South Western Ambulance Trust via the NHS 111 service.

The number of male and female patients aged between 25 and 45 years old is higher than the national average. The practice is based in an area of high social deprivation and includes a very transient population of varying ages. The practice has more than twice the national average for patient turnover. Approximately 25% of the practice population changes every year; however the number of patients registered at the practice has remained constant. A high proportion of patients at the practice are effected by serious mental illness and/or substance misuse.

Approximately one third of patients registered at the practice do not speak English as a first language, with the majority of these originating from an Eastern European background.

The practice has one GP and one salaried GP who together offer 14 sessions to patients. Both GPs are male. The practice has one female practice nurse and a female health care assistant. The GPs and the nursing staff are supported by a team of admin staff, a practice manager assistant and a practice manager.

We carried out our inspection at the practice's only location which is situated at:

Dr Richard Hattersley

Florence Road

Boscombe

Bournemouth

Dorset

BH5 1QH

We previously inspected Dr Richard Hattersley on 2 September 2015. Following this inspection, the practice was given an overall rating of Requires Improvement. A copy of the report detailing our findings can be found at www.cqc.org.uk

Why we carried out this inspection

We carried out an announced inspection at Dr Richard Hattersley on 2 September 2015 when we rated the

Detailed findings

practice as requires improvement overall. Specifically, the practice was rated as good for providing responsive services and being caring and requires improvement for providing safe, effective and well-led care.

As a result of the inspection in September 2015, the provider was found to be in breach of regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that blank prescriptions were not safely tracked by the practice. There were also gaps in the employment checks necessary for staff. We also found a lack of governance systems to adequately monitor patient outcomes and manage risks to patients and staff.

The provider sent us an action plan of the changes they would make to comply with the regulations they were not meeting at that time.

How we carried out this inspection

We revisited Dr Richard Hattersley as part of this inspection. We carried out a focused review based on the evidence observed on inspection and information the practice provided to us prior to and during our inspection.

We visited the practice on 31 May 2016 to check the necessary changes had been made.

Requires improvement

Are services safe?

Our findings

Monitoring risks to patients

At our last inspection on 2 September 2015, we found that appropriate recruitment checks were not consistently undertaken. A GP and a health care assistant had started to work at the practice without written evidence of conduct in their previous employment, written employment history, proof of eligibility to work in the United Kingdom and proof of identity. This meant the practice could not be assured that staff employed were appropriate. On 31 May 2016, we checked the files of these staff members and found all checks had now been appropriately undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We also reviewed the files of two further staff members employed since April 2013 and found recruitment checks were appropriately conducted.

At our last inspection, we found that blank prescription forms were not tracked to record how they were distributed within the practice. This was not in accordance with national guidance so that prescription usage can be identified when required. On 31st May 2016 , we found evidence that national guidance had been cascaded to all staff. Prescriptions were now logged at the time of issue to each GP. We found that prescriptions were stored securely when not in use, including at the end of each day. Staff we spoke to could explain the process for the safe tracking of prescriptions clearly.

The practice also shared with us the progress they had made to areas which were recommended following our last inspection.

At our last inspection, we found areas of concern related to fire safety. We found incomplete records of fire safety tests which included fire alarms and emergency lighting. We recommended that the practice review their fire safety procedures. Since our last inspection, the practice had undertaken significant work to improve fire safety at the practice. A new fire alarm system had been installed in January 2016, which included new smoke detectors. New fire door closures had also been installed in February 2016. Staff carried out regular checks which included emergency lighting, fire extinguishers escape routes, smoke alarms and fire drills were occurring on a monthly basis. The practice had been independently assessed and was found to be fully compliant with fire safety legislation.

At our last inspection, we found that the practice did not have a defibrillator available on the premises or a recorded rationale for why this was not needed. We found on 31 May 2016, the practice had completed a risk assessment and maintained that a defibrillator was not necessary. We were given a copy of a risk assessment conducted in March 2016 by the GPs, however the risk assessment was not adequate. It referred to a review of evidence which supported the practice view that a defibrillator was not necessary. No further details of this evidence was detailed and the risk assessment did not refer to national guidance. No estimation of the level of risk was included in the assessment. We were told that the response time of emergency services to the practice was seven minutes, and therefore a defibrillator was not necessary. We were told the risk assessment will be reviewed every two years.

At our last inspection, we found that not all emergency equipment was in date. An adult mask was found to be dated November 2013, this was replaced by the practice. On 31 May 2016, we were shown records that emergency equipment was checked every three months that included a date and a tick to indicate a check had been carried out at regular intervals, but not what these checks related to. We were told that the checks included expiry dates and to confirm that packaging was intact. The practice had recently purchased new adult masks; these did not display a visible expiry date. The practice nurse was unable to say how the practice were reassured that the masks were in date and safe to use. We found a children's oxygen mask that was past its use by date of November 2013. The practice informed us they would replace this immediately.

At our last inspection, we found two tubes of medicine in a cupboard which belonged to a patient who no longer needed it. Since this inspection, the practice have developed a protocol for the disposal of medicines that were expired or no longer required by patients.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for patients

At out last inspection on 2 September 2015, we found that improvements to the quality of services, based on data from quality outcome tools, had not been acted upon. The practice participated in the Quality and Outcomes Framework (QOF). QOF is a system intended to improve the quality of general practice and reward good practice.

Concerns associated with the high exception reporting were raised with the GP and practice manager at our last inspection. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Since our last inspection, the practice held a meeting in November 2015 to discuss exception reporting levels and a practice wide approach to reduce this. The practice had conducted an audit of a randomly selected 25 patients who had previously been exempt from QOF to review whether the exception reporting had been appropriate. Of 25 patients, the practice found that exception reporting was appropriate in 22 patients (88%). They identified a coding error for one patient and the other two patients were thought to have moved out of the area but had remained registered at the practice. Further review identified other patients no longer using the practice. The practice list records were being amended accordingly, following the local health authority procedure.

For the QOF period 2014-2015, the practice's exception reporting was 26%, which was higher than local and national averages. However the practice level data, which had not been externally verified, showed that the current exception reporting at the time of our inspection had decreased to 22%. The practice were aware that this rate was still high and were actively seeking to improve on this figure through better coding and the removal of other patients from the list who have moved out of the area. A protocol had also been developed to support the recall process for patients who did not attend for appointments.

On 31 May 2016, we saw that exception reporting for cervical smears was 21% for 2014-2015. The practice had improved the efforts taken to promote the uptake of cervical smears by eligible women. A large proportion of the practice population were people newly arrived to the United Kingdom without complete records of cervical smear testing. All of these patients received a new patient health check. The practice had implemented a new protocol so that women receiving health checks who were eligible for cervical smears, were booked an appointment for this as part of their health check. The practice had also introduced an item in the practice newsletter highlighting the importance of smears. The practice also highlighted that women could speak with the practice nurse to find out more about cervical smears and to discuss any concerns.

At our last inspection we identified that for 2013-2014, the practice uptake for flu vaccination for patients aged over 65 years was lower than the national averages. Since our last inspection, the practice had completed an audit to identify which patient groups were not attending for Flu vaccination. We were told by the practice that some patients had chosen to attend local pharmacies for their vaccination instead of the practice and that the exact number of patients who attended pharmacies for their vaccine was difficult to determine. Flu rates had been discussed in a practice meeting. The practice had a plan for additional dedicated clinics for the next flu season in Autumn 2016.

Are services well-led?

Requires improvement

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

Our findings

Governance arrangements

At our last inspection in September 2015, we found that the practice lacked systems to monitor staff recruitment, medicines management and patient outcomes as set out in the Quality and Outcomes Framework (QOF). We also found that staff met regularly on an informal basis and that these meetings were not minuted.

On 31 May 2016 , we were shown evidence of where the practice had made improvements to its governance systems:

- There was a robust system for the management of blank prescriptions.
- The staff recruitment process was consistently safe and included all necessary checks. The recruitment policy had been updated to reflect the needs and requirements of the practice, and this was followed.
- The GP partner had attended a clinical governance meeting at a local high performing practice to observe how meetings were run at this practice. We were told that the GP had found this useful, but learning from this had not yet been implemented at the practice.

However, we found areas which required improvement:

- Although improvements had been made, exception reporting rates for the practice remained high. We were shown an action plan to address the high QOF exception reporting. This included details of an audit of patients who had been exempted from QOF, practice wide learning with regard to the importance of following up patients who do not attend for reviews and minutes of regular meetings to review exemption figures. The practice told us the current exemption figure was 22%, which is a reduction of 4% from our inspection in September 2015. The average for the Clinical Commissioning Group is 12% and the national average is 9%.
- There was a lack of robust systems to check emergency equipment and the risk assessment in support of the absence of a defibrillator was not adequate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not operate suitable systems and processes to assess, monitor and mitigate the risks relating to the health and safety of service users in the carrying on of the regulated activity.** • Systems for checking emergency equipment were not robust. • The provider had not completed an adequate risk assessment in relation to whether to hold a defibrillator. • Data relating to patient outcomes had not improved. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**