Dogsthorpe Medical Centre

Quality Report

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

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Overall summary

Letter from the Chief Inspector of General Practice

This was the third inspection that we had carried out at First Health (Peterborough) UK – Dogsthorpe Medical Centre.

On 19 May 2015 we carried out a comprehensive inspection of First Health (Peterborough) UK – Dogsthorpe Medical Centre. The practice was rated as requires improvement for providing safe, effective, caring, responsive and well led services. As a result of the findings on the day of the inspection the practice was issued with requirement notices for regulation 17 (Good governance) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 18 April 2016 we carried out a second comprehensive inspection. This inspection was responsive to a whistleblower raising concerns about the practice and to check if the practice had made the changes identified in May 2015. The practice was rated inadequate for providing safe, effective, responsive and well led services, and requires improvement for providing caring services.

Summary of findings

At our April 2016 inspection we found that the practice had taken some action to address a number of the shortfalls previously identified. However, inadequate action had been taken to assess or act on other risks, such as the monitoring of significant events and improving patient access. Patients were at risk of harm because systems and processes were not in place to keep them safe. The systems and processes in place to ensure good governance were ineffective and did not enable the provider to assess and monitor the quality of the services and identify, assess and mitigate against risks to people using services and others. As a result of the findings on the day of the inspection the practice was issued with requirement notices for regulation 9 (Person-centred care) and regulation 13 (Safeguarding service users from abuse and improper treatment), and a warning notice for regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The practice was placed into special measures for six months.

On the 14 September 2016, we conducted a focused inspection to ensure that the practice had made the required improvements detailed in the warning notice that had been issued on 17 May 2016 following our inspection of 18 April 2016.

Our findings from this inspection are as follows:

- The practice was unable to demonstrate that they had made sufficient improvements to drive all of the changes necessary for the practice to meet the requirements of Regulation 17 (Good governance) to keep patients safe.
- The practice did not maintain appropriate records to demonstrate that significant events had been analysed, investigated and reviewed at a later date. Learning outcomes were not detailed and showed a lack of clinical oversight in ensuring that the significant events did not reoccur.
- Not all staff we spoke with felt confident that robust arrangements were in place to safeguard children and vulnerable adults from abuse.
- The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system. The practice failed to review pathology results and discharge paperwork from secondary care providers in a timely manner, and the management of correspondence was not always delegated to a staff member who was appropriately trained and qualified.
- Patients we spoke to on the day of inspection told us that they were unable to get appointments when they needed them. We were also told that same day appointments were not always available for children.

Following our focused inspection on 14 September 2016 we took urgent action to suspend First Health (Peterborough) UK from providing general medical services at Dogsthorpe Medical Centre.

This report covers our findings in relation to our focused inspection. You can read our findings from our last inspections by selecting the 'all reports' link for Dogsthorpe Medical Centre on our website at www.cqc.org.uk

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

Dogsthorpe Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a second CQC inspector, a practice nurse specialist adviser and an expert by experience.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was carried out because at the 18 April 2016 inspection the service was identified as being in breach of the legal requirements and regulations associated with the Health and Social Care Act 2008.

Specifically, these were breaches of Regulation 9 (Person-centred care), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our concerns led us to serve a warning notice for breaches of Regulation 17 (Good governance) and requirement notices for breaches of Regulation 9 (Person-centred care) and Regulation 13 (Safeguarding service users from abuse and improper treatment).

The inspection undertaken on 14 September 2016 was carried out to check the provider had made sufficient improvements to the issues detailed in the warning notice served on 17 May 2016 following the inspection on 18 April 2016 or to see if further enforcement action was necessary.

How we carried out this inspection

Before visiting, we reviewed the issues found at the 18 April 2016 inspection and the warning notice served 17 May 2016. We also reviewed the information supplied by the provider as evidence of the actions taken to address those issues. We carried out an announced visit on 14 September 2016.

During our visit we spoke with a director of First Health (Peterborough) UK Limited, a locum GP, a nurse, and managerial, administration and reception staff. We also spoke with patients who used the service. We viewed medical records, policies, procedures, significant event and complaints logs, and minutes of meetings held at the practice.

Our inspection focused on the safe, effective, responsive and well led domains.

Are services safe?

Our findings

Safe track record and learning

During our inspections on 19 May 2015 and 18 April 2016 we found evidence that there was scope to improve the reporting, analysis and learning from significant event reporting at the practice. For example, on 18 April 2016 we viewed minutes of the practice's clinical meetings for 6 January 2016, 20 January 2016, 3 February 2016 and 2 March 2016 and found a number of significant events that had been discussed at the meeting but had not been entered on the practice's significant event log.

On this visit, we reviewed the practice significant event log alongside minutes from recent clinical meetings. We found that the practice did not maintain appropriate records to demonstrate that significant events had been analysed, investigated and reviewed at a later date. The significant events we viewed lacked detail and additional evidence to support investigation of why the significant event occurred. Learning outcomes were not detailed and showed a lack of clinical oversight in ensuring that the significant events did not reoccur. Significant event forms did not include a review date, nor was there a system in place to identify and investigate trends in the significant events being reported.

We reviewed a significant event dated 20 June 2016. A patient's blood test result had been received on a Friday afternoon and had not been dealt with by a clinician until the following Monday. The patient had a deranged blood result and was then urgently admitted to hospital. The learning outcome of this significant event was for administration staff to alert clinicians of urgent blood results for actioning straight away. Another learning outcome was to create a protocol for the administration team, however we were unable to locate a copy of this. We did not find evidence of how members of the administration team were trained to recognise an urgent blood result, or how the impact on the patient was considered within the significant event.

We reviewed the minutes of a clinical meeting dated 29 June 2016. Item six, listed as a new item on the agenda, stated that a midwife had called in regard to a patient not being prescribed iron supplements as the reception team had refused to take the written prescription request. The meeting minutes noted that the practice manager was due to discuss the refusal of written prescription requests with the reception team by 6 July 2016. This had not been logged as a significant event and we did not see any evidence of further investigation to ascertain how and why this had occurred.

Overview of safety systems and processes

Not all staff we spoke with felt confident that robust arrangements were in place to safeguard children and vulnerable adults from abuse. We viewed the safeguarding policy which was accessible to all members of staff, however we were told by a member of staff that due to the lack of permenant staff the safeguarding lead was a locum GP who was unaware that they had the safeguarding lead role. A member of staff told us that they had raised a concern to practice management, however this had not been taken further.

During our inspection on 18 April 2016 we found no evidence that the practice had a system in place to monitor and record the quality of cleaning undertaken by the external cleaning company used. This was against the practice policy. On our inspection on 14 September 2016 we found that regular spot checks were being undertaken and appropriately recorded.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

During our inspection on 18 April 2016 we found that there was no formal system in place to ensure that guidance from the National Care Institute of Health and Care Excellence (NICE) was disseminated effectively to staff. One GP told us that no NICE guidance had been received since November 2015, as a result of the practice manager being on sickness leave.

On our inspection on 14 September 2016 we found that an effective system had been implemented by a regular locum GP who worked at the practice. This meant that all clinical staff were kept up to date with best practice guidelines to deliver care and treatment that met patients' needs.

Coordinating patient care and information sharing

During the course of our inspection on 14 September 2016 we found that the information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system.

We identified that the practice failed to review pathology results and discharge paperwork from secondary care providers in a timely manner, and that the correspondence was not always delegated to a staff member who was appropriately trained and qualified.

For example, we saw evidence of nursing staff and emergency care practitioners reviewing pathology results and patient discharge letters. We found that there was no formal support, training or supervision of these members of staff to review this incoming correspondence. Furthermore, we were told that the work was allocated to nursing staff and emergency care practitioners by a reception supervisor. We did not see any evidence of formal training or supervision to enable safe and correct delegation of incoming correspondence to different members of the clinical team.

Patient records we reviewed demonstrated a lack of clinical oversight in managing incoming correspondence. For example, we viewed a patient record with a letter from a Rheumatology Department attached. The correspondence recommended that the patient was commenced on a medicine and actively monitored, however the letter had been filed away by the administration team and not seen by a clinician for over six weeks.

During our inspection on 18 April 2016 we found that multidisciplinary team meetings were irregular, therefore it was unclear how the practice was assessing and co-ordinating patients' care. On our latest inspection, we found that multidisciplinary team meetings were being held fortnightly.

In April 2016 we found that the practice had signed up for the Avoiding Unplanned Admission enhanced service, however only seven out of the 81 patients listed on the register had a care plan in place. On our latest inspection, we saw that the practice had proactively reviewed patients registered on the Avoiding Unplanned Admissions register, and that all of the patients on the register now had a care plan in place to ensure the care delivered met their needs.

Furthermore, on 14 September 2016 we found that the practice had increased the number of health checks provided to people with learning difficulties.

Supporting patients to live healthier lives

During our inspection on 18 April 2016, we found that breast and bowel cancer screening rates were significantly below local and national averages. We found that the practice was not taking any active measure to improve uptake of these checks. Since the previous inspection, the practice had placed health promotion materials in the waiting area of the practice to encourage uptake.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During our inspection on 18 April 2016, we found that there was no system in place for seeking the views and feedback from the large Asian population within the practice catchment area. A patient participation group had been set up since the previous inspection and two meetings had been held at the practice. However, we did not see any meeting minutes to evidence discussion.

Access to the service

In order to meet demand for appointments, the practice had implemented a new patient triage system whereby the nurse and an emergency care practitioner screened requests for appointments. The practice felt that this had improved patient access to appointments. We viewed the appointments available for the next seven days and saw that there was a range of appointment slots available.

However, people told us on the day of inspection that they were unable to get appointments when they needed them.

We were also told that same day appointments were not always available for children. A paient told us that they had moved their child to another practice as they were unable to get urgent appointments when required. Another patient told us that they had been registered for many years, and that it was becoming increasingly difficult to access timely care.

Healthcare professionals from the wider community team told us that they found it difficult to communicate with the practice due to the long wait on the telephone line.

These comments correlated with data taken from the National GP Patient Survey results which were published in July 2016. For example, survey results indicated that 66% of patients said that they were able to get an appointment to see or speak to someone last time they tried. This compared to a local average of 87% and a national average of 85%. Furthermore, only 43% of patients said that they found it easy to get through to the practice by phone, compared to a local average of 75% and the national average of 73%.

Are services well-led?

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

Our findings

Governance arrangements

During our inspections on 19 May 2015 and 18 April 2016 we found evidence that there were inadequate systems or processes in place to ensure that care and treatment was provided to patients in a safe way. We had found evidence that the governance framework at the practice was not sufficiently robust to keep patients safe.

During our inspection on 14 September 2016 the practice was unable to demonstrate that they had made sufficient improvements to drive all of the changes necessary for the practice to meet the requirements of Regulation 17 (Good governance) to keep patients safe.

In addition to this, we found further concerns during the course of the inspection which demonstrated that there was no overarching governance framework in place at the practice. For example, the practice had failed to implement policies and procedures to ensure that patients' medicines were managed safely. Furthermore, the practice had failed to implement robust policies and procedures to give assurance that pathology results and correspondence from secondary care centres were managed safely. These concerns illustrated a lack of clinical oversight into the management of patients' health needs.

The practice did not reassure us that the practice had an effective leadership structure and management capability to facilitate necessary change. Furthermore the practice's leadership team was not underpinned by safe and effective systems, processes, and governance arrangements designed to protect patients.

Some members of the practice staff we spoke with felt that there had been a greater emphasis on trying to improve the service since the previous inspection in April 2016. However, other members of the team felt that services had not improved and that access to safe care for patients had become progressively worse. This was because it was felt that there had not been sufficient leadership capacity in place to adequately encourage and embed improvement.