Rigg Milner Medical Centre

Inspection 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.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Overall summary

We carried out an announced inspection at Rigg Milner Medical Centre on 28 May 2021. Overall, the practice is rated as Inadequate.

Safe - Inadequate

Effective - Inadequate

Caring - Inadequate

Responsive - Inadequate

Well-led - Inadequate

Following our previous inspection on 24 February 2020, the practice was rated Requires Improvement overall and for all key questions and population groups.

The full reports for previous inspections can be found by selecting the 'all reports' link for Rigg Milner Medical Centre on our website at www.cqc.org.uk

Why we carried out this inspection

This inspection was a comprehensive inspection to follow up on:

A requirement notice served following our last inspection relating to:

- Legionella flushing.
- Reviews of monitoring tests prior to prescribing a repeat medication.
- The risk posed to two patients diagnosed with Atrial Fibrillation, who were not prescribed appropriate medicine to reduce the risk of a stroke.
- Systems for patient feedback on satisfaction.
- Sustainability of new governance systems.

Also, to review areas identified at our last inspection as a should:

- Ensure that where actions are identified from a risk assessment, there is a clear, documented track of actions taken.
- Continue to monitor and improve the practice performance for cancer screening and childhood immunisations.
- Improve the effectiveness of the quality improvement and audit.
- Review confidentiality arrangements for receptionists handling calls at the front reception desk.

How we carried out the inspection

Throughout the pandemic, the Care Quality Commission has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

Overall summary

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice's patient records system and discussing findings with the provider.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit.
- Sending a questionnaire to practice staff to complete.

Our findings

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as Inadequate overall and Inadequate for all population groups.

We found that:

- Not all areas identified at our last inspection had been addressed.
- Systems in place to keep patients safe and safeguarded from abuse were not effective.
- There were gaps in systems to assess, monitor and manage risks to patients.
- Systems for learning and improving the quality of care were ineffective.
- We were not assured that all staff were trained to perform their role, supported by leaders and aware of their roles and responsibilities, due to a lack of oversight and effective leadership.
- There was limited evidence that where areas of lower performance were identified a whole practice approach was taken to drive improvements.
- Feedback from patients about their experience of care and ability to access care and treatment remained below the local and national averages.
- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic.
- Complaints were not being handling in accordance with guidance and the system was ineffective.
- The culture within the practice was not conducive to staff feeling supported to put forward ideas to improve the quality of care or raise concerns.
- The way the practice was led and managed did not promote the delivery of high-quality, person-centred care.

We found one repeated breach of regulation. The provider **must**:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Take action to display the CQC rating and link to the latest report, on a website maintained by the practice.

Overall summary

- Take proactive steps to improve the practice performance for cancer screening and childhood immunisations.

Due to the level of concerns identified at this inspection, as to non-compliance, the Commission decided to issue a notice of proposal to impose conditions on the provider's CQC registration. For further information see the enforcement section of this report.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. Special measures will give people who use the service the reassurance that the care they get should improve.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

Older people	**Inadequate**
People with long-term conditions	**Inadequate**
Families, children and young people	**Inadequate**
Working age people (including those recently retired and students)	**Inadequate**
People whose circumstances may make them vulnerable	**Inadequate**
People experiencing poor mental health (including people with dementia)	**Inadequate**

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Rigg Milner Medical Centre

The service is provided by Dr Reshma Rasheed and is based at Rigg Milner Medical Practice in East Tilbury. The practice has two sites at which it provides regulated activities; one at East Tilbury and one at Corringham. Patients can access services at either surgery. Corringham branch address: 114 Giffords Cross Road, Corringham, Essex, SS17 7QQ. We did not visit the branch site as part of our inspection.

The practice is situated within the Thurrock Clinical Commissioning Group (CCG) and delivers General Medical Services (GMS) to a patient population of about 6252. This is part of a contract held with NHS England. The practice is registered with the CQC to carry out the following regulated activities - diagnostic and screening procedures, surgical procedures, family planning services, maternity and midwifery services and treatment of disease, disorder or injury.

The practice has one female GP, who is supported by several long-term locums, a number of nursing staff and a number of administrative and clerical staff including an operations manager. The practice is part of a primary care network (PCN) of local GP practices. Extended access is provided locally by Thurrock Health Hubs, where late evening and weekend appointments are available. When the practice is closed, out of hours cover for emergencies is provided by IC24 via 111.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations. If the GP needs to see a patient face-to-face then the patient is offered a choice of either the main GP location or the branch surgery.

There are slightly higher numbers of patients aged 65+ registered at the practice. Both female and male life expectancy is higher at the practice compared with the CCG average. 95.2% of the practice population are white, with the remainder being of mixed race, Asian, black or other ethnicity.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures Family planning services Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Following the inspection, a Notice of Proposal to impose conditions on the provider's registration was issued under Section 12 of the Health and Social Care Act. The registered persons had not done all that was reasonably practicable to establish and operate effectively systems and processes to assess, monitor and mitigate the risks relating to the health and safety of service users. In particular: • Not all areas identified at our last inspection had been addressed. • Systems in place to keep patients safe and safeguarded from abuse were not effective. • There were gaps in systems to assess, monitor and manage risks to patients. • Systems for learning and improving the quality of care were ineffective. • We were not assured that all staff were trained to perform their role, supported by leaders and aware of their roles and responsibilities, due to a lack of oversight and effective leadership. • There was limited evidence that where areas of lower performance were identified a whole practice approach was taken to drive improvements. • Complaints were not being handling in accordance with guidance and the system was ineffective. • The culture within the practice was not conducive to staff feeling supported to put forward ideas to improve the quality of care or raise concerns. • The way the practice was led and managed did not promote the delivery of high-quality, person-centred care.