Dr Mark Stevens

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Following our inspection which took place on 1 September 2016, we took urgent action to suspend Dr Mark Stevens from providing general medical services at Mapperley Park Medical Centre.

We conducted a further announced focused inspection on 30 November 2016 to check whether the provider had made sufficient improvements in respect of being safe and well led and to decide whether the suspension period should be ended.

Summary of findings

The ratings remain the same, inadequate overall and that the special measures period continues. We will inspect again to ensure that improvement requirements have been met.

This report covers our findings in relation to our focused inspection of safe and well led. You can read our findings from our last inspections by selecting the 'all reports' link for Dr Mark Stevens on our website at www.cqc.org.uk.

Our key findings across the areas we inspected were as follows:

- A system had been developed to ensure significant events and patient concerns were monitored in a systematic way to ascertain lessons learnt and to indicate any areas for on-going development.
- Systems had been established to ensure the practice was receiving national patient safety alerts.
- A system had been established to ensure contemporaneous patient records were always maintained for every patient consultation.
- New systems had been implemented to made sure referrals to secondary care were acted upon in a timely manner to ensure co-ordinated care and treatment for patients.
- Two new part time practice managers had been recruited, along with new reception staff and a practice nurse.
- During previous inspections we found that accurate and contemporaneous record were not being kept for each patient following consultation. Although we could not test this operationally, at this inspection we found that the provider had further implemented a system that would allow accurate and contemporaneous records to be kept.
- At our previous inspection we found that nationally available patient safety information including Medicines Health and Regulatory Authority (MHRA) alerts were not always being obtained and followed. At this inspection we found that the provider had ensured that they were registered to receive all patient safety alerts.
- At our previous inspection we found that the provider did not have an effective system for the review and management of high risk medicines. The provider had reviewed their systems and incorporated improvements.
- All of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

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?

We reviewed the systems developed by the practice to ensure that the practice governance, systems, and processes were in place to ensure that patients were kept safe. We found that improvements had been made; these improvements required embedding into the structure and culture of the practice. Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

Are services well-led?

We reviewed the systems developed by the practice to ensure that the practice governance, systems, and processes were in place to ensure that patients were kept safe. We found that improvements had been made; these improvements required embedding into the structure and culture of the practice. Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability andsustainability of the new systems and processes can be determined.

Dr Mark Stevens

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 second CQC Inspector and a member of the CQC's Medicines Optimisation Team.

Background to Dr Mark Stevens

Dr Mark Stevens is a single handed GP providing primary medical services to 2,185 patients in the Mapperley Park and St Ann's area. The practice is also known as Mapperley Park Medical Centre and is located at Malvern House, 41 Mapperley Park Road, Nottingham, NG3 5AQ.

The practice holds a General Medical Services (GMS) contract for the delivery of general medical services. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Opening times are between 8.30am and 1pm every morning and 2pm to 6.30pm every afternoon with the exception of Thursday when the practice is closed. The practice operates an open access system for GP appointments each morning and patients are guaranteed a same day appointment if requested before 11.15am. Pre-bookable appointments are available six weeks in advance for afternoon surgery which runs from 3pm to 6.30pm Monday to Friday (with the exception of Thursday).

The level of deprivation within the practice population is above the national average with the practice population falling into the third most deprived decile. Income deprivation affecting children and older people is above the national average.

The clinical staff comprises of a full-time GP (male), a female GP who undertakes a Friday morning clinical session (five hours) and a full-time female practice nurse. Locum GPs are used to cover the primary GP in their absence The non-clinical team includes a co-proprietor (psychologist), a part-time practice manager and five part-time reception / administrative staff.

Dr Mark Stevens is a teaching practice for undergraduate medical students. There were no students on placement at the time of our inspection.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening procedures; maternity and midwifery services; and treatment of disease, disorder or injury. The practice has been inspected on the following dates:

- 14 January 2014, 14 August 2014 and 10 November 2014 based on the former inspection methodology which focused on specific outcomes.
- 13 and 14 March 2015 under the comprehensive inspection programme. The practice was rated Inadequate overall and placed in special measures for a period of six months.
- 1 December 2015 - The practice was rated inadequate overall and remained in special measures as it had not made the required improvements to achieve compliance with the regulations.
- 2 June 2016 – This was a focused inspection in response to information of concern indicating the provider was not meeting the conditions of its registration.

Detailed findings

- 1 September 2016 – This was a comprehensive inspection that led to the CQC urgently suspending the provider for a period of three months.

The practice has opted out of providing out-of-hours care to patients. Out-of-hours care is provided by Nottingham Emergency Medical Service (NEMS) through the 111 number.

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 because at the inspection on 1 September 2016 the service was identified as being in breach of the legal requirements and regulations associated with the Health & Social Care Act 2008.

Specifically breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our concerns led us to take urgent action to suspend Dr Mark Stevens from providing regulated activities at Mapperley Park Medical Centre.

We conducted a focused inspection on 30 November 2016 to check whether the provider had made sufficient improvements in respect of being safe and well led and to decide whether the suspension period should be ended.

How we carried out this inspection

Before visiting, we reviewed the issues found at the previous inspections and reviewed the Notice of Decision for the suspension. We reviewed the information supplied by the provider as evidence of the actions taken to address those issues. We carried out an announced visit on 30 November 2016.

During our visit we spoke with the sole GP, the two practice managers and three reception staff. We could not speak with the practice nurse who had recently been recruited. We viewed medical records, policies, procedures and recruitment files.

Our inspection focused on the safe and well led domains.

Are services safe?

Our findings

During all of our previous inspections, we found that accurate and contemperanaeous records were not being kept by the provider following patient consultations. The provider had implemented a new system in consultation with another local GP, to ensure that patients would have 12 minute appointment times with 3 minute breaks in between for the provider to complete records. Staff were involved in this process and would monitor the time patients spent with the GP. As part of this new process and to change the culture of the practice, a re-education programme for patients relating to their appointment times was also planned following the practice re-opening.

When we inspected on 1 September 2016, we saw examples of delayed referrals to secondary care and medicines not being added or removed from prescriptions following instructions from secondary care professionals between the period June and August 2016. During our inspection on 30 November 2016, we saw that the provider had implemented a new system to ensure that referrals to secondary care were not delayed. The new staff recruited were aware of the system.

When we inspected on 1 September 2016 the system in place for managing and acting upon alerts was not always effective and did not protect patients against the risk of harm. The GP was not routinely undertaking searches in response to all alerts that had been received within the practice. During our inspection on 30 November 2016, we saw that the provider had signed up for all available patient safety alerts, as well as printing these off to store in a file. Although we were not able to see evidence of this in practice due to the suspension, the provider and their staff could confidently talk about the process of receiving alerts and then actioning them.

When we inspected on 1 September 2016 the provider did not have systems in place to ensure patients prescribed high risk medicines were receiving essential blood monitoring. During our inspection on 30 November 2016, we saw that the provider had audited patients prescribed high risk medicines and had developed a new process of on-going monitoring. Although we were not able to see evidence of this in practice due to the suspension, the provider and their staff could confidently talk about the process of ensuring that patients who were prescribed high risk medicines were being monitored appropriately, in line with national guidelines.

Although the provider had been suspended from carrying on regulated activities, they had recently recruited a new practice management and reception team. A new practice nurse had also been recruited, although they had not yet started working for the provider. The new staff we spoke with were enthusiastic and appeared to be fully involved with the provider in implementing new systems to ensure the safety of patients.

Are services well-led?

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

Our findings

At our inspection on 1 September 2016 the practice was unable to demonstrate that they had made improvements to drive the changes necessary for the practice to meet the requirements of Regulation 12 (Safe care and treatment) and so keep patients safe.

During our inspection on 30 November 2016 we saw improvements had been made, although these improvements were theoretical rather than embedded and tested. Comprehensive risk assessments had been introduced to give the provider and practice managers oversight of the practice and the improvements needed. None of these systems had been tested operationally due to the suspension, so these systems and process needed to be embedded into the day to day running of the practice.

The sole GP told us that they had formed a peer group with another GP provider in the locality. The peer support allowed the GP to reflect on his practice, as well as developing good practice within Mapperley Park Medical Centre.

The practice had recruited new administrative staff, including two new part time practice managers. Support networks had been established with other GP practices in the area, so that the staff spent time working in a GP practice to develop skills and experience that could be used at Mapperley Park Medical Centre.

Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined. We will make a further assessment when we inspect again at the end of the special measures period.

The practice manager had received support from the management team of a local practice. They told us that this had been very educational and supportive. The provider told us that support for the practice manager and GP peer support would be continued in the future.