Delapre 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?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

We carried out an announced comprehensive inspection at Delapre Medical Centre from 26 June 2023 to 5 July 2023. Overall, the practice is rated as **Inadequate**.

Safe - Inadequate.

Effective – Requires Improvement.

Caring – Good (rating carried over from previous inspection)

Responsive – Good.

Well-led – Inadequate.

Why we carried out this inspection

Following our previous inspection on 2 March 2016, the practice was rated as good overall and for all key questions. We carried out this inspection in line with our inspection priorities. The risk had increased for this service as we identified some concerns through our monitoring activities of the practice.

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

How we carried out the inspection

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing facilities.
- Completing clinical searches on the practice's patient records system (this was with consent from the provider and in line with all data protection and information governance requirements).
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit of the practice and branch site.

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.

We rated the provider as **inadequate** for providing safe services:

Overall summary

- Systems or processes were not established and operating effectively to assess, monitor and mitigate risks relating to the health, welfare and safety of service users. In particular, risks associated with staff undertaking chaperoning duties without a Disclosure and Barring Service (DBS) background check, had not been assessed. Nor had risks associated with the absence of appropriate health and safety checks for electrical, gas and water safety been assessed.
- There was no assurance on the immunity and vaccination status of staff employed to ensure risks to themselves and patients were minimised.
- There were gaps in infection prevention and control (IPC) systems. We found IPC standards were not always met.
- Safety procedures for fire were not adequate.
- Medicines management arrangements were insufficient.
- Systems for managing test results were ineffective.
- Staff were not always aware of action to take to report significant events.
- Safety alerts were not appropriately actioned.

We rated the provider as **requires improvement** for providing effective services:

- We found gaps in systems to support some patients with long term conditions.
- We found evidence to demonstrate all patients taking medicines that required routine review were not receiving adequate care.
- Childhood vaccinations were below national targets.
- The practice had not met the national target for uptake of cervical cancer screening.
- There was no evidence of targeted quality improvement, for example through regular clinical audit.
- There was insufficient oversight of staff training, with evidence that multiple staff had not completed mandatory training (as designated by the practice).
- Not all staff received regular appraisals and there was no evidence of formal clinical supervision for non-medical prescribers.
- There was no embedded approach to managing and supporting patients with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) to demonstrate the practice maintained effective oversight of DNACPR decisions.

We rated the provider as **good** for providing responsive services:

- The practice identified a high prevalence of patients with complex mental health needs and responded by recruiting two dedicated mental health nurses.
- In an effort to improve patient experience the practice had invested in an e-consultation tool to support patients in accessing appropriate care. Steps were taken to ensure all patients, including those who were digitally excluded were still able to access care.

We rated the provider as **inadequate** for providing well-led service:

- There was a lack of clear responsibilities, roles and systems of accountability to support good governance.
- There were gaps in polices and protocols which resulted in an inconsistent approach in the management of risks.
- There was ineffective governance and clinical oversight to provide an adequate and safe service for service users.
- There were insufficient systems and processes established and operating effectively to assess, monitor and mitigate risks relating to the health, welfare and safety of service users.
- Staff feedback on the visibility and support offered by senior management and GPs was mixed.

We found two breaches of regulations, the provider **must**:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Overall summary

In addition, the provider **should**:

- Continue to monitor the efficacy of recently introduced systems to manage blank prescription safety.
- Take steps to improve uptake of childhood immunisations.
- Continue to encourage and engage patients to attend for cervical screening.

Due to the breaches of regulation identified we will be carrying out further enforcement action against the provider.

I am placing this service in special measures. The Care Quality Commission will refer to and follow its enforcement processes in taking action reflecting these circumstances.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted.

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

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

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 Delapre Medical Centre

Delapre Medical Centre is located in Northamptonshire at:

42-44 Gloucester Avenue

Northampton

NN4 8QF.

There is a branch site at:

Whitefields Surgery

Hunsbury Hill Road

Camp Hill

Northampton

NN4 9UW.

Both premises are purpose-built health centres.

The provider, Eleanor Cross Healthcare, is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury, family planning and surgical procedures.

The practice is situated within the Northamptonshire Integrated Care System (ICS) and delivers General Medical Services (GMS) to a patient population of about 19,300. This is part of a contract held with NHS England.

The practice is part of a wider network of GP practices known as the ARC Primary Care Network (PCN). This consists of four practices in total working together to provide services to the local population.

Information published by Public Health England shows that deprivation within the practice population group is six (on a scale of 1 to 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 87.7% White, 4.8% Asian, 3.7% Black, 3.2% Mixed, and 0.6% Other.

There is a team of seven GP partners and five salaried GPs. The practice has a team of three nurse practitioners one prescribing practice nurse and four practice nurses who provide nurse led clinics for long-term conditions. In addition, there are two dedicated mental health nurses and four health care assistants. There is a clinical pharmacist partner. The GPs and clinicians are supported at the practice by a team of reception/administration staff. There is team of managers and team leaders, including the manager partner, practice, business and operations managers. The practice is a training practice. At the time of our inspection there were four GP registrars (registrars are qualified doctors training to be GPs) in situ. At the time of our inspection, the practice was actively recruiting for more staff.

The practice is open between 8am to 6.30pm Monday to Friday. In addition, enhanced access to appointments is available from 6.30pm to 9.30pm Monday to Friday and between 9am and 5pm on Saturdays which is provided by the local GP Federation, General Practice Alliance. Patients can also access GPs online via an online app which is available between 6am and 10pm daily. Appointments for enhanced access appointments can be booked via reception (in hours) and NHS 111. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments. Out of hours services are provided by NHS 111 services.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users** **How the regulation was not being met:** The provider had failed to assess the risks to the health and safety of service users receiving care or treatment and had not done all that is reasonably practicable to mitigate any such risks. In particular: • There were insufficient measures in place to assess the risk of, and to prevent, detect and control the spread of infections, including thoe that are health care associated. • Medication reviews were not being completed and reviewed regularly. Patients taking medicines that required regularly monitoring were not receiving appropriate care. Service users with long term conditions were not routinely monitored and reviewed. • Not all relevant Medicines and Healthcare Products Regulatory Agency (MHRA) alerts had been sufficiently actioned. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

The provider had failed to establish systems and processes that operated effectively to ensure compliance with requirements to demonstrate good governance. In particular:

- There was a lack of clear responsibilities, roles and systems of accountability to support good governance. We reviewed training records and found there was insufficient managerial oversight with multiple gaps in training for several members of staff.
- There was no evidence of formal clinical supervision for non-medical prescribers. The provider could not demonstrate they were doing their own prescribing audits or reviews of consultations to ensure that appropriate prescribing following current best practice guidelines was taking place.
- Not all staff received regular appraisals.
- Staff feedback advised senior managers and GPs were not always supportive or visible.
- Not all staff were aware there was a Freedom to Speak Up Guardian to provide support and advice to staff who want to raise concerns.
- There were gaps in policies and protocols which resulted in an inconsistent approach in the management of risks. There was no staff immunisation policy available and records to demonstrate the provider maintained oversight of staff vaccination and immunity status were not available.
- We found policies, such as the test result policy, that had not been reviewed since 2013.
- There was ineffective governance and clinical oversight to provide an adequate and safe service for service users. This was demonstrated by gaps and inconsistencies in systems and processes in use. We found there was an ineffective policy and system for test result management as we found there were 371 outstanding pathology results that had not been reviewed.
- Risks associated with staff undertaking chaperoning duties without a disclosure and barring service (DBS) background check, had not been assessed. Nor had risks associated with the absence of appropriate health and safety checks for electrical, gas and water safety been assessed.

Evidence to support the provider maintained securely an accurate, complete and contemporaneous record in

This section is primarily information for the provider

Enforcement actions

respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was lacking. In particular,

- There was no embedded approach to managing and supporting patients with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) that demonstrated the provider maintained effective oversight of DNACPR decisions.

This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.