Dr Tom Frewin

Quality Report

52 Clifton Down Road
Clifton
Bristol
BS8 4AH
Tel: 0117 9732178
Website:

Date of inspection visit: 15 July 2015
Date of publication: 08/10/2015

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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Dr Tom Frewin, Clifton Village Practice on 15 July 2015. This was the fourth inspection at this practice since 15 April 2015.

- 15 April 2015. A Comprehensive inspection was undertaken. At this inspection a number of significant areas of high risk concerns for patients were found. This was in respect of patient health, safety and wellbeing.
- 15 May 2015 we issued two Warning Notices to the provider. We outlined within our statement of reasons the identification of risks and our concerns for patients. The provider was given until 29 May 2015 to take remedial action and comply with these notices.
- 16 June 2015. A follow up inspection was undertaken. This was in order to review the actions taken by the provider as a result of our issuing the two warning notices. We found very little action had been taken by the provider and we had continued concerns for the safety and welfare patients. We suspended the provider's registration and the regulated activities which were being provided Clifton Village Practice on 19 June until the 17 July 2015. During this period the expectation was the provider could rectify those immediate risks to patients' safety and welfare.
- 15 July 2015. A follow up inspection was undertaken. This was in order to check that these Warning Notices in respect of previous breaches of Regulation 12, (Safe care and treatment) and Regulation 17, (Good governance) had been met. From that inspection, we found that the provider had taken some steps to rectify these concerns but it was clear that they had not taken sufficient action to comply with the warning notices and the risks for patients' health, safety and wellbeing remained a concern. Due to continued risks to patient because of the reasons cited within this report. We made a decision to extend the period of suspension of registration until 3 September 2015 to ensure the provider has sufficient time to rectify our concerns.

Following the inspection on 15 April 2015 we also issued six requirement notices in respect of the following areas, the provider must:

- Ensure the practice environment is accessible in regard to meeting the Equality Act 2010.
- Ensure patients consent is obtained and recorded before treatment is provided.

Summary of findings

- Ensure the practice has effective systems in place for cleaning.
- Ensure that persons employed at the practice receive the appropriate support, training, supervision and appraisal to carry out their role. There must be safe recruitment procedures in place and sufficient staff employed to meet the needs of patients.

These will be reviewed by us when we next undertake a comprehensive inspection.

On the basis of the findings at the inspection on 15 April 2015 we placed the provider into special measures. (Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled).

At this inspection, specifically we found the practice continues to be requires improvement for caring and inadequate for safe, effective, responsive well led services. Services provided to all population groups are inadequate.

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

- Patients remain at risk of harm because systems and processes were not in place to keep them safe. Areas of concern were the equipment and medicines to respond to medical emergencies had not been fully implemented; the planned system for the safe handling for chemicals be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) had not been fully implemented and training for all staff for health and safety had yet to be completed.
- There was no clinical lead, no clinical audit and no governance systems in place. The lack of clinical leadership, audit and governance meant that there were no systems to identify patient need; improve patient outcomes and improve performance.
- Whilst systems had been developed for providing regular reviews of patients with long term conditions this had not been tested because of the suspension of registration of the practice. Therefore it was uncertain this process was effective. Clinical staff were employed on an ad-hoc and locum basis resulting in insufficient continuity of care.

It must be noted that although some areas of concern have been rectified because the provider has developed systems and processes. However, we are unable to test that they are appropriate and implemented effectively because the practice is currently not providing a service directly to patients.

Due to continued risks to patient because of the reasons cited above. We made a decision to extend the period of suspension of the providers registration until 3 September 2015 to ensure the provider has sufficient time to rectify our concerns.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

Patients remain at risk of harm because systems and processes were not in place to keep them safe. Areas of concern were the equipment and medicines to respond to medical emergencies had not been fully implemented; the planned system for the safe handling for chemicals be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) had not been fully implemented and training for all staff for health and safety had yet to be completed.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. There was no clinical lead, no clinical audit and no governance systems in place. The lack of clinical leadership, audit and governance meant that there were no systems to identify patient need; improve patient outcomes and improve performance.

Whilst systems had been developed for providing regular reviews of patients with long term conditions this had not been tested because of the suspension of registration of the practice. Therefore it was uncertain this process was effective. Clinical staff were employed on an ad-hoc and locum basis resulting in insufficient continuity of care.

Dr Tom Frewin

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 GP, specialist advisor.

Background to Dr Tom Frewin

Provider Dr Tom Frewin, of the location Clifton Village Practice is situated in a residential area of the city of Bristol. The practice had approximately 2,590 (July 2015) registered patients from the Clifton area. Based on information from Public Health England the practice patient population were identified as having a low level of deprivation. The practice did not support any patients living in care or nursing homes.

The practice is located in a Victorian adapted large former private residence. The practice is accessible via six steps up from street level. There are four floors within the building and a basement. There is a consulting room, reception, waiting room and office on the ground floor. A further consulting/meeting room is on the first floor. A consulting room, treatment room and meeting room is situated in the basement. There is no lift. The practice is on a primary medical service contract with Bristol Clinical Commissioning Group.

The provider is Dr Tom Frewin, services were provided at the one location of Clifton Village Practice:

52 Clifton Down Road, Clifton, Bristol. Avon. BS8 4AH

The practice had patients registered from all of the population groups such as older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 65.6% of patients registered with the practice were aged from 15 to 44 years and 20.4% were aged from 45 to 64 years old. Just above 5% were over 65 years old. Around 1.8% of the practice patients were 75-84 years old and just over 1.2% of patients were over 85 years old. Just below 6% of patients were less than 14 years of age, 2.1% of these were below the age of 4 years. Information from NHS England showed that 4.9% of the patients had long standing health conditions, which was below the national average of 54%. The percentage of patients who had caring responsibilities was just over 8% which is below the national average of 18.5%. Of the working population 4.1% were unemployed which is below the national average of 6.2%.

The practice consists of an individual GP who is registered as the provider. They had engaged locum GPs to cover providing clinical support each day. GP locums were male or female and for some there were set working days but for others there were no set days per week when they attended the practice. There was also a regular a locum practice nurse who provided one session per week. The provider (an individual GP) had not undertaken any clinical activity since March 2014 therefore there was no monitoring, support or supervision provided to the locum GPs or locum nurse. There was also no clinical oversight or governance at the practice.

The practice building is open to patients during the whole of the working day from 9 am up to 6.30 pm and until about 7.15 pm on days when there are extended hours appointments. Prior to suspension of services, the appointments for extended hours run from 6.30 pm to 7.00 pm on three evenings per week, usually Mondays,

Detailed findings

Tuesdays and Wednesdays. The day of the week can vary according to GP availability. There is open surgery every morning between 9 am and 10.30 am and anybody arriving between those hours will be seen. Appointments were available on every weekday afternoon. The practice referred patients to another provider, BrisDoc for an Out of Hours service to deal with any urgent patient needs when the practice was closed. Details of what the practice provided were included in their practice leaflet and answerphone message. The provider did not have a website to inform patients of the Out Of Hours arrangement.

Why we carried out this inspection

On the basis of the findings at the inspection on 15 April 2015 we placed the provider into special measures. (Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid having its registration cancelled). As a result of a follow up inspection to check compliance on 16 June 2015 because we had concerns for the safety and welfare of patients we suspended the provider's registration and the regulated activities which were being provided by the provider at Clifton Village Practice on 19 June until the 17 July 2015. During this period the expectation was the provider could rectify those immediate risks to patients' safety and welfare.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission at that time.

How we carried out this inspection

During our visit we spoke with the registered provider. We also spoke with the practice manager and deputy practice manager. We reviewed documents and information provided by the practice and reviewed the physical changes the provider had put in place to the environment.

We sought information from NHS England and Bristol Clinical Commissioning Group prior to our inspection.

Inadequate

Are services safe?

Our findings

Medicines management

At this inspection we found systems had been implemented for the safe management of prescription pads and prescription printer paper. Prescription paper and pads had been locked away in filing cabinets and printer locks had been installed. We found that a system had been developed for logging prescription pad numbers and printer prescription paper serial numbers However, we were unable to test this system worked as the practice had not been providing a service to patients directly.

During this inspection we looked at the measures the practice had in place for medicines safety. We found one medicine refrigerator, which had damaged seals had been removed. Medicines had been moved to another refrigerator which now had a suitable maximum and minimum thermometer. This refrigerator was locked and kept in a locked room. Temperatures were checked daily and there was evidence that medicines were checked, in date and a system was in place to monitor stock levels. A policy and procedure for vaccine management and to maintain the cold chain had been developed. No controlled medicines were kept in the practice.

Cleanliness and infection control

At this inspection there were significant changes implemented to improve infection control at the practice. The practice had updated and implemented infection control policies or procedures. We found these to be detailed and covered all aspects such as hand washing, 'needle stick' injuries and waste management. A recent infection control audit, 14 July 2015, had been carried out by an external health professional with recommendations. Two members of senior staff had undertaken eLearning for infection control and were now the named infection control leads at the practice. Training for other staff was planned for 20 July 2015. We found the infection control audit had been carried out effectively and in detail. The practice had taken advice and implemented appropriate foot operated pedal bins where required. Female sanitary waste bins had been installed in the patient and staff toilets. Staff had addressed the concerns regarding the baby changing station and implemented appropriate cleaning equipment and bins; they had replaced the changing mat, provided cleaning wipes, nappy disposal bags and placed a foot operated bin in close proximity. We also found the practice was in the process of finalising a system to ensure reusable equipment such as sphygmomanometer cuffs, oximeter, or thermometers, were routinely cleaned.

The practice had implemented a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). They had taken advice and assessed the risk to patients from the water systems at the practice. They had also included detailed information in their infection control policy and procedure for staff to maintain safe water systems at the practice.

An external contractor was engaged to remove and dispose of clinical waste at the practice. We found changes had been implemented to the storage of clinical waste and was now safe and in accordance to National Institute of Health and Care Excellence (NICE) guidelines. The staff at the practice had separated clinical waste containers and clinical wastes from other items which were now kept in an individual cupboard. This cupboard was now secure with a lock which was within a room with a key code to the door. We were unable to test this compliance was sustained as the practice was not providing clinical care to patients.

The practice provided evidence of proposed actions they had put in place for cleaning at the practice and that safe systems were being implemented in regard to chemicals and cleaning fluids that should be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002 (COSHH). We saw that chemicals and cleaning fluids had been removed from where they were previously were stored. The practice had engaged a professional cleaning company to provide a regular cleaning service at the premises. We saw detailed information, schedules, risk assessments and audits were provided by the contractor. They would also take responsibility for the safe manage of COSHH items. We saw the practice had provided a specific storage facility that was waiting for a lock to be fitted for cleaning chemicals to be kept at the practice. This cupboard was within a room with a key code entry pad.

Equipment

There was evidence that portable appliance testing in line with the Electricity at work Regulations 1989 had now been carried out on equipment. We were told that a larger

stand-on weighing scales (last tested 28/03/2013) in the ground floor consulting room were not used for weighing and was used to display a sign to patients about chaperones.

We found the locum GP in the practice during our first visit April 2015 had un-calibrated equipment in their bag used for home visits. On this visit we shown a document given to locums that the practice which had advised locums that they should only use the practice equipment or could have their own calibrated.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to follow when recruiting clinical and non-clinical staff. During the previous visits we found their policy, as previously, had not been followed.

We found during this inspection information about a new member of staff who had been employed had been retrospectively obtained. Work history, references or proof of identity had now been obtained. There was no change in the provision of nurse care at the practice. No permanent nursing staff were employed to provide on-going care and treatment for patients with long term conditions. A locum nurse worked one session per week to provide this.

If a chaperone was required only one member of staff had been trained for this role; however no Disclosure and Baring (DBS) check had been carried out on this member of staff and a risk assessment had not been carried out to ensure this approach did not compromise patients' safety and welfare. We were told that DBS checks were in the process of being applied for, for other staff.

Monitoring safety and responding to risk

There was no overall health and safety risk assessment and no risk assessments in relation to risks of slips, trips or falls available at this inspection 15 July 2015. The deputy practice manager on behalf of the provider informed us that this almost completed and we could see that changes had occurred to environment to eliminate health and safety risks. For example, electrical cables had been safely secured, a drop down hand rails fitted to the patients toilet and a food refrigerator had been replaced in a staff area. Following the inspection, within 48 hours, the provider submitted a completed health and safety risk assessment for the premises. The documents submitted included a policy, procedure and a plan of how identified risks had been managed some actions had been completed others were to be completed within a short timescale. The action plan also outlined that staff were to receive health and safety training, although no date was given. We have not been able to check these actions have been implemented.

Regular servicing of equipment such as the gas boilers had been carried out. Carbon monoxide sensors had been installed in the rooms where boilers were sited. The testing, servicing and renewal of batteries was contracted out to the fire safety company responsible for the testing of fire safety equipment at the practice. We saw evidence that electrical safety at the practice had been carried out by a fire safety engineer 13 July 2015.

The practice had been visited by a representative of the Fire Service to review fire safety at the practice during June and July 2015. A general review of the fire safety procedures, equipment and precautions had been undertaken and we could see that steps had been taken to adhere to advice given. A new fire policy and procedure was in place. Changes to signage, fire extinguishers, and door closures had all been implemented. A map of exit points had been put on display for visitors to view. Steps had been taken to remove or diminish sources of ignition in the practice premises. For example, a gas cooker, washing machine and tumble dryers had been disconnected, removed or moved to safe areas.

We found at this inspection, that some steps had been taken to ensure that all staff were up to date with fire training. Senior staff and two other staff had undertaken eLearning fire training and there were plans for all remaining staff (four) to complete training and a fire drill was planned on the Monday following this inspection. There were also plans for the three senior staff to undertake fire marshal training on the same day.

We found there had been some actions taken to address the areas of concern about the lack of systems for monitoring patients with long term conditions, end of life care and those patients identified as vulnerable and at risk. The practice had employed locum GPs and a practice nurse to check patient records in regard to key triggers such as prescribed medicines, test results and coding. From this information they could now provide a better overview of the needs of the patients they served. They had identified that they supported one patient with a learning difficulty, five patients with a primary diagnosis of dementia, 17 patients with a mental health need and 42 patients with

diabetes. The practice was treating 203 patients with hypertension (high blood pressure), and 12 patients with a chronic lung disease. They had identified that they had less than five patients (adults and children) they considered vulnerable or at risk. Of all of these patients it was unclear who had received an appropriate review of their needs as we sampled only a small number of records. We had been supplied with details of weekly nurse led patient clinics, however, the specific numbers, patients' needs or purpose of attending these clinics was not provided.

We sampled 11 patient records randomly chosen from these population groups to check what actions the practice and the locum GPs had implemented. We could see from these records that information had been flagged up to call or recall the patients to make an appointment for a review at intervals defined by the clinicians. There was no current system for annual medicines review. There was no strong evidence there would be continuity of care provided to patients.

Of those 11 patients we found that two patients who had been identified by the practice as being on a cancer pathway and were receiving active treatment from their specialists or under the care or their oncologist rather than having active end of life care. One patient identified as with a mental health need and vulnerable had appropriate records in place and the decision making for a referral to a consultant physician for a general medical problem had been undertaken. There was evidence of review dates for patients with long term conditions being put in place.

Two patient's records that we reviewed led to questions about actions that should have been taken following test results received after the practice was suspended from providing a service. Practice staff provided information to the Care Quality Commission following the inspection that these patients current, temporary GPs had been contacted and alerted to the concerns. However, we also had concerns about the standard of record keeping in some of the patient records we reviewed. For example, the reason for re- authorising a prescription for depression on a continuing basis for a patient for mental health and substance abuse without comment or review by the GP. Another, where the GP had recorded a suggested follow-up appointment when blood test results been returned, we could see these had returned with abnormal results but there was no recorded comments or information in the patient records by GP as to the outcome. A similar record was seen in regard to a patient with diabetes with abnormal test results where the GP had not commented about further test results or follow up for this person.

The practice informed us of the system the practice intended to put in place to screen/monitor patients with long term conditions or identified as at risk. Currently there was no evidence to show how this system would work as no process was in place to evidence the actions and outcomes for patients. The locum practice nurse only provided one session per week. This session was for diabetic patients and the system to recall and see these patients had not been fully imbedded or evaluated. Likewise, there was no evidence there was a thorough system for patients medication reviews in place.

Arrangements to deal with emergencies and major incidents

We looked at the practices arrangements to deal with emergencies. At his inspection we found that the provider and senior staff had had discussions and had sought advice in regard to implementing systems to manage medical emergencies. We were provided with information that they had ordered oxygen and storage and safety signage to respond to a medical emergency which was due to be received the following day. Staff had already engaged a contractor to supply and maintain an automated external defibrillator which had arrived the day before the inspection visit. We were provided with information following the inspection about the planned medicines to be kept at the practice in order to respond appropriately to medical emergencies. We have been unable to check that this has been completed, their policy and procedure changed to reflect the new approach is in place or that compliance has been sustained.

Are services well-led?

Inadequate

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

Our findings

Governance arrangements

We found on this visit to the practice there had been only minor changes to the governance arrangements since our last inspection undertaken in April 2015.

The practice had policies and procedures in place to govern how services were provided and we could see that a number of these had been reviewed or developed since our initial inspection. For example, infection control and fire safety. There were improvements in the structure in which named members of staff had lead roles. For example, infection control leads had been appointed and there was evidence that they had received training to carry out these roles. Not all new policies and procedures had been fully implemented such as COSHH (2002) and the monitoring of prescription pads and paper as systems had either not commenced or that patients were not being seen at the practice.

There was a practice manager and deputy practice manager who led the day to day running of the service. We did have concerns again at this inspection that the provider was the named lead for clinical governance. However, the issues remained the same as the provider continued to be on long term sick leave and there was no evidence of stability of clinical cover at the practice as all roles were provided by locums. We saw there was no member of clinical staff to provide leadership and there was not an effective planned programme of audits in place and or governance arrangements. We were informed by NHS England that the one long term locum GP had withdrawn from the PMS contract for which they were a signatory. This meant that any continuity of care that had been in place as there was no assurance patients' would see the same locum GP. There was no method of monitoring, support or supervision provided to the locum GP's or the locum nurse to assess and govern their activity at the practice

The practice used both electronic and paper record systems for patient records. Patients' paper records were stored in filing cabinets in the ground floor office near the reception area. Archived patient records were kept in filing cabinets in a room upstairs. Both these rooms had now been tidied and patients' records stored safely and key code entry systems had been placed on the doors preventing unauthorised access.