Dipple Surgery

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

On 20 January 2016, we carried out a comprehensive announced inspection. We rated the practice as inadequate overall. The practice was rated as inadequate for providing safe, effective, caring and well-led services and requires improvement for providing responsive services. As a result of the inadequate rating overall the practice was placed into special measures for six months.

On 14 September 2016 we returned to the practice and carried out a comprehensive inspection. Overall the practice was rated as requires improvement with the safe domain being rated as inadequate. The practice remained in special measures and we issued the practice with a warning notice in relation to providing safe care and treatment at the practice. The issue of concern was as follows;

- Patients remained on medicine combinations that presented a risk to their health and one medicine alert had not been actioned in a timely and appropriate manner.

The practice was required to be compliant with the warning notice by 20 October 2016. We conducted a focused inspection of the practice on 8 February 2017 to establish whether the requirements of the warning notice had been met. We found;

- The practice had a safe and effective system in place to ensure the timely actioning of patient safety and medicine alerts. We checked patient records and found that patients were being reviewed in accordance with guidance.

The practice had complied with the notice. However, the practice will remain in special measures until their inspection in 2017. 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.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

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?

The practice is rated as inadequate for providing safe services.

In September 2016 we found improvements were required in the managing of patient safety and medicine alert information relating to medicines. We previously found some patients remained on medicines combinations that may be detrimental to their health and an alert had not been actioned in a timely and appropriate manner.

- At the inspection on 8 February 2017 we found the practice had introduced a safe and effective system to ensure the timely actioning of safety alerts. We checked patient records and found that patients were being reviewed in accordance with guidance and the practices medicine management policies.

Dipple Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser and a second CQC Inspector.

Background to Dipple Surgery

The practice is situated in a purpose built health centre located on a main road with parking facilities. It occupies the east wing of the premises with a neighbouring surgery, sharing the patient waiting area, patient toilets and a staff kitchen.

Dipple Surgery is part of a large organisation called Malling Health (UK) Limited. Malling Health (UK) Limited is a separate legal entity but operates under the umbrella of IMH. IMH have a range of primary care sites throughout the UK providing GP services, walk in centres and urgent care centres. Resources are shared across their sites.

The practice has a patient population of approximately 4470 patients and they hold an Alternative Provider Medical Services (APMS) contract. Their clinical team consists of a full time GP working Monday to Thursday, a regional medical director (management position within Malling Health (UK) Limited) working Monday, Tuesday and half day Wednesday, one locum GP who works a Thursday and Friday and a further locum GP who works on a Friday. The locum GPs are contracted for a further three months. This arrangement ensures two GPs see patients daily.

The clinical team have both female and male GPs. They are supported by a pharmacist who undertakes clinical reviews of patient records, a nurse prescriber who undertakes clinical assessments, a practice nurse and health care assistant. The clinical team is supported by an administrative team overseen by a deputy practice manager and the area manager. The area manager is assisting the deputy manager in fulfilling the practice manager role three days a week.

The practice is open and appointments are available between 8am and 6.30pm Monday to Friday. Extended surgery hours are offered on a Tuesday morning when the surgery opens at 7.30am and on Wednesday it closes at 8pm and on Thursday evenings at 7pm.

The practice does not provide out of hours care but direct their patients to the NHS 111 service. Out of hours care is provided by IC24 who are commissioned by Basildon and Brentwood Clinical Commissioning Group (CCG).

The practice has high levels of deprivation amongst children and older people. The life expectancy of the male and female patients within the area is also lower than the CCG and the national averages.

The practice has a website detailing opening times, online services, health information and how to access local services.

Why we carried out this inspection

We carried out a follow up inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

The inspection was to check whether the provider had complied with the requirements of the warning notice served following their last comprehensive inspection on 14 September 2016.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 8 February 2017. During our visit we:

- Spoke with a range of staff (the area manager for Malling Health (UK) Limited, the deputy practice manager, regional medical director and lead onsite GP) and spoke with patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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 CQC at that time.

Are services safe?

Our findings

Safe track record and learning

At our last inspection on 14 September 2016 we rated the practice as inadequate for providing safe services. We found improvements were required in the management of patient safety and medicine alert information relating to medicines. We previously found some patients remained on medicine combinations that may be detrimental to their health and an alert had not been actioned in a timely and appropriate manner. For example;

- We found 18 patients on a combination of interacting medicines contrary to an alert and potentially causing potential muscle damage.
- We found seven patient's on repeat prescriptions for an anti-sickness medicine that may cause neurological side effects.
- We asked about the most recent safety alert which required actioning within 48 hours. The practice told us none of their patients were affected and the clinicians confirmed they had read the alert. However a search of the patient record system showed two patients were potentially affected and their care had not been reviewed, as required.

As a consequence of these findings we issued the practice with a warning notice to be compliant with the regulations by 20 October 2016. Following the inspection the practice had produced an action plan to address risks identified. On returning to the practice in February 2017 we found that the practice had complied with the warning notice.

We asked the practice how they now managed safety alerts such as Medicines and Healthcare Regulatory Agency to ensure they were being actioned appropriately. MHRA notifications are generated by the Department of Health Central Alerting System. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us safety alerts were received by the practice manager who shared them with the lead GP and clinical team. They conducted a search on the patient record system to identify those patients who may be adversely affected by the alert. Where patients were affected, the lead GP tasked the clinicians and ensured the patient was appropriately reviewed. On confirmation of this, the practice manager updated their records to reflect actions taken.

We asked the practice if they were revisiting safety searches to ensure information had been appropriately actioned. They told us that were and showed us evidence that this was being done. For example, the practice manager had established a system of batched monthly computer searches. If there were potential conflicts with patient medicines the practice manager was alerted by their computerised patient record system and action was taken. These they shared with the lead GP for actioning.

We revisited previous searches conducted of their patient records and found;

- No patients were now receiving a combination of interacting medicines that may have caused them potential muscle damage.
- Four patients were being prescribed anti sickness medicines and all were being appropriately monitored.

We also checked two other recent safety alerts. The practice was able to demonstrate they had taken timely and appropriate actions in response to these. We saw patients on high risk medicines were being appropriately monitored in accordance with guidance and the practices own medicine management policies.

The practice also conducted reviews on their clinician's consultations. They showed us a structured assessment, performance criteria and agreed outcome plans which they reported against.