Bowburn Medical Centre

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

We carried out an announced comprehensive inspection at Bowburn Medical Centre on 13 July 2017. We identified breaches of four legal requirements. Requirement notices were issued for three breaches and a warning notice for one breach was issued. This focused inspection on 5 October 2017 was to check whether the provider had taken steps to comply with the legal requirements of the warning notice against:

- Regulation 12 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Summary of findings

This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Bowburn Medical Centre on our website at www.cqc.org.uk.

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

- Action had been taken to address all concerns identified, although the provider should ensure these arrangements are embedded in the way the practice functions.
- A new significant event policy had been introduced which set out the responsibilities of each staff group. Arrangements were put into place to ensure any learning would be shared with relevant staff during clinical meetings and practice team meetings.
- A new system for reviewing patient safety alerts had been implemented and three members of staff had been given responsibility for taking action (two clinical and one administrative).
- Some patients with a learning disability had received a health check; a further patient was booked in to attend imminently. The practice nurse was in the process of contacting the other patients to arrange a time for them to attend, in line with the patients' preferences. Staff told us all checks would be completed by the end of 2017.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients by making sure the remaining patients with learning disabilities receive health checks by the end of December 2017.

In addition, the provider should:

- Take steps to provide training for staff on the newly implemented policy on significant events.
- Implement a system to document significant events and patient safety alerts to ensure they are all recorded and reviewed as necessary.

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?

At our previous inspection on 13 July 2017, we rated the practice as inadequate for providing safe services as some arrangements, including dealing with patient safety alerts and significant events were not satisfactory.

We found these arrangements had improved when we undertook a follow up inspection on 5 October 2017, although there were still areas where further improvements were required.

- A new significant event policy had been introduced which set out the responsibilities of each staff group. Arrangements were put into place to ensure any learning would be shared with relevant staff during clinical meetings and practice team meetings. Staff were to receive training on the new policy during a forthcoming 'time out' session.
- A new system for reviewing patient safety alerts had been implemented and three members of staff had been given responsibility for taking action (two clinical and one administrative). We looked at the most recent alert and found this had been reviewed, although this had not been discussed by the clinical team. Notes were made on the alerts to demonstrate what action had been taken but there was no log to ensure all alerts were recorded and acted upon.

Are services effective?

At our previous inspection on 13 July 2017, we rated the practice as requires improvement for providing effective services. Some patients had not received appropriate health checks.

These arrangements had improved when we undertook a follow up inspection on 5 October 2017.

- Some patients who had a learning disability had received a health check and a further patient was booked in to attend imminently. The practice nurse was in the process of contacting the other patients to arrange a time for them to attend, in line with the patients' preferences. Staff told us all checks would be completed by the end of 2017.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Ensure care and treatment is provided in a safe way to patients by making sure the remaining patients with learning disabilities receive health checks by the end of December 2017.

Action the service SHOULD take to improve

Take steps to provide training for staff on the newly implemented policy on significant events.

Implement a system to document significant events and patient safety alerts to ensure they are all recorded and reviewed as necessary.

Bowburn Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector.

Background to Bowburn Medical Centre

Bowburn Medical Centre provides care and treatment to around 4,000 patients in the town of Bowburn, County Durham. The practice is part of North Durham clinical commissioning group (CCG) and operates on a General Medical Services (GMS) contract agreement for general practice.

The practice provides services from the following address, which we visited during this inspection:

- Bow Street, Bowburn, Durham, DH6 5AL.

The practice is located in a purpose built single storey building. There is on-site parking, accessible parking, an accessible WC, wheelchair and step-free access.

Opening hours are between 8.30am and 1pm then 2pm to 6pm Monday, Tuesday, Wednesday and Friday then between 8.30am and 1pm on Thursdays. The practice has a contact with the local CCG to provide cover from 6pm. Patients can book appointments in person, on-line or by telephone.

Appointments with a GP or nurse practitioner are available at the following times:

- Monday - 8.30am to 11.40am; then from 2.50pm to 5.40pm
- Tuesday – 8.30am to 11.40am; then from 2.50pm to 5.40pm
- Wednesday – 8.30am to 11.40am; then from 2.50pm to 5.40pm
- Thursday – 8.30am to 11.40am
- Friday – 8.30am to 11.40am; then from 2.50pm to 5.50pm

A doctor is available every Thursday afternoon until 6pm to deal with any medical emergencies or urgent appointment requests. Telephone calls are answered throughout the day, until 6pm each week day, at all other times an answer machine message directs patients to the NHS 111 service.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and the local CCG.

The practice has:

- two GP partners (both male), although only one is active in the practice,
- one nurse practitioner and two practice nurses (all female),
- a clinical pharmacist
- a practice administrator, and
- four staff who carry out reception and administrative duties.

The age profile of the practice population is broadly in line with the CCG averages, but there is a higher than average proportion of patients under the age of 18 (22.3% compared to the CCG average of 18.8%). Information taken from Public Health England placed the area in which the practice is located in the fifth less deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Bowburn Medical Centre on 13 July 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection in July 2017 can be found by selecting the 'all reports' link for Bowburn Medical Centre on our website at www.cqc.org.uk.

We undertook an announced follow up focused inspection of Bowburn Medical Centre on 5 October 2017. This inspection was carried out to check whether the provider had taken action to address shortfalls in relation to legal requirements which had been identified at our previous comprehensive inspection.

How we carried out this inspection

We carried out an announced visit on 5 October 2017. During our visit we:

- Visited the practice.
- Spoke with a range of staff (the lead GP, a practice nurse, the practice clinical pharmacist and the operations manager) and
- Looked at information the practice used to deliver care and treatment.

Are services safe?

Our findings

At our previous inspection on 13 July 2017, we rated the practice as inadequate for providing safe services as some arrangements, including dealing with patient safety alerts and significant events were not satisfactory.

These arrangements had improved when we undertook a follow up inspection on 5 October 2017, although there were still areas where further improvements were required.

Safe track record and learning

When we inspected in July 2017 we found the system for reporting and recording significant events was ineffective. During the inspection we found evidence of issues which had been reported but not recorded as significant events.

During this focussed inspection we saw a new significant event policy had been introduced which set out the responsibilities of each staff group. Arrangements were put into place to ensure any learning would be shared with relevant staff during clinical meetings and practice team meetings. Staff were to receive training on the new policy during a forthcoming 'time out' session. The operations manager told us that a log of significant events was going to be maintained to make sure all issues were documented. There had not been any significant events reported since our last report was published, some three weeks prior to the inspection.

At the inspection in July 2017 we found the process for dealing with safety alerts was inadequate. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. There was no recorded evidence to show that alerts had been actioned and relevant searches carried out to determine if any patients were affected. There were no arrangements in place to discuss the alerts at appropriate meetings to ensure all relevant staff were aware of any necessary actions.

During this focussed inspection we found improvements had been made. A new system had been implemented and three members of staff had been given responsibility for taking action (two clinical and one administrative). Weekly checks were carried out to identify any new safety alerts. These were reviewed and a clinician would decide whether any action was necessary. Alerts would then be discussed at the weekly clinical meetings.

We looked at the most recent alert and found this had been reviewed, and there were no patients affected by the alert. However, the latest clinical meeting minutes did not contain a record of this being discussed.

Notes were made on the alerts to demonstrate what action had been taken but there was no log to ensure all alerts were recorded and acted upon. Managers told us this was something they would start to do.

Although new alerts had been reviewed, there had been no retrospective analysis of previous alerts (other than two identified at the previous inspection). The practice pharmacist carried out a review of the recent alerts when we attended and was able to demonstrate that no patients were affected by those previous alerts.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 13 July 2017, we rated the practice as requires improvement for providing effective services. Some patients had not received appropriate health checks.

These arrangements had improved when we undertook a follow up inspection on 5 October 2017.

Supporting patients to live healthier lives

When we last inspected we found that patients with learning disabilities had not received health checks in the previous 12 months. One of the nurses had identified this and had put plans into place to ensure that all 10 patients received a health check over the coming months.

During this inspection we found that five patients had received a health check, and a further patient was booked in to attend imminently. The practice nurse was in the process of contacting the other patients to arrange a time for them to attend, in line with the patients' preferences. Staff told us all checks would be completed by the end of 2017. Following this, a new system was to be implemented whereby patients would be recalled in their month of birth each year.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 How the regulation was not being met: Assessments of the health and safety of service users receiving care and treatment were not being carried out. Specifically: The arrangements for reviewing the health needs of patients with learning disabilities need to be completed for this year and run on an annual basis. Regulation 12(1)