The Old Dispensary

Inspection report

32 East Borough
Wimborne
BH21 1PL
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Date of inspection visit: 15 November 2022
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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?	Inadequate
Are services well-led?	Inadequate

Overall summary

We carried out an announced focused follow up inspection at The Old Dispensary on 15 November 2022.

This inspection was undertaken because on 3 August 2022 we completed a comprehensive inspection where the practice was rated overall as inadequate. The service was issued urgent conditions on the provider's registration with CQC and placed into special measures.

This focused inspection was undertaken to assess if improvements had been made in accordance with the provider's action plan and the urgent conditions placed on their registration. The practice demonstrated some improvements but in line with our methodology, the ratings have not changed.

Following the inspection on 15 November 2022 the ratings remain:

Safe - Inadequate

Effective – Inadequate

Caring - Good

Responsive – Requires Improvement

Well-led - Inadequate

The practice registered with CQC as a partnership 12 June 2019 and was last inspected 3 August 2022.

Why we carried out this inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, considering the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing facilities.
- Speaking with staff during the visit to the practice.
- Completing clinical searches on the practice's patient records system and discussing findings with the provider.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- A site visit.

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.

Overall summary

- Information from the provider, patients, the public and other organisations.

We found that:

- The provider was able to demonstrate some improvements, however the new systems and processes implemented since our inspection in August 2022, required further embedding to ensure patients received the appropriate reviews and treatment to meet their needs.
- Clear clinical oversight was needed to ensure all aspects of patient monitoring and review were completed. These included medicine reviews and reviews of patients with long-term conditions.
- Systems for receiving electronic documents from other services had been addressed and staff had the information they needed to support safe care and treatment.
- Systems for nursing staff to use a selection of Patient Group Directions (PGDs) to administer some previously agreed specific medicines had been updated and now followed the legal framework.
- The storage and monitoring of emergency medicines had improved and was safely managed.
- There was limited monitoring of the outcomes of care and treatment. Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate staff had the skills, knowledge and experience to carry out their roles. Staff were not consistent and proactive in helping patients live healthier lives and the practice was unable to demonstrate it always obtained consent to care and treatment in line with legislation and guidance.
- Leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care. The overall governance arrangements required more clinical oversight and support to ensure safe, effective care and treatment was being delivered to patients.
- The practice did not have embedded and effective processes for managing risks, issues and performance. However the practice had a clear vision and credible strategy and involved the public, staff and external partners.

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.

Whilst we found no breaches of regulations, the provider **should**:

- Continue with the programme of coverage of women eligible to be screened for cervical cancer.

Consider the development of an active Patient Participation Group (PPG)

Following the inspection in August 2022, we undertook enforcement action against the provider, The Old Dispensary.

We placed this service in special measures. 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 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.

Overall summary

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.

Special measures will give people who use the service the reassurance that the care they get should improve.

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 Hospitals and Interim Chief Inspector of Primary Medical Services

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 lead inspector was supported by a second CQC inspector. The team also 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 The Old Dispensary

The Old Dispensary is in Wimborne, Dorset at:

32 East Borough

Wimborne

Dorset

BH21 1PL

The Old Dispensary provides NHS GP services to adults and children. The practice offers services from one main location.

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

The practice is owned by a Partnership Dr Mark H Deverell and Mrs Sarah A Deverell and as a condition of registration has a person registered with the Care Quality Commission as the registered manager.

The practice is situated in the town of Wimborne in Dorset. The practice provides a primary medical service to 3,750 patients

The practices population is in the tenth decile for deprivation, which is on a scale of one to ten. The lower the decile the more deprived an area is compared to the national average. The practice population ethnic profile is predominantly White British.

The practice team includes two partners, one is the lead practice GP and the other is a non-acting partner. The practice has a part time salaried GP and also uses a locum GP part time. The team are supported by a practice manager, an assistant practice manager, a practice nurse, an assistant practioner and six additional administration and reception staff.

The practice is part of a wider network of GP practices, the Wimborne & Ferndown Primary Care Network (PCN) which is made up of five GP practices. PCNs provide proactive, coordinated care to their patients, in different ways to match different people's needs, with a strong focus on prevention and personalised care.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations. If the GP needs to see a patient face-to-face then the patient is offered a choice of either the main GP location or the branch surgery.

Extended access is provided, where evening appointments are available. Out of hours services are provided by locally by the NHS 111 service.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Medicine reviews were not being consistently and completely undertaken to evidence a full medicine review for all relevant patients. • Not all patients with long-term conditions had received and appropriate regular monitoring review of their condition.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Appropriate systems and processes were not in place to assess the risk to the health and safety of patients receiving care or treatment and were not doing all that was reasonably practicable to mitigate such risks. Risk assessments were not used by you to monitor and mitigate all identified risks. • Systems did not identify all appropriate monitoring had been undertaken to ensure safe care and treatment to meet patients individual needs. Overview systems of clinical governance did not ensure a holistic review of tests and monitoring results.