Dr Richard Hattersley

Quality Report

Boscombe Manor Medical Centre
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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 focussed inspection of Dr Richard Hattersley on 11 April 2017. This was to check compliance relating to the serious concerns found during a comprehensive inspection on 2 February 2017 which resulted in the Care Quality Commission issuing a Warning Notice with regard to Regulation 17, Good Governance.

Other areas of non-compliance found during the inspection undertaken on 2 February 2017 will be checked by us for compliance at a later date.

Summary of findings

Following our inspection undertaken on 2 February 2017 we rated the practice as requires improvement overall. Specifically, the domains of caring and responsive were assessed as providing good services. The domains of safe and effective were rated as requires improvement and the well-led domain was rated as inadequate. The ratings for the provider will remain in place until a comprehensive inspection is undertaken.

This report covers our findings in relation to the warning notice requirements only and should be read in conjunction with the latest comprehensive inspection report for the February 2017 inspection. This can be found by selecting the 'all reports' link for Dr Richard Hattersley on our website at www.cqc.org.uk. The full reports for the September 2015 and May 2016 inspections can also be found here.

At this inspection in April 2017, we checked the progress the provider had made to meet the significant areas of concern as outlined in the Warning Notice dated 16 February 2017, for a breach of Regulation 17 (Good Governance). We gave the provider until 31 March 2017 to rectify these concerns about governance of the practice. The Warning Notice was issued because we found there were inadequate systems or processes to effectively reduce risks to patients and staff as follows:

- Patients were at risk of harm because systems and processes were not being followed to keep them safe. For example, not all staff had received training in safeguarding and public areas were not effectively monitored for potential risks to patients and staff.
- The practice had no clear leadership structure and limited formal governance arrangements to ensure high quality care.
- Staff were able to report incidents, near misses and concerns; however the practice had not ensured that all staff understood what should be reported. Learning was not consistently shared with all staff to ensure improvements to care were made.
- Data showed patient outcomes were low in some areas compared to the locality and nationally. A limited amount of clinical audits had been carried out, and there was no effective system to manage performance and improve patient outcomes. There was limited focus on prevention and early detection of the health needs of all patients.
- Medicine safety alerts were not monitored to ensure they were followed through.

At our inspection on 11 April 2017 we found the provider had achieved compliance in some areas of regulation 17 as set out in the warning notice. However, there were still areas relating to the warning notice that required improvement. Our key findings were:

- There were effective systems in place to ensure learning from significant events and complaints occurred.
- Clinical audits had been commenced; these focussed on the areas of greatest risk to the practice, such as clinical workload.
- The practice had taken steps to reduce any potential health and safety risks for patients and staff.
- Patient outcomes were not closely monitored. For example, some patients with long-term conditions had not been reviewed by the practice in line with national guidance.

The other key lines of enquiry will be reassessed by us at another inspection when the provider has had sufficient time to meet the outstanding issues. At that time a new rating will be assessed for the provider. The outstanding issues that the practice must address are:

- Ensure policies reflect procedures in the practice and are readily available to staff.
- Ensure that all patients including those with long term conditions have their needs assessed and met.

In addition, the issues that the practice should address are:

- Review engagement with the patient participation group.
- Review the process to encourage patients to participate in screening programmes for breast and bowel cancer.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups, it will be re-inspected no longer than six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures.

Summary of findings

Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to 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 requires improvement for providing safe care until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that the areas relating to safe care had been met. These were:

- Systems to support communication and sharing of learning between all staff were in place. For example, with regard to complaints, medicines and healthcare products alerts, audits and service feedback.
- There was an effective system for reporting significant events and ensuring learning from this was disseminated to improve the quality of care.
- The practice had taken steps to reduce any potential health and safety and infection control risks for patients and staff.

Are services effective?

The practice is rated as requires improvement for providing effective services until a further comprehensive inspection takes place. Some improvements had been made since the previous inspection and we found that the Warning Notice relating to providing effective services had been partly met.

- Clinical audits had been commenced; these focussed on the areas of greatest risk to the practice, such as clinical workload.
- However, the recall system for patients who needed monitoring or a review to ensure they received the most appropriate care was not effective.

Are services well-led?

The practice is rated as inadequate for being well-led until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that the Warning Notice had been partly met. These were:

- Systems to support communication and sharing of learning between all staff were in place. For example, with regard to complaints, medicines and healthcare products alerts, audits and service feedback.
- The practice had taken steps to reduce any potential health and safety risks for patients and staff.
- The practice had taken steps to mitigate further risks to the practice.

Summary of findings

However, some areas detailed in the warning notice still require improvement:

- Some governance arrangements were still unclear. For example, the practice could not locate an up to date business continuity plan and some policies were incomplete.
- Not all systems were effective. For example, the recall system for patients who needed monitoring or a review to ensure they received the most appropriate care.

Dr Richard Hattersley

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. The team also included a GP specialist advisor.

Background to Dr Richard Hattersley

Dr Richard Hattersley, known locally as Boscombe Manor Health Centre, is based in Boscombe, a suburb of Bournemouth, Dorset. It has been at its present location since 1996, and operates out of a converted Victorian era building.

The practice is part of NHS Dorset Clinical Commissioning Group (CCG) and has an NHS general medical services contract to provide health services to approximately 2,900 patients. The practice is open from 8am to 6pm from Monday to Friday. Pre bookable extended hours appointments are available between 7.30am and 8am on Mondays and Thursdays. The practice has opted out of providing out-of-hours services to their own patients and refers them to the NHS 111 service or a local out of hours service.

The number of patients aged between 25 and 45 years old is up to four times higher than the national average. The practice is based in an area of high social deprivation and life expectancy for both males and females is lower than the CCG and national averages. The practice has more than twice the national average for patient turnover. Approximately 25% of the practice population changes every year; however the number of patients registered at the practice has remained constant. A high proportion of patients at the practice, approximately 13%, are affected by serious mental illness and/or substance misuse. Approximately 16% of patients registered at the practice do not speak English as a first language, with the majority of these originating from an Eastern European background.

The practice has one GP and one salaried GP who together are equivalent to 1.3 full-time GPs. Both GPs are male. The practice has one female practice nurse, who worked half a day per week and a female health care assistant, who worked one and half days per week. At the time of our inspection, the practice was also employing a locum nurse on a regular basis to undertake a day every fortnight. The clinical team are supported by a team of two full-time reception staff.

We carried out our inspection at the practice's only location which is situated at:

Dr Richard Hattersley

Boscombe Manor Medical Centre

40 Florence Road

Boscombe

Bournemouth

Dorset

BH5 1QH

Why we carried out this inspection

We carried out an announced focussed inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection

Detailed findings

was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service.

We carried out an announced focussed inspection on 11 April 2017 to look specifically at the shortfalls identified in the warning notice served to the practice after our inspection in February 2017.

How we carried out this inspection

We carried out an announced focussed inspection on 11 April 2017 to check that necessary improvements had been made in respect of the warning notice served following our inspection in February 2017.

During this inspection, we did not look at population groups or speak with patients who used the service.

We spoke with the lead GP, a supporting practice manager and two reception staff.

We looked at policies and procedures and inspected records related to the running of the service. These included minutes of staff meetings, significant events and action plans produced by the practice to address concerns and complaints.

Are services safe?

Our findings

Safe track record and learning

At our inspection on 2 February 2017 we found shortfalls in identifying and acting on significant events. Reporting processes did not ensure that significant events were reported, recorded appropriately and monitored when action points had been identified. Significant events were discussed at clinical meetings however there were no regular staff meetings for all staff to keep informed of significant events. This meant that learning was not effectively shared with relevant staff members.

At this inspection , we found that the processes for managing significant events had been improved. Significant events, verbal incidents and complaints were now discussed and minuted in monthly whole staff meetings to ensure learning was shared. Appropriate actions were taken where necessary. Agendas for partner and staff meetings were standardised to ensure that significant events, incidents and complaints were standing items to be discussed. There was a system to ensure that all staff received a copy of the minutes and any actions arising from meetings were monitored for completion.

Discussion with staff confirmed that these were discussed in meetings and they were able to describe changes in practice as a result of significant events. The practice had also conducted a retrospective review of untoward incidents going back to June 2016 to ensure improvements to care were made. For example, a patient had fraudulently attempted to gain a prescription for a controlled medicine by claiming to be a health professional. The request was denied by staff who followed the correct procedures. The clinical lead reviewed the patient's notes and ensured they were receiving appropriate support and treatment.

Monitoring risks to patients

At our inspection in February 2017, we found limited oversight of monitoring risks to patients and staff. Systems, processes and policies were not in place to manage and monitor risks to the health, safety and welfare of patients, staff and visitors to the practice. For example, we found disused equipment and paperwork, as well as a large piece of chipboard stored in public areas. Vaccines were stored in fridges which were not secure and in a publically accessible area of the practice.

At this inspection, we found that the practice had implemented an action plan to manage all shortfalls identified in the warning notice served. Health and Safety risks to patients and staff were monitored and mitigating actions had been taken. Debris, which posed a fire or accident risk, had been removed from public areas and the previously unsecure vaccine fridge had been decommissioned. Health and Safety risk assessments had been reviewed since our last inspection in February and all appropriate actions had been taken. Practice staff conducted a daily walk-around of the practice to check for any health and safety issues.

At our last inspection in February 2017, we found that there was limited oversight of the infection control procedures in the practice. We found that a locum nurse was mostly employed by the practice and could describe infection control procedures appropriately. However, no records of cleaning for clinical equipment were kept so that practice could not demonstrate equipment did not pose an infection risk.

At this inspection, we found that the infection control lead nurse had implemented cleaning records for clinical equipment, such as a spirometer (a device for measuring breathing) and ear syringing equipment. These were completed for before and after each use and had been implemented since 7 February 2017. In addition, a protocol outlining the steps required for adequate cleaning was available to staff.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for patients

At the inspection in February 2017, we found that Quality and Outcome Framework (QOF) reporting exceptions were significantly higher than national and clinical commission group averages for cervical screening and for long-term conditions. QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. We found the practice was not proactive at conducting reviews for people with long-term conditions.

At this inspection we found that a protocol had now been written for the recall of patients with four specific long-term conditions. A member of staff conducted a monthly search of patients due a recall for these conditions. The practice then invited them to attend for a review.

However, we found that patients with other long-term conditions were not part of this recall system. We identified approximately 60 patients who had not been recalled by the practice for a review, or for tests to help monitor their condition. We reviewed the care of a random sample of ten of these patients and found that some patients had not had all of the blood tests or reviews required at the correct times to ensure their care and treatment was appropriate.

We raised this with the practice. The clinical lead agreed to review these patients as a priority to ensure there were no safety issues. The practice manager supporting the practice agreed to help develop the recall systems for patients to ensure all patients received the care they required at the required intervals. The practice agreed to give us weekly updates with regard to the progress of these actions. Actions included increasing the number of clinical slots available to help support these patients.

The practice told us that patients were not excepted from cervical screening data. Patients eligible for this screening test were invited by the clinical commissioning group but were not actively followed up by the practice if they chose not to attend.

The practice had effective systems in place to ensure children registered at the practice received relevant immunisations. A receptionist checked that appointments were made for immunisations against a weekly schedule generated by Child Health Services. Families were phoned or contacted by text message if no appointment had been made. If there was no response families then received a letter. If there was still no response, appropriate referrals were made to health visitors.

At the inspection in February 2017, we found there was limited oversight of quality improvement. The provider was reliant on leadership from the organisation it had at that time planned to merge with to drive quality improvement. Audit activity in the last 12 months was limited to medicine audits supported by the clinical commissioning group.

At this inspection, we found that the provider had commenced two clinical audits in March 2017. These focussed on the areas of greatest risk to the practice, such as uptake of the early morning surgeries offered and the outcomes of two week wait cancer referrals. Due to the short time since our previous inspection in February 2017, the second cycle of the audits were not complete. We were told they would be re-audited to monitor improvements.

At our last inspection in February 2017, we found limited oversight with regard to care plans for patients receiving end of life care. For example, we reviewed the records of two patients receiving end of life care, and found that neither patient had a care plan in place. This meant the practice could not demonstrate that care was communicated effectively between relevant teams and specialities.

At this inspection, we reviewed the care given to end of life patients and found that all care was appropriate.

Are services well-led?

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

Our findings

Following our inspection in February 2017, we rated the provider as inadequate for well-led. A warning notice was issued in respect of regulation 17 (Good Governance) of the Health and Social Care Act 2014. This was because the delivery of high-quality care was not assured by the leadership and governance in place. The provider did not have an effective governance framework which supported the delivery of the strategy and good quality care.

At this inspection on 11 April 2017, we specifically assessed gaps highlighted in the warning notice dated 16 February 2017 relating to good governance.

Governance systems

At our inspection in February 2017, we found the practice did not have suitable systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. Systems in place to monitor or mitigate risks were not operated effectively to ensure that risks to patients were minimised as far as possible.

During that inspection we found limited systems relating to medicines safety alerts. Medicines safety alerts were disseminated to staff. However, the practice could not demonstrate that medicine safety alerts were monitored to ensure they were followed through. Clinicians were unable to discuss recent medicine alerts issued in the previous year and the implications these had for patients. This meant the practice could not demonstrate prescribing remained in line with recommended guidance.

At this inspection we found that all safety alerts were reviewed by the clinical lead. Alerts were categorised as red, for the urgent attention of GPs or amber for less urgent attention. The clinical lead also kept a log of all alerts received by the practice. National Institute for Health and Care

Excellence (NICE) best practice guidelines were now discussed as a standing agenda item at clinical meetings. The practice also uses NICE templates for the recording of patient care. We saw evidence that the clinical lead prompted and supported staff to use NICE guidelines for treatment of conditions.

At our last inspection in February 2017, we found that the policies which the practice had in place did not reflect procedures in the practice. For example, the complaints policy referred to the practice manager who had left and the business continuity plan referred to procedures in 2013. There had been no liaison with the patient participation group since the departure of the practice manager.

At this inspection, we found that the practice had developed an action plan to monitor and review policies. At the time of our inspection, this was marked as 75% complete. Policies were available to staff electronically via a shared area on the computer. Hard copies of some policies were also kept in the reception area. We were told that an up to date business continuity plan was available on the shared area, however this could not be found by staff. Other policies, such as the Legionella Disease policy, and Health and Safety policy still referred to staff who were no longer at the practice.

There were also examples of improvements. The practice had reviewed its policy for the management of blood form requests and had created a spreadsheet to monitor patients who did not collect forms for blood tests. The practice monitored patients to ensure they received their tests as appropriate.

Leadership and culture

At our last inspection we found that the lead GP in the practice had the experience to run the practice, however they did not have the capacity to ensure consistently safe and high quality care. The practice did not have a permanent practice manager and leadership was in part provided by another organisation for human resources and for emergency cover. It was not clear how the duties of the practice manager were being covered by the practice.

Since our last inspection, the provider had been supported by external stakeholders, such as the clinical commissioning group (CCG) and local medical council (LMC), to look at ways to improve patient care. Actions taken to reduce any potential risks included:

- Following the inspection in February 2017, the practice consulted with the CCG, LMC and NHS England about the need to suspend patient registrations during a recovery period for the practice. A patient list closure had been agreed with effect from 31 March 2017.

Are services well-led?

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

- The provider had previously pursued a merger with a local practice to provide and improve services for patients and had liaised with the CCG to achieve the merger. We were told on this inspection that the merger was no longer proceeding.
- The provider had decided to terminate their contract to provide general medical services to patients and had handed in their notice. The provider was being supported by the CCG and LMC to minimise disruption to patients. Patients had been notified of the closure.
- The provider was receiving support from two external practice manager specialists appointed by the LMC to support the practice.

At our last inspection in February 2017, we found there were no routine whole staff meetings or meetings for specific staff roles. Staff told us the outcomes of complaints were not always feedback to staff so learning and improvements to care could be made. At this inspection we found that regular staff meetings were now taking place and these were minuted. Staff told us they felt informed of the outcomes of complaints. The practice kept a log of complaints received. We reviewed the log and found that since our last inspection in February 2017, two verbal complaints had been recorded, responded to appropriately and discussed in staff meetings for learning.

The practice was due to cease providing services to patients at the end of June 2017. Staff were well informed with regard to how they could support patients during the closure of the practice. Some staff had decided to leave the practice and the remaining staff had agreed to increase their hours to ensure reception duties were covered. The practice was following the correct procedures to support staff through the practice closure and redundancy processes.