Fitzalan Medical Group

Inspection report

Fitzalan 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.

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Inadequate**

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Fitzalan Medical Group on 19 December 2017. The overall rating for the practice was inadequate. The full comprehensive report on the December 2017 inspection can be found by selecting the 'all reports' link for Fitzalan Medical Group on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 4 April 2018 to confirm that the practice was compliant with a warning notice issued following the December 2017 inspection. A warning notice was issued against regulation 17 (1) (good governance) and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report covers our findings in relation to the requirements against regulation 17 (1) (good governance).

The ratings remain unchanged from the December 2017 inspection as the purpose of the April 2018 inspection was to review compliance against the warning notice issued.

Our key findings were as follows:

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  - A fire safety risk assessment had been undertaken with fire alarm tests and drills logged.
  - Data provided by the practice showed that performance against the Quality Outcomes Framework and patient recalls for monitoring had improved.
  - There was positive progress with clinical audits and an audit activity plan was in place.
  - There was positive planning for supervision and audit of prescribing activity for the non-medical prescribers.
  - A Disclosure and Barring Service (DBS) policy and been updated to include a risk assessment for each role within the practice. There was evidence that the policy was being followed.
  - Improvements were seen to policy updates and the practice had developed a system of review to sustain this improvement over time.

However, there were also areas of practice where the provider needs to make improvements.

- There was some improvement to the review of significant events and action taken as a result, however, this was not consistent. There was no system to ensure that an overview of trends and themes was maintained so it was not clear that trends and themes would be identified.
- Water temperature checks were outside of the range recommended within the legionella risk assessment and policy. This had not been identified by the practice; therefore action to address it had not been taken.

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.**
The team included a second CQC inspector.

Background to Fitzalan Medical Group

The practice is situated near the centre of Littlehampton, West Sussex, and provides general medical services to approximately 17,075 patients. The patient list was capped at the time of inspection. In October 2016 the practice took on 2,500 additional patients following the closure of a neighbouring practice. There are four GP partners (male and female) and seven salaried GPs (male and female). The practice also employs three paramedic practitioners, a nurse practitioner, seven practice nurses and three health care assistants.

Opening hours are Tuesdays, Thursdays and Fridays 8.00am to 6.30pm and Mondays and Wednesdays 8.00am to 8.00pm. The practice also provides nurse and health care assistant appointments from 7.30am on Thursdays. The practice provides a wide range of services to patients, including asthma and diabetes clinics, chronic disease monitoring, cervical screening, childhood immunisations, family planning, smoking cessation and minor illness clinics. Ear, nose and throat and kidney clinics were hosted by the practice.

The practice has a contract with NHS England to provide general medical services. The practice has a higher than national average percentage of its population over the age of 65. It also has a higher than local and national average percentage population with income deprivation affecting children and older people. The practice serves a high number of registered patients from Eastern Europe.

The practice has opted out of providing Out of Hours services to their own patients. Patients were able to access Out of Hours services through NHS 111.

The practice provides a service to all of its patients at two locations :-

Fitzalan Road

Littlehampton

BN17 5JR

And;

Wick Surgery

66 Clun Road

Littlehampton

BN17 7EB

Our inspection was undertaken on the practice premises at Fitzalan Road.

Inadequate

Are services safe?

At our previous inspection on 19 December 2017, we rated the practice as inadequate for providing safe services as safety systems and processes and lessons learned and improvements made were not adequate.

These arrangements had improved when we undertook a follow up inspection on 4 April 2018. We found that the practice had taken action against most areas of the warning notice issued following the December 2017 inspection. However, action relating to the risk of legionella and lessons learned and improvements made as a result of significant events were insufficient. The ratings remain unchanged from the December 2017 inspection as the purpose of the April 2018 inspection was to review compliance with the requirements of the warning notice.

Safety systems and processes

At this inspection we found that the practice had clear systems to keep people safe and safeguarded from abuse.

- In December 2017 we found that non-clinical staff were employed without first considering whether they should receive a DBS (Disclosure and Barring Service) check to help decide their suitability for working with vulnerable adults and children. A risk assessment had not been carried out on each role within the practice to identify which roles should be subject to DBS checks, including those non-clinical staff undertaking chaperone duties.
- At the April 2018 inspection we found that the practice had reviewed their DBS policy and that all roles working within the practice were now subject to a risk assessment to help identify which roles should be subject to DBS checks. We reviewed risk assessments for two members of the administrative team where the level of risk was identified as low and as a result a DBS check was not deemed to be required.

Track record on safety

The practice did not have a good track record on safety.

- At our inspection in December 2017 we found the practice had undertaken some safety risk assessments. However, a Legionella risk assessment that had last been carried out in 2013 had not been monitored to ensure that a repeat risk assessment due in 2015 was carried out. Risks were not always mitigated. Hot water temperatures were routinely monitored, but the results of these at times fell below the recommended hot temperature range indicated by the 2013 risk assessment. A fire risk assessment had not been reviewed since 2015 and there was no record of fire drills taking place within the practice.
- At the April 2018 inspection we found that the practice had ensured an external fire risk assessment had been carried out in April 2018. There was also evidence of weekly fire alarm testing and two fire drills had been recorded as having been carried out in January 2018. A Legionella risk assessment had been carried out by an external water treatment company in January 2018. The risk identified from this was rated as a medium level risk and issues were identified with the hot water temperatures being too low. The risk assessment stated that if remedial action was taken to rectify the remedial actions identified then the potential site risk rating would reduce to low. However, there was no evidence that remedial actions had been taken.

Lessons learned and improvements made

The practice did not consistently learn and make improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- During the December 2017 inspection we found that learning was not consistently shared and used to make improvements. While there was some evidence that improvements had been made as a result of complaints, there was little evidence to demonstrate that improvements resulted from a review of significant events. In April 2018 there were some systems in place for reviewing and investigating when things went wrong. However, the practice did not consistently learn and share lessons, nor had they identified themes or ensured consistent comprehensive action to improve safety in the practice.

Please refer to the Evidence Tables for further information.

Inadequate

Are services effective?

At our previous inspection on 19 December 2017, we rated the practice as inadequate for providing effective services as Quality Outcomes Framework (QOF) data showed the practice was performing significantly below national standards in a number of areas and there was no comprehensive audit plan for the practice and no evidence of current auditing of clinical performance.

These arrangements had improved when we undertook a follow up inspection on 4 April 2018. We found that the practice had taken action against most areas of the warning notice issued following the December 2017 inspection. There were improvements in the practice performance against QOF and an audit plan had been developed with evidence of clinical audit having been undertaken.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

Monitoring care and treatment

The practice had worked to improve their programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

- At the December 2017 inspection we found that the most recent published Quality Outcome Framework (QOF) results were 83% (a drop from 98% the previous year) of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. Exception reporting was high at 20% compared with a national average of 10%, this had been consistently higher than average for the previous four years. (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 decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)The practice used information about care and treatment to make improvements.
- At our April 2018 inspection the published QOF data was the same as the data available in December 2017 so it was not possible to measure any changes based on this data. However, the practice provided us with unverified data during the inspection that showed improvement in performance. Exception reporting figures were not available; however the practice was aware of areas where improvements could be made.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Please refer to the Evidence Tables for further information.

Are services well-led?

At our previous inspection on 19 December 2017, we rated the practice as inadequate for providing well led services as systems and processes for assessing, monitoring and mitigating risk and improving the quality of services were not adequate.

These arrangements had improved when we undertook a follow up inspection on 4 April 2018. We found that the practice had taken action against most areas of the warning notice issued following the December 2017 inspection. The ratings remain unchanged from the December 2017 inspection as the purpose of the April 2018 inspection was to review compliance with the requirements of the warning notice.

Governance arrangements

- At the December 2017 inspection we found there was no system to ensure regular review of practice policies.
- At the April 2018 inspection we found that the practice had improved the management of policies and those we viewed had been reviewed. The practice had also changed the structure of their meetings and implemented a system where policies were discussed on a regular basis to ensure that they were reviewed and up to date.
- At the December 2017 inspection we found that practice leaders had not established proper policies, procedures and activities to ensure safety and assure themselves that they were operating as intended.
- At the April 2018 inspection we found improvements to the management and review of practice policies and procedures. There were some improvements to activities involving the review of significant events; however there was no identification of trends and themes within the practice.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

- In the December 2017 inspection it was identified that the practice did not have a comprehensive clinical audit plan in place. They had not demonstrated the performance of employed clinical staff through the audit of their consultations, prescribing and referral decisions.
- In April 2018 we found that a clinical audit programme was being developed. The audits carried out demonstrated a positive impact on quality of care and outcomes for patients. There were plans in place to audit the consultations, prescribing and referral decisions of employed clinical staff.
- In December 2017 risks had not been adequately assessed and mitigated in relation to fire and Legionella risks.
- In April 2018 fire and Legionella risks had been identified and there was evidence of mitigation relating to fire risk in the form of regular fire drills. However, risks relating to Legionella had not been adequately mitigated.

Please refer to the Evidence Tables for further information.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:The provider did not have oversight of significant events and safety incidents in order to identify trends and themes. Learning opportunities as a result of significant events and safety incidents were not consistently identified and acted on. The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:The provider did not take action to ensure that mitigation of the risk of Legionella was sufficient and in line with the practice policy and risk assessment.