Dosthill 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.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced inspection at Dosthill Surgery on 17 March 2015. The inspection was to follow up warning notices we issued after an inspection on 28 September 2015 when the practice was rated as inadequate and placed into special measures.

At our inspection on 28 September 2015, we found the provider to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued warning notices in respect of the following breaches of regulations:

Regulation 12: Safe care and treatment

Regulation 17: Good governance

Our follow up inspection on 17 March 2016 was to look at the areas we identified in the warning notices to determine if the required improvements had been made. During the inspection we saw other areas of serious concern.

Our key findings were as follows:

- Patients' blood test results were not being actioned in a timely manner. Evidence was seen that 1,314 blood results had not been reviewed, 904 of which were highlighted by the system as abnormal.
- We reviewed thirteen of the unactioned blood results that were more than one month old. Eight of the 13 patients were at risk of avoidable harm. For example, one patient was at risk of a stroke.
- Patients on repeat prescription were not managed effectively. For example, a patient on a controlled drug had not had their medication reviewed since 9 July 2014.
- A review of patient letters found that the processing of correspondence was up to date. However we found a deleted email that had not been not been actioned or attached to the patient record.
- Patients on high risk medication had been identified and recalled for retest appointments when needed. However medication had been stopped by the practice for two patients with no reasons recorded, no notification to the patient, and no notification to the consultant who had initialised the medication. Evidence sent after the inspection confirmed that one of the patient's had had their medication stopped by a hospital consultant.
- Staff files contained appropriate checks. For example, proof of professional qualifications, two forms of personal identification.
- Relevant staff training had been completed or planned.

Summary of findings

- Health and safety improvements had been made following our inspection in September. For example, risk assessments completed included use of visual display units, slips and trips and lone working.

Following the inspection, we wrote to the provider requiring them to take immediate steps to clear the backlog of blood test results, and to put in place a series of measures to ensure patient safety. We reviewed the provider's response and decided that they had taken sufficient action to maintain patient safety.

As this inspection only focussed on the two warning notices previously issued, the practice's original rating of Inadequate remains. This will be reviewed at a further comprehensive inspection within two months, when we will also check that the improvements made after this inspection have been maintained.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because blood test results were not being reviewed and actioned in a timely way to keep them safe. We reviewed 13 abnormal blood test results that dated back to 11 December 2015. Eight of the 13 required follow up action.
- There was no robust system to ensure patients on repeat prescriptions were receiving medication reviews. We saw evidence of a patient on a controlled drug with an overdue medication review that dated back to July 2014.
- A review of two patients on Methotrexate showed that the medication had been stopped by the practice with no reason recorded, no notification to the patient, and no notification to the consultant rheumatologist who had initialised the medication. Evidence sent after the inspection confirmed that one of the patient's had had their medication stopped by a hospital consultant.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

We found a lack of leadership and governance relating to the overall management of the service. The practice was unable to demonstrate strong leadership to improve safety, outcome for patients or learning from significant events.

- One clinical audit was completed since the September 2015 inspection. A second audit planned had not started. A GP partner stated that this had been completed.
- There was insufficient recording, reviewing and learning from significant events.
- Complaints were not always recorded, reviewed and shared with staff.

Summary of findings

- A meeting schedule had been completed for 2016 that included clinical meetings, administration team meetings and safeguarding meetings. The implementation of the complaints and significant events review meeting had been delayed to allow time to update staff fire training.
- A health and safety action plan had been written and actions had been completed or planned. For example, chaperone training had been completed by non-clinical staff, and risk assessments had been completed for the premises.
- Disclosure and barring service (DBS) checks had been completed for all staff.
- Staff training was effectively recorded and monitored.

Dosthill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by two Care Quality Commission (CQC) Inspectors and a GP specialist adviser.

Background to Dosthill Surgery

Dosthill Surgery is situated in Tamworth, Staffordshire. It has a branch surgery in Parsonage Street in Wilnecote We found that the provider is incorrectly registered with CQC as they had registered their two sites as separate locations when they operate as a main location with a branch surgery with the same patient list, and with the governance arrangements managed from Dosthill Surgery. An application to correct the registration had been submitted to the CQC.

The patient population totals 7,800 patients of all ages registered at the practice. The practice is owned by a partnership of two GPs. The staff team comprises the two full time male GP partners, a long term female locum GP (the practice also uses other locum GPs when required).

The practice clinical team includes four practice nurses, two mental health nurses on a self-employed basis and a health care assistant, working various part time hours across both of the providers' surgery locations.

Why we carried out this inspection

This unannounced focused inspection was carried out under Section 60 of the Health and Social Care Act 2008 in follow up from previous comprehensive inspection at Dosthill Surgery in September 2015. At our previous inspection we identified breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008.

We took enforcement action against CNCS by issuing two warning notices to tell them that services must be improved.

This inspection was to ensure that the provider had met the requirements and timescales of two warning notices issued to them under the Health and Social Care Act 2008.

How we carried out this inspection

We carried out an unannounced inspection on 17 March 2016. During our inspection we spoke with the two GP partners and the practice manager, the practice nurse and three members of administrative staff. We reviewed care and treatment records and other supporting information. We did this to establish how people were being cared for and to check that improvements had been made following our previous inspection.

Inadequate

Are services safe?

Our findings

During our previous inspection in September 2015, we saw that responsibility for checking blood test results had been delegated to staff who were not suitably qualified, experienced or skilled. Following that inspection, the practice had introduced a protocol which stated that all blood test results had to be checked by a GP. However we found that there was a backlog of results that had not been reviewed or actioned.

- We saw that 1,314 patient blood test results had not been reviewed or actioned, 904 of which were indicated as being abnormal. The oldest blood test result not reviewed dated back to 11 December 2015.
- Thirteen of the unactioned blood results were reviewed by the inspection team. We found that eight of the 13 patients reviewed were at risk due to the unactioned results. For example, one patient was at risk of a stroke, and one patient was at risk of impaired eyesight.

During our inspection, we checked to ensure the provider was providing care to nationally recognised standards. We saw that the overall management and oversight in the way that patients received medicines was unsafe and placed them at risk of harm.

- We found a repeat prescription for one patient on a controlled drug that had a medication review date overdue from 9 July 2014. Further investigation showed that the patient had been seen by a GP since the review date but no medication review had been done. This contradicted what we were told by the GPs who said that they performed opportunistic medication reviews when patients attended for other reasons.
- A review of patient letters found that the processing of correspondence was up to date. However we found a hospital letter in the deleted items box of the email account used to receive letters that had not been acted and had not been attached to the relevant patient record.
- Following a serious incident last year, the GPs had cancelled automatic repeat prescriptions for patients on Methotrexate, a high risk drug commonly used to treat rheumatoid arthritis.Although well intentioned, this action appears to have resulted in the GPs losing oversight of which patients were on the medication. A review of two of the 20 patients thought to be on this drug found that they had stopped taking it, but no reasons as to why had been recorded in their notes, there was no evidence that the patients had been informed, and there was no evidence that the hospital consultant who had initialised the prescription had been told. Regular blood tests had continued on these patients even the medication had been stopped. Evidence sent after the inspection demonstrated that one of the patients had their medication stopped by a hospital consultant.

Are services well-led?

Inadequate

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

Our findings

Improvements had been made in some of the administrative requirements detailed in the warning notice :

- A health and safety action plan had been written and actions had been completed or planned. For example, an approved health and safety advisor had completed a comprehensive review of compliance.
- A fire risk assessment of both surgeries had been carried out in January 2016. Regular fire drills were undertaken. The date of the last one was 14 January 2016. The fire alarm was tested weekly.
- Disclosure and barring service (DBS) checks had been completed for all staff. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- A business continuity pan had been produced and a copy was kept off site.
- A system was in place to provide notification to clinical staff of national guidance and guidelines issued by the National Institute for Health and Clinical Excellence (NICE).
- Staff training had been completed or planned for all staff. For example we saw evidence that staff had completed training in safeguarding, acting as a chaperone, and fire safety.
- The practice safeguarding policy had been revised and implemented. There was clear governance around safeguarding and staff were aware of who was the safeguarding lead. Regular meeting were held with health visitors and social workers. A notice in reception provided contact details for local safeguarding leads and the safeguarding board. Staff had received the appropriate training. For example, the GPs had received level three safeguarding training for adults and children.
- A locum pack had been introduced. This included a checklist completed for each locum used and information for that locum on roles of staff within the practice.
- Staff files checked included evidence of professional registration, proof of identity, immunisation status for clinical staff, medical insurance, DBS checks and appraisals. There was no health screening done on new staff.
- The business continuity plan (BCP) had been reviewed and a copy was kept off site.

There was no evidence that GPs used clinical audit to monitor patient outcomes of care and treatment. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Knowledge of and reference to national guidelines was inconsistent.

- One clinical audit had been completed since the September 2015 inspection. This was reviewed and found to be a response to a Medicines and Healthcare products Regulatory Agency (MHRA) alert for a drug to lower cholesterol issued in December 2014.
- A second clinical audit was said to have been completed. We asked to see a copy but we were then told that the audit had been planned but not yet started.

  Quality and Outcomes Framework (QoF) data was regularly reviewed by the practice manager. The overall performance for 2015/16 showed a small improvement on the previous year. In 2014/15 the total QoF achievement was 79.5%. On the day of inspection the practice had achieved 82.3% for 2015/16 with two weeks of the QoF year remaining.
- There was insufficient recording, reviewing and learning from significant events. During the inspection we asked to see a copy of any events or incidents that had been recorded since the last inspection. We were told that none had been recorded. When asked, practice staff were able to tell us of events that should have been recorded. For example, the practice had experienced staff shortages.
- Not all clinical staff were aware of the Duty of Candour.

There was a complaints policy. One complaint had been recorded since the last inspection. However, staff confirmed:

- Not all complaints were recorded, reviewed and shared with relevant staff.

Are services well-led?

Inadequate

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

- Complaints were not a standard agenda item for practice meetings as indicated in the practice's own policy.

The one complaint recorded had been dealt with appropriately