Daneshouse 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 Daneshouse Medical Centre on 5 April 2017. The overall rating for the practice was inadequate, and we issued warning notices for breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints) and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). The full comprehensive report following the inspection in April 2017 can be found on our website here: http://www.cqc.org.uk/location/1-586401697.

This inspection was an announced focused inspection carried out on 22 August 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches identified within the warning notices.

Summary of findings

Our key findings were as follows:

- The practice had made improvements to its procedures for handling complaints and was found to be meeting Regulation 16 (Receiving and acting on complaints).
- While some progress within the practice's governance arrangements had been made, we found that further improvements were required.
- The system for identifying, recording, and investigating significant events had improved.
- Some improvements had been made around managing risk.
- Information contained in practice policy and procedure documents remained inconsistent, with updated documents not yet fully embedded into practice.
- Full ownership of designated lead roles had not been assumed. For example, the infection prevention and control lead was not aware of the content of the most recently completed IPC audit, and action had not been taken to address issues the audit had identified.

At our previous inspection on 5 April 2017, we rated the practice as inadequate and placed the service into special measures. As per our published inspection methodology, a further full comprehensive inspection visit will be carried out shortly in order to monitor the work the practice has begun to implement the required improvements to the service.

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 5 April 2017, we rated the practice as inadequate for providing safe services. Findings identified as breaching regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance) included:

- Inadequate systems to monitor the location of blank prescription paper.
- Incorrect contact details for local safeguarding teams being available for staff.
- Inadequate systems and processes to manage, assess and mitigate risks.
- Action had not been taken following a recent infection prevention and control audit.
- The system for identifying, recording, investigating and monitoring significant events was not adequate.

There had been some improvements with these arrangements when we undertook a follow up inspection on 22 August 2017, although further improvements were still required.

- The location of blank prescription paper was now monitored and recorded appropriately.
- The contact details for local safeguarding teams had been updated in practice policies, but information displayed in consultation rooms was inconsistent, with some rooms displaying incorrect information.
- Some improvements had been made around managing risk. Premises safety checks were now more comprehensive. However, a recommended control regime to mitigate the risk of legionella had not been implemented.
- Actions had not yet been undertaken that were identified in the infection prevention and control audit completed in March 2017.
- The system for identifying, recording, and investigating significant events had improved. We found evidence that identification of a recent significant event had resulted in appropriate action being taken.

Are services responsive to people's needs?

At our previous inspection on 5 April 2017, we rated the practice as inadequate for providing responsive services. We found that the provider had not established an accessible or effective system for

Summary of findings

identifying, receiving, recording, handling and monitoring complaints. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints).

When we revisited the practice on 22 August 2017 we saw that the practice's system for managing complaints had improved. One complaint had been documented by the practice since the new practice manager had been appointed and we saw that this had been appropriately handled.

Are services well-led?

At our previous inspection on 5 April 2017, we rated the practice as inadequate for providing well led services. We identified significant gaps in the practice's governance arrangements and these were found to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

At our August 2017 inspection we found some improvements had been made, but ongoing work was required to appropriately embed governance systems into practice.

- Some policies had been updated to make them more practice specific. However, we saw examples where others were duplicated, with inconsistent information contained in each. Staff were not always accessing the most up to date version of policies.
- Full ownership of designated lead roles had not been assumed. For example, the infection prevention and control lead was not aware of the content of the most recently completed infection prevention and control audit.
- Some improvements had been made around the management of risk.
- The practice demonstrated how it was taking action to address patient feedback around difficulty accessing appointments. An audit of appointment demand and capacity was underway with a view to reviewing the appointment system on its completion.

Daneshouse Medical Centre

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 second CQC inspector.

Background to Daneshouse Medical Centre

Daneshouse Medical Centre (Old Hall Street, Burnley, BB10 1LZ) is housed in purpose built, single story premises on the outskirts of Burnley. The practice has a small car park, with designated disabled spaces and a ramp to facilitate access for those patients experiencing mobility difficulties.

Since our previous inspection visit, the provider has appropriately updated their registration with the Care Quality Commission and so is now registered to deliver regulated activities as a single handed GP rather than a partnership.

The practice delivers primary medical services to approximately 3400 patients through a personal medical services (PMS) contract with NHS England, and is part of the NHS East Lancashire Clinical Commissioning Group (CCG).

The average life expectancy of the practice population is below national but in line with CCG averages for females and below both the local and national averages for males (81 years for females, compared to CCG average of 81 and national average of 83. For males; 73 years compared to CCG average of 77 and national average of 79). The practice patient population contains a higher proportion of younger people when compared to local and national averages. For example, 9% are aged between 0 and 4 (CCG and national averages 6%), 25% aged between five and 14 years (CCG and national averages of 12%) and 39% aged under 18 (CCG average 22% and national average 21%). Conversely, only 5% of the practice's patient population are aged over 65, compared to the CCG average of 18% and national average of 17%, while 2% are aged over 75 (CCG and national averages 8%).

A higher proportion of the practice's patients are unemployed; 10% compared to the CCG average of 5% and national average of 4%. The practice caters for a lower proportion of patients with a long standing health condition (44% compared to the CCG average of 56% and national average of 53%).

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by the lead GP (male), with two long term locum GPs (one male, one female) adding a further 0.4 whole time equivalent GP time each week. The practice employs a practice nurse for two days each week. On the day of our visit, a new long term locum practice nurse was also commencing work at the practice, with a view to working there two days per week. The practice had also employed a health care assistant since our previous visit. The clinical team are supported by a newly appointed practice manager, who had commenced employment at the practice two weeks prior to our most recent visit, an assistant practice manager and a team of four receptionists / administrative staff.

The practice telephone lines are staffed between 8am and 6.30pm each working day, apart from between 12.30pm and 2pm on a Monday. The practice premises are open from 8am until 6:30pm Monday to Friday, again apart from 12.30 until 2pm on a Monday afternoon. Appointments with the GP are available between 9:30am and 11:40am each

morning and between 3.30pm and 5:50pm each afternoon, apart from Wednesday afternoon when appointments start at 4pm. Extended hours appointments are also available between 6:30pm and 7.15pm each Monday and Tuesday evening.

Outside normal surgery hours, patients are advised to contact the out of hour's service, offered locally by the provider East Lancashire Medical Services.

The practice has previously been a teaching practice, but has not had a student placement for over a year.

Why we carried out this inspection

We undertook a comprehensive inspection of Daneshouse Medical Centre on 5 April 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate, and we issued warning notices for breaches identified to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints) and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). The full comprehensive report following the inspection in April 2017 can be found on our website here: http://www.cqc.org.uk/location/1-586401697.

We undertook a follow up focused inspection of Daneshouse Medical Centre on 22 August 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice had addressed concerns identified in the warning notices issued.

How we carried out this inspection

We carried out a focused inspection of Daneshouse Medical Centre on 22 August 2017.

During our visit we:

- Spoke with a range of staff, including the lead GP, new practice manager, new practice nurse, reception and administration staff.
- Reviewed a range of practice documents, policies and procedures.
- Observed practice premises and facilities.

During the visit we focussed on the content of the two warning notices issued following our previous inspection in April 2017:

- The practice's processes for managing complaints.
- The governance structures that were in place to support the delivery of safe, effective care.

Are services safe?

Our findings

At our previous inspection on 5 April 2017, we rated the practice as inadequate for providing safe services. Findings identified as breaching regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance) included:

- Inadequate systems to monitor the location of blank prescription paper.
- Incorrect contact details for local safeguarding teams being available for staff.
- Inadequate systems and processes to manage, assess and mitigate risks.
- Action had not been taken following a recent infection prevention and control audit.
- The system for identifying, recording, investigating and monitoring significant events was not adequate.

There had been some improvements with these arrangements when we undertook a follow up inspection on 22 August 2017, although further improvements were still required.

Safe track record and learning

At our previous inspection in April 2017, we found the practice lacked an effective system for reporting and recording significant events. In August 2017 we found that improvements had been made. Since the new practice manager had commenced employment with the organisation we saw that a significant event had been clearly documented relating to a break in the cold chain (a term used to describe the cold temperature conditions certain products, including vaccines, need to be kept during storage and distribution in order to maintain their effectiveness). We saw that actions the practice had taken following the event's identification were clearly documented; the practice had sought advice appropriately from the local vaccination and immunisation team, staff responsible for checking vaccine fridge temperatures had been spoken to and reminded of the practice's cold chain policy and the settings of the new electronic temperature logger updated to ensure it was recording temperatures at an appropriate frequency. Staff we spoke to were aware of these changes. We also saw the incident and associated learning outcomes were identified on the practice's meeting agenda for the next practice meeting.

Overview of safety systems and process

During our April 2017 inspection we found the practice lacked clearly defined and embedded systems, processes and practices to minimise risks to patient safety. For example, there were some gaps in arrangements for safeguarding; the practice's safeguarding policy contained out of date contact details for further guidance if staff had concerns about a patient's welfare. In August 2017 we found that while the practice had updated its policy documents to include current contact details of local safeguarding teams, the contact numbers displayed on the walls in consultation rooms were not consistent, with some still out of date or incorrect. This potentially meant that new staff members may have difficulty contacting the appropriate safeguarding team should the need arise.

In April 2017 we identified that patients did not have appropriate access to trained members of staff to act as chaperones during intimate examinations. During our August 2017 inspection, practice staff confirmed that only clinical staff members acted as chaperones. Since our previous inspection an additional practice nurse had been recruited, meaning there was increased capacity for an appropriate chaperone to be offered to patients who required one.

In April 2017 we found some gaps in the management of infection prevention and control (IPC). These gaps remained evident at our inspection in August 2017. Actions identified following an infection prevention and control audit completed in March 2017 had not been completed, and there was no action plan documented to demonstrate timescales for their completion. During our visit, we observed there were no paper towels available in the practice nurse's consultation room to facilitate appropriate hand washing. The sharps bin used for safe disposal and storage of used needles was also full in the nurse's room.

During our April 2017 visit we had found there to be inadequate arrangements in place to monitor the location and use of handwritten prescription forms. In August 2017 we found this had been improved, and that an appropriate logging system had been implemented.

Monitoring risks to patients

Are services safe?

Our inspection in April 2017 concluded that while there were some procedures for assessing, monitoring and managing risks to patient and staff safety, these were not comprehensive. For example, none of the electrical equipment had been portable appliance tested to ensure it was safe to use, not all clinical equipment was checked and calibrated to ensure it was in good working order, the building's annual gas safety check was six months overdue and a legionella risk assessment had not been completed (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

We saw in August 2017 that arrangements in this area had improved. The practice was able to evidence that portable appliance testing had been completed for electrical equipment, that the clinical equipment previously omitted had now been calibrated and that appropriate gas and electrical installation safety checks had been completed. A legionella risk assessment had also been undertaken on 19 April 2017. However, the outcome of this risk assessment included a recommended control regime in order to minimise the risk of legionella, for example regular temperature checks at a sample of water outlet in the premises; this control regime had not been commenced by the practice at the time of our August 2017 visit.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 5 April 2017, we rated the practice as inadequate for providing responsive services. We found that the provider had not established an accessible or effective system for identifying, receiving, recording, handling and monitoring complaints. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Receiving and acting on complaints).

Listening and learning from concerns and complaints

At our most recent inspection visit in August 2017 we found the practice's systems and processes for managing patient's complaints had improved. There had been one complaint received and documented by the practice since the new practice manager had commenced employment. This complaint had been received by telephone and logged appropriately, with a complaint form sent to the patient inviting them to make a formal complaint in writing should they remain dissatisfied. At the time of our inspection visit a complaint form had not been returned by the complainant.

Are services well-led?

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

Our findings

At our previous inspection on 5 April 2017, we rated the practice as inadequate for providing well led services. We identified significant gaps in the practice's governance arrangements and these were found to be in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

Governance arrangements

At our recent inspection in August 2017 we found that continued improvements were required to further develop and embed the practice's governance arrangements.

- While there was a staffing structure, we found that not all staff had taken full ownership of the roles and responsibilities to which they had been assigned. For example, the lead GP was identified as the practice's infection prevention and control lead, however was unaware of the contents of the infection prevention and control audit completed in March 2017 by the assistant practice manager. Action had not been taken to rectify issues highlighted as part of this audit process.
- In April 2017 we had found practice policy documents were not consistent and were not always specific to the organisation. While we did note some improvements in this area in August 2017, further improvements were required. Reference to another practice and its staff had been removed from the prescription security protocol. However, we found examples of duplicated policy and procedure documents that gave differing information; for example an electronic version of the practice's repeat prescribing policy made reference to postal and urgent telephone prescription requests being accepted, while a hard copy of the prescriptions protocol stated that prescriptions could not be made over the telephone and made no reference to postal requests.
- We saw that recently updated policies and procedures had not been embedded into practice. For example, while the practice's complaints policy had been updated, we found that reception staff were still accessing an out dated electronic version of the document which contained incorrect information around timescales for handling complaints, inconsistent with information which was provided to the patients.
- We saw agendas for upcoming practice meetings where significant events were identified as standard agenda items in order to facilitate the implementation of any learning identified.
- We found there were improved systems in place for identifying, recording and managing risks, issues and implementing mitigating actions. For example, safety certificates for gas and electrical installation were available and a legionella risk assessment had been completed. However, we noted the recommended control regime to mitigate the legionella risk had not been actioned at the time of our recent visit.

Seeking and acting on feedback from patients, the public and staff

In April 2017 we found the practice had not systematically reviewed feedback from patients nor taken comprehensive action to address concerns raised, particularly around difficulties accessing appointments.

During our August 2017 inspection we saw that the practice was engaged in an appointment audit in order to assess demand and capacity for appointments with a clinician. Staff told us the appointment system would be reviewed on completion of this audit in an effort to streamline patient access to the service.