Mayfield 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Mayfield Medical Centre on 5 September 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the September 2016 inspection can be found by selecting the 'all reports' link for Mayfield Medical Centre on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 6 July 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection 5 September 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice remains rated as requires improvement.

Our key findings were as follows:

- The practice had undertaken a fire risk assessment and implemented the majority of the required actions. However, many of the actions marked for urgent attention had not been completed within their set timeframes. There was also no record of fire drills.
- No staff had completed fire safety awareness training but this was scheduled to be completed by the end of July 2017. No fire marshal had been allocated for the practice.
- There were shortfalls in infection prevention control. The practices infection control policy was not fully adhered to as staff had not received training in this area and there was no infection control audit. Bi-monthly spot checks had not been completed as per the infection control policy. The practice had created a waste management policy.
- The practice had improved the storage of emergency medicines.
- All patient group directions had been signed by the nursing staff and an authorising member of staff in order that the nurses had the correct legal authority to administer the vaccines.
- The practice had added an alert to patient's records to identify carers. The practice had only identified 1% of its patient population as carers.

Summary of findings

- Policies had been reviewed and updated however, not all were adhered to by the practice.
- The chaperone policy had been updated to clearly reflect processes at the practice.
- Staff had still not received customer care training despite being recognised by the practice as needed following ongoing complaints around this theme.
- The practice had continued to work with the local clinical commissioning group to enhance patient services for example to set up a mental health café.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

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

In addition the provider should:

Continue to review arrangements for identifying carers.

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?

Requires improvement

The practice remains requires improvement for providing safe services.

- No staff had a record of having completed infection prevention control or fire safety training. Training for both of these areas had been booked for staff to attend at the end of July 2017.
- Hand hygiene posters were on display to encourage good practice but there was no overarching infection control audit or annual statement in place. Bi-monthly spot checks had not been completed as per the infection control policy.
- There was a fire safety risk assessment in place with many of the identified actions completed. However, there remained outstanding recommendations.
- Fire drills had not taken place or been recorded as having taken place in the past two years.
- Water temperatures were not compliant with the practice's legionella policy and risk assessment.
- The practice had reviewed and updated their chaperoning and waste management policies.

Are services well-led?

Inadequate

The practice is rated as inadequate for providing well-led services.

- There was no clear leadership and governance oversight and a lack of support for staff to complete their allocated tasks and responsibilities in a timely manner.
- The practice had a number of policies and procedures to govern activity. These had recently been reviewed but not all of the policies were being adhered to following the review, for example the infection control policy.
- The specific training needs of staff were not addressed. For example, no staff had a record of having completed fire safety or infection control training. Receptionists and administration staff had not received customer care training.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Requires improvement

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

People with long term conditions

Requires improvement

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

Families, children and young people

Requires improvement

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

Working age people (including those recently retired and students)

Requires improvement

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

People whose circumstances may make them vulnerable

Requires improvement

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

Summary of findings

People experiencing poor mental health (including people with dementia)

The provider had resolved some of the concerns for safety and well-led identified at our inspection on 5 September 2016. However, not all of these had been resolved at our follow up inspection on 6 July 2017. The areas of concern that remain apply to everyone using this practice including this population group. The population group ratings therefore remain requires improvement.

Requires improvement

Summary of findings

Areas for improvement

Action the service MUST take to improve

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

Action the service SHOULD take to improve

Continue to review arrangements for identifying carers

Mayfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector. The team also included a GP specialist advisor.

Background to Mayfield Medical Centre

Mayfield Medical Centre is located in a purpose built building in Farnborough, Hampshire. The practice has approximately 9,400 patients registered with it. The practice provides services under an NHS General Medical Services contract and is part of NHS North East Hampshire and Farnham Clinical Commissioning Group (CCG).

The population in the practice area is in the fifth less deprived decile compared to the national average. (Level one represents the highest levels of deprivation and level 10 the lowest). The practice has a higher than national average number of patients aged 20 to 45 years old. A total of 12% of patients at the practice are over 65 years of age which is lower than the national average of 17%. A total of 52% of patients at the practice have a long-standing health condition, which is slightly lower than the national average of 54%. Mayfield Medical Centre has a multi-cultural mix of patients. The local population is mainly White British, however approximately 30% of the practices patient list is Nepalese due to the significant military presence in the area including a Ghurkha regiment. The practice also has patients of Romanian and Polish ethnicity.

The practice has four GP partners, three of the partners are female and one is male. Together the GPs provide care equivalent to approximately 38 sessions per week which included 2 sessions per week in local care homes. The GPs are supported by two salaried GPs and one retained GP and two part time practice nurses. The clinical team are supported by a practice manager and administrative and clerical staff. The practice is a training practice for doctors training to be GPs. The practice has recently become involved with the University of Surrey for students training to become physician associates.

Mayfield Medical Centre is open between 8am and 6.30pm Monday to Friday. Extended hours surgeries are available every Wednesday from 7am to 8am or later from 6.30pm to 7.30pm and every Saturday morning from 8.30am to 11am. The GPs also offer home visits to patients who need them.

The practice has opted out of providing our-of-hours services to their own patients and refers them to the Hampshire Doctors On Call who are run by Partnering Health who provide an out of hours' service via the NHS 111 Service.

The practice offers online facilities for booking of appointments and for requesting prescriptions. The practice is also part of the North East Hampshire and Farnham Vanguard. (The vanguard is made up of providers and commissioners of health and social care which focus on the development of an integrated health social care and wellbeing systems for patients to support them in the community).

We inspected the only location:

Mayfield Medical Centre

Croyde Close

Farnborough

Hampshire

GU14 8UE

Detailed findings

Why we carried out this inspection

We undertook a comprehensive inspection of Mayfield Medical Centre on 5 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on 6 September 2016 can be found by selecting the 'all reports' link for Mayfield Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Mayfield Medical Centre on 6 July 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 was meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including the practice manager, GP partners and nursing staff.
- Reviewed training records for all staff working at the practice.
- Reviewed Complaints received by the practice since our last inspection.
- Reviewed a range of policies, procedures implemented at the practice.
- Looked at health and safety risk assessments and fire safety records.
- Reviewed storage of emergency medicines.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 5 September 2016, we rated the practice as requires improvement for providing safe services as there were shortfalls in systems and processes that keep patients and staff safe. There was an absence of infection control audits and training for staff in this, a lack of a fire safety risk assessment and regular fire drills and no chaperone training for non-clinical staff who undertake the role. Storage of emergency medicines was also not adequate for access in an emergency.

The practice had made improvements to some areas when we undertook a follow up inspection on 6 July 2017 however, for other areas there remained issues that had not been resolved. The practice therefore remains as requires improvement for providing safe services.

Overview of safety systems and process

- At our previous inspection on 5 September 2016 only the practice nurse had been trained in infection prevention and control and no audits had been completed since training was undertaken in January 2016. The practice had just begun completing hand hygiene audits but there was no information on display in a clinical room to show hand hygiene techniques. Following this inspection the practice submitted an action plan to us which stated that the deadline for all staff to have completed infection control training would be the end of February 2017. At our follow up inspection on 6 July 2017, we reviewed training records for all staff and there was no evidence to show that training had been completed for any of the staff working at the practice. We discussed with the practice why they had been unable to achieve their own deadline set for completion of training. The practice told us that they had had a changeover of staff at the end of 2016 and early 2017 with a new practice nurse taking over the role of infection control lead in February 2017. The practice told us that it had taken time for the nurse to complete training and to disseminate this to staff. Infection control training had been booked for all staff to attend on 21st July 2017. Therefore at the time of the July 2017 inspection we could not be certain that staff had an understanding of infection control principles.
- The practice had an infection control policy in place since 2016. The practice had completed an annual review of the policy in June 2017. We found that the policy was not being fully adhered to or embedded, as the practice had not identified that they were not following aspects of their policy. For example, the practice stated that an unannounced infection control inspection would take place on at least a bi-monthly basis and findings would be reported to the partners meeting for remedial action. We could not find evidence to show that these took place in the files presented to us. We discussed this with the management team who told us that they had not been conducting these.
- The practice had continued to complete hand hygiene audits since our previous inspection in September 2016 and we saw that hand hygiene posters were on display in clinical rooms, kitchens and toilets.
- The practice had not completed an overarching infection control audit.
- The practice had created a waste management policy adapted from the government policy around waste management.
- The practice had improved processes for chaperone training. The practice had updated their policy since the previous inspection to make direct reference to the process when non-clinical staff would be used as chaperones. The policy specified that when a non-clinician is required for chaperone duties they must be trained and have a valid DBS. If a DBS is not complete then the risk assessment must be followed. We saw a copy of the practice's risk assessment. The practice had identified a selection of staff to complete chaperone training as an additional responsibility and training took place in December 2016. There was evidence of this in the staff training records.
- At our follow up inspection on 6 July 2017 we reviewed the practice's emergency medicines storage. The practice had improved access to these medicines by purchasing a specially designed lockable steel cabinet which was stored in a lockable room. The practice had previously been using a cable and padlock system which had caused concerns around accessing medicines in the event of an emergency.
- At our inspection in September 2016 the practice was operating using a set of patient group directions (PGDs) which authorise nursing staff to administer vaccines and medicines in line with legislation. We found that not all

of these PGDs had been signed by both the nursing staff and a member of staff who was able to authorise nurses to administer the vaccines. We reviewed the process of administering the PGDs at our follow up inspection and found that all PGDs were signed and authorised by the appropriate personnel.

Monitoring risks to patients

At our previous inspection on the 5 September 2016 we found that several of the practice's health and safety risk assessments and monitoring had not taken place. For example, the practice had not undertaken a fire risk assessment and there was no evidence of the practice having undertaken fire drills. The practice had completed an emergency lighting test in January 2016 but at the time of inspection identified maintenance was still outstanding. The practice did not have a waste management policy or infection prevention and control policy. The practice had undertaken a Legionella risk assessment in August 2016 but actions were still outstanding. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

At our follow up inspection on 6 July 2017 we found that the practice had made progress in the health and safety risk assessments but there continued to be shortfalls in some areas:

- The practice had completed a fire risk assessment which was conducted by an external contractor on 10 December 2016. There were 20 actions to be undertaken following this inspection with several having a prioritised completion date of 14 January 2017. We viewed the risk assessment and saw that none of the prioritised actions had been completed in the timeframe. However, 12 of the 20 actions had subsequently been completed on 26 June 2017. Five actions remained outstanding with estimated completion dates for the end of July 2017 and a further three awaiting on external contractors to undertake the work. As part of the risk assessment an action was for the practice to allocate a fire marshal and for all staff to have completed fire safety awareness training as a priority. We reviewed training records for staff and no staff had completed formal fire training. We were told this was booked for 28 July. The practice had identified that fire training would be mandatory for all new members of staff with annual updates thereafter for all staff.
- The practice had created a fire policy in December 2016 outlining the processes the practice would undertake in discussing fire principles with new staff. The policy also stated that evacuation drills will take place at least twice a year. However, the practice had not undertaken any fire drills in the past two years.
- The August 2016 Legionella risk assessment seen at our previous inspection in September 2016 was still in use by the practice and there remained outstanding issues. The practice had not conducted a full risk assessment for Legionella testing but had booked for an external company to complete one sometime in the future. The practice had not been recording hot and cold water temperature checks in line with their policy prior to June 2017. We saw evidence that the temperatures did not comply with guidance, for example, the last hot water recording was 56.7 degrees Celsius and the guidance stated the minimum temperature should be 60 degrees Celsius. This was similar to the cold water temperature which had a recording higher than the recommended maximum temperature. There was no information to detail what actions would be implemented as a result of these readings. We discussed this with the practice who showed us emails to demonstrate that the practice was in the process of liaising with a contractor to address these issues and that the contractor had visited the practice on the 5 July 2017. No outcome had been found to resolve the issue and the practice continues to work with the contractor.

Arrangements to deal with emergencies and major incidents

At the September 2016 inspection we found that the practice's business continuity plan did not contain emergency contact numbers for staff which meant the practice could not implement their contingency plan effectively. We reviewed the business continuity plan as part of the follow up inspection in July 2017 and found that the plan still did not contain contact numbers for staffs The practice had a separate document stored on the shared drive in the business continuity folder which contained this information. The local clinical commissioning group also held the information for key contacts at the practice to start the cascade process should this be required.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 5 September 2016 we rated the practice as requires improvement for providing well-led services as governance systems did not always support the strategy for good quality. The systems and process to address these risks were not implemented well enough to ensure patients were kept safe. Some of these arrangements had improved when we undertook a follow up inspection on 6 July 2017, however there remained some outstanding issues.

Due to the outstanding issues which had not been resolved around governance arrangements the practice has been given a warning notice for regulation 17 and therefore the practice is now rated as inadequate for well-led services.

Governance arrangements

At our previous inspection on the 5 September 2016 we found that the practice had structures in place to identify record and manage risk issues and mitigate actions but that these were not always full implemented. For example:

- Not all staff had completed training suitable for their role. This included but was not exclusive to infection control training.
- Not all staff had records of having completed induction training.
- A fire risk assessment had not been completed and there was no evidence of fire drills being conducted.
- Not all policies and procedures had been reviewed and adhered to for example the business continuity plan, patient group directives and chaperoning policy.

At our follow up inspection on 6 July 2017 we reviewed the evidence presented to us and found the following:

- No staff had records of having completed training in areas including infection prevention and control and fire safety. Action plans submitted to us following our previous inspection in September 2016 showed that the practice had set a deadline for training to be completed by all staff by the end of February 2017; however, this was not achieved. Training had now been booked for the end of July 2017. A fire risk assessment conducted by an external company had highlighted the need for a fire marshal and staff training for fire safety as a matter of urgency but this had not been completed.
- The practice had not followed up on actions identified following a review of their complaints. At our first inspection in September 2016 the inspection team reviewed complaints and the largest amount of complaints related to reception staff attitude and the practice had identified an action to complete customer care training for their staff which was on the training plan but had not been booked. At our follow up inspection in July 2017 we reviewed a selection of complaints and saw that this trend had continued. We reviewed staff training records and saw that customer care training was on the training plan but again no staff had a record of having completed this training.
- A fire risk assessment had been completed in December 2016 and most recommendations actioned. Dates were in place for any outstanding work to be completed. The practice had not completed fire drills for the past two years. The practice told us they were informed at the time of the risk assessment not to conduct drills until all staff had received fire safety training.
- We reviewed three induction training records for staff that had commenced employment since our last inspection. Two of the three had completed induction training records. One staff member had an induction record but this had not been completed.
- All policies and procedures had been reviewed and updated. However, not all these policies were being adhered to, for example the infection prevention and control policy. The chaperone policy had been updated to clearly reflect the process for when non-clinical staff are required as chaperones.

Leadership and culture

At the follow up inspection on 6 July 2017 there was a lack of leadership and governance oversight to ensure that staff were adequately supported in their roles, this included but was not exclusive to ensuring they had received training in order to undertake their roles and responsibilities given to them. There was no registered manager in post at the time of the follow up inspection.

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. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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 **How the provider was not meeting the regulations:** • The registered provider did not have suitable systems in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Systems did not assess, monitor or mitigated risks related to health, safety and welfare of service users. For example: • **Actions from a fire risk assessment had not been completed within the recommended timescale. There were still outstanding recommendations requiring action.** • **Staff had not received training in fire safety.** • **No fire drills had been completed within the past two years.** • **Hot and cold water temperature checks were not compliant with practice policy or recommended guidance. There was no documented evidence alongside the checks to demonstrate what action would be taken.** • **There was no overarching infection control audit.** • **Staff had not been trained in infection control policies.** • **Training had not been completed in the timescales set by the practice in the action plan submitted to the CQC following the previous inspection in July 2017.** • **Staff had not received customer care training despite having identified this in 2016 as an action following a review of patient complaints. No date had been booked for this training.**

This section is primarily information for the provider

Enforcement actions

- The practice had reviewed policies but had not picked up on the fact that for some of the policies the policy was not being adhered to or full embedded into practice; for example the infection control policy.
- There was a lack of leadership to ensure staff were adequately supported to undertake their role effectively this included but was not exclusive to ensuring staff had received training for their role and undertaking tasks actioned to them in a timely manner.