Richmond Surgery

Inspection report

Richmond Close
Fleet
Hampshire
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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	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

We carried out an announced focused inspection at Richmond Surgery on 4 December 2019 as part of our inspection programme and following our annual review of the information available to us. We last inspected Richmond Surgery on 15 October 2014 (comprehensive inspection) & 17 July 2015 (focused follow up inspection). Following that inspection, the practice was rated as good overall.

This inspection looked at the following key questions; Effective and well led. We did not check whether this practice was providing safe, caring and responsive services at this inspection because our monitoring of the practice indicated no significant changes since the last comprehensive inspection (October 2014).

The rating of good for the key questions of safe, caring and responsive, has been carried forward from the last inspection.

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as good overall and good for all population groups. Specifically, we have rated the practice as good for effective and requires improvement for well led services.

We found that:

- Patients received effective care and treatment that met their needs.
- Staff were trained for their role and knew when they needed to be updated.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.
- We found some governance and risk monitoring processes that required a review. Specifically, patient specific direction processes, patient group direction authorisation and monitoring and oversight of the cold chain.

The areas where the provider **must** make improvements are:

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

The areas where the provider **should** make improvements are:

- Continue to improve childhood immunisations and cervical screening uptake rates to be in-line with national targets.
- Implement a system to consider and understand the duty of candour when reviewing issues, events and occurrences.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP Specialist Advisor.

Background to Richmond Surgery

Richmond Surgery is located in a purpose built building in a residential area of Fleet, Hampshire. It provides GP services for approximately 14,118 patients and is part of North East Hampshire and Farnham Clinical Commissioning Group (CCG). The practice is also a member of the federation of all the CCG practices and in July 2019, became a primary care network with three other Fleet locality practices.

There are five GP partners (whole time equivalent (WTE) XX), three practice nurses (WTE XX), a senior healthcare assistant and a phlebotomist/healthcare assistant. The practice is also a training practice for medical students and trainee GPs.

Day to day coordination of the service are managed by a managing partner, a practice administrator, two administrators, a lead medical secretary, two medical secretaries and 12 reception staff.

The practice provides services from: Richmond Surgery, Richmond Close, Fleet, Hampshire, GU52 7US.

They are registered with the CQC to provide the following regulated activities: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

According to national statistics, there is a higher than average number of patients over the age of five to 18 years and aged over 65 to 75 years. The practice is in an area of low deprivation. The local population is predominantly white British, with approximately 5% of the population originating from a black, mixed or other non-white minority ethnic backgrounds.

Richmond Surgery has been inspected before. You can view the previous reports by selecting the “all reports” link for Richmond Surgery on the CQC website.

This section is primarily information for the provider

Requirement notices

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 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 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 **How the regulation was not being met…** There were inconsistent systems or processes that enabled 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: • PGDs had not been authorised by an appropriate person. • PSDs did not meet the requirements of legislation. • There was no monitoring of cold chain documentation to ensure it was being maintained in line with guidance.