Cecil Avenue 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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cecil Avenue Surgery on 22 September 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the 22 September 2016 inspection can be found by selecting the 'all reports' link for Cecil Avenue on our website at www.cqc.org.uk. The concerns at that inspection related to incomplete recruitment checks and ineffective processes and procedures relating to infection control, emergency response capability, risk management and the practice's performance in patient outcomes measurements, childhood immunisations and cervical screening.

This inspection was an announced focused inspection carried out on 19 June 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 on 22 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:

- Systems to minimise risks to patient safety were not sufficiently defined or embedded. For example in relation to infection control, fire safety and staff training.
- A system was in place to monitor emergency medicines; however this did not extend to vaccines stored in the fridge. Medicines and blank prescription forms and pads were not stored securely.
- Staff had received infection control training but had not received training in information governance and fire safety.
- Arrangements to deal with emergencies and major incidents required reviewing.
- Quality and outcomes framework (QOF), a measure of clinical performance, showed that performance for the care of some patient groups was below local and national averages.

At the inspection on 22 September 2016 we mentioned areas where the provider should make improvements. At this inspection on 19 June 2017 we found meeting minutes were being kept and shared and business plans and strategies were in place detailing the goals for the development and improvement of the practice. The

Summary of findings

practice now had access to a translation service. Patients who were carers were identified on the patient records system. A poster was on display and leaflets were available providing information about local support services for carers.

The areas where the provider must make improvements are:

- Assess and mitigate against the risks to the health and safety of service users associated with the fire and the storage of medicines and prescription forms and pads.
- Monitor and work to improve patient outcomes in QOF. For example, in relation to patients with some long term conditions, childhood immunisations and cervical screening.
- Provide staff with appropriate support and training to carry out their duties.
- Assess the risk of and prevent, detect and control the spread of, infections.
- Ensure staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties.

In addition the provider should:

- Seek patient's views and take appropriate action in relation to access to a female GP

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 is rated as requires improvement for providing safe services.

- Improvements had been made in relation to disclosure and barring service (DBS) checks and there was some improvement in relation to infection control.
- Systems to minimise risks to patient safety were not sufficiently defined or embedded.
- Not all staff had received training on fire safety and information governance.
- The practice did not have adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework continued to show patient outcomes were below average for some clinical indicators compared to the national average.
- Staff had not received appropriate training to meet their learning needs and to cover the scope of their work.
- The practice's uptake for cervical screening and childhood immunisations continued to be below the national average.

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
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

People with long term conditions
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

Families, children and young people
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

Working age people (including those recently retired and students)
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

People whose circumstances may make them vulnerable
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

People experiencing poor mental health (including people with dementia)
The provider had not sufficiently resolved the concerns for safety and well-led identified at our inspection on 22 September 2016 which applied to everyone using this practice, including this population group. The population group ratings remain unchanged to reflect this.

Requires improvement

Cecil Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Cecil Avenue Surgery

Cecil Avenue Surgery provides primary medical services in Havering to approximately 2580 patients and is a member practice in the NHS Havering Clinical Commissioning Group

(CCG). The practice population is in the second least deprived decile in England. It has less than CCG and national average representation of income deprived children (12% of children live in income deprived circumstances compared to a CCG average of 20%, and a national average of 20%) and older people children (12% of older adults live in income deprived circumstances compared to a CCG average of 14%, and a national average of 16%). The practice had surveyed the ethnicity of the practice population and had determined that 82% of patients described themselves as white, 9% Asian, 8% black and 1% as having mixed or other ethnicity.

The practice operates from a converted residential property with all patient facilities on the ground floor that is wheelchair accessible. There are offices for administrative and management staff on the ground floor. The practice operates under a General Medical Services (GMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract). The enhanced services it provides are: childhood vaccination and immunisation scheme; rotavirus and shingles immunisation; and unplanned admissions.

The practice team at the surgery is made up of two partners, one partner (male) works full time and is also the practice manager. The second partner (male) provides no clinical input. In addition, there is one part-time locum GP (male) doing two sessions per week. The doctors provide, between them, 10 clinical sessions per week. There is one part-time female practice nurse. There are four administrative, reception and clerical staff. The practice is open between 8.30am and 12.30pm Monday to Friday, and 2.30pm to 6.30pm on Monday to Wednesday and Friday. On Thursday the practice is open from 8.30am to 12.30pm. Appointments are available as follows:

Morning appointments:

• Monday to Friday: 9.00am to 10.40am, plus urgent and walk-in appointments, and telephone appointments.

Afternoon appointments:

• Monday. Tuesday. Wednesday and Friday: 4.30pm to 5.20pm, plus urgent and walk-in appointments, and telephone appointments.

• Wednesday evening from 6.00pm two additional appointments are offered for patients who cannot attend during normal surgery hours

• Tuesday or Friday 12.00pm post-natal and 6-8 week baby checks, as needed.

Nurse appointments are available:

• Tuesday from 9.30am to 12.00pm.

• Last Tuesday of the month 4.30pm to 6.30pm.

Detailed findings

The practice is also a member of Havering Health which provides appointments at two locations (one in Hornchurch and one in Romford), on:

• Monday to Friday from 6.30pm to 10.00pm

• Saturday from 12.00pm to 5.00pm

• Sunday from 12.00pm to 4.00pm

The practice does not open on a weekend. The practice has opted out of providing out of hours (OOH) services to their own patients when closed and directs patients to the OOH provider for NHS Havering CCG.

Cecil Avenue Surgery is registered as a partnership with the Care Quality Commission to provide the regulated activities of family planning; treatment of disease, disorder or injury; diagnostic and screening procedures; and maternity and midwifery services.

This practice was previously been inspected by CQC on 22 September 2016 and was rated requires improvement.

Why we carried out this inspection

We undertook a comprehensive inspection of Cecil Avenue Surgery on 22 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 22 September 2016 can be found by selecting the 'all reports' link for Cecil Avenue Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Cecil Avenue Surgery on 19 June 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 now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of staff GP, secretarial/ administrative, nursing and spoke with patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Visited the practice location
- Looked at information the practice used to deliver care and treatment plans.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 22 September 2016, we rated the practice as requires improvement for providing safe services as not all staff acting as chaperones had undergone a Disclosure and Barring Service (DBS) check. There were also concerns around infection prevention and control, medicine management, staff recruitment, electrical safety and business continuity planning. We also found concerns around arrangements to deal with emergencies and major incidents.

At this inspection on 19 June 2016 we found some improvement had been made however a number of concerns remained unaddressed. The practice remains rated as requires improvement for providing safe services.

Overview of safety systems and process

- At the inspection on 22 September 2016 we found not all staff who acted as chaperones had undergone a Disclosure and Barring Service (DBS) check. At this inspection on 19 June 2017 we found all staff who acted as chaperones were trained for the role and had received a DBS check. (DBS 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).
- At the inspection on 22 September 2016 we found annual infection prevention and control (IPC) audits were not undertaken. At this inspection on 19 June 2016 we found an infection control audit had been carried out by the local clinical commissioning group (CCG) in March 2017. Issues identified included the presence of textured wall paper, non-compliant handwashing sinks and taps and the failure to calibrate the vaccine fridge. The action plan stated the time frame allowed to address the issues with the sinks, taps and wall paper was 12 to 24 months. The issue with the fridge was to be addressed immediately. At this inspection we found the fridge had been calibrated and the provider told us the remaining issues would be addressed within the given time frame. We also found all taps at the practice had lime scale deposits on them and were not levered so they could be operated without using hands. One of the taps in the patient's toilet did not have a head on it and therefore could not be operated.
- We found since the last inspection of 22 September 2016 the practice had installed privacy curtains in the consulting rooms. The provider informed us the cleaner cleaned these curtains; also told us they would dispose of and replace these curtains when the need arose,
- We were told clinical waste was stored in a bin outside at the rear of the property. We noted this was a general household type receptacle and were showed a chain and pad lock used to keep the lid secure. .
- At the inspection of 22 September 2016 we found there was no system for regularly checking and updating the contents of the emergency medicines supply. At this inspection on 19 June 2017 we found there was a system in place to check emergency medicines were available and within date. We showed these to the provider and they were immediately removed for disposal.
- We found several boxes of various medicines in an unlocked drawer in the nurse's room, the doors to which were not lockable. We were told the key to the drawer was lost. The provider undertook to ensure this room was secured by installing a lock on the door leading from reception.
- At the inspection of 22 September 2016 we found blank prescription forms and pads were

  securely stored, but there were no systems in place to monitor their use. At this inspection we found blank prescription forms were not stored securely. We found blank forms in the printer and in a drawer in the consulting room used only by the nurse, who only worked two hours per week. There were two doors leading into this room, one from the reception area, and neither door was lockable. The drawer containing the prescription pads was lockable and we were told that blank forms were removed from the printer at the end of each day and locked in the drawer. However as the drawer was left unlocked every day and blank forms were left in the printer regardless of whether the room was occupied that day or not, this presented a risk to

the security of the blank prescription forms. We also found prescription pads for the GP partner who provided no clinical services at the practice being stored in the same drawer.

- At the inspection of 22 September 2016 we found not all necessary recruitment checks had been carried out prior to the employment of new staff members. At the inspection of 19 June 2016 the practice was in the process of recruiting a new practice manager. We were told the provider was awaiting receipt of the Disclosure and Barring Service (DBS) check prior to a formal offer of employment being made. We also saw interview notes. We were told identity documents were being held by one of the partners off site. These had been required in order to apply for the DBS check. They had not recruited any other members of staff since the last inspection. The practice nurse was registered with the relevant professional regulator.

Monitoring risks to patients

Some procedures for assessing, monitoring and managing risks had improved however there remained areas of concern.

- At the inspection of 22 September 2016 we found electrical equipment was not regularly checked to ensure it was safe to use. At this inspection on 19 June 2017 we saw evidence that electrical safety testing had been carried out on all relevant equipment following the previous inspection. All items had passed apart from a lamp in the nurse's room. This lamp was no longer being used.
- The practice did not have an up to date fire risk assessment and did not carry out regular fire drills. Only two members of staff had received fire safety training. An in house fire risk assessment had been carried out but this was not supported by a professional inspection of fire safety procedures and equipment. The practice had a small portable fire extinguisher, however staff did not know when it had been obtained or if it was in good working condition. There were no accompanying records available for this fire extinguisher and no information on the item itself giving an expiry date. Therefore the provider was not assured that this extinguisher was appropriate and sufficient for the practice.

Arrangements to deal with emergencies and major incidents

At the inspection on 22 September 2016 we found the practice did not have a defibrillator or a risk assessment detailing how the practice would mitigate against the associated risks.

- At this inspection on 19 June 2017 we found the practice now had a defibrillator and staff knew how to use it. The defibrillator was checked regularly to ensure it was in good working order.
- The practice had a source of oxygen however they did not have any paediatric masks with it.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 22 September 2016, we rated the practice as requires improvement for providing effective services due to below average patient outcomes for some quality outcome indicators and issues around sharing information from practice meeting minutes. The staff induction programme also required review.

These arrangements showed no improvement when we undertook a follow up inspection on 19 June 2016. The practice remains rated as requires improvement for providing effective services.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 77% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 95%. The overall exception reporting rate was 4% compared to the CCG and national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). (Data from 1 April 2015 to 31 March 2016).

At the time of the previous inspection on 22 September 2016, published data showed the practice's performance in diabetes management was below average. At the time of this inspection on 19 June 2017 published data from 1 April 2015 to 31 March 2016 showed at 37% performance for diabetes related indicators was significantly below the CCG average of 81% and the national average of 90%. The practice was aware of this and we saw a strategy plan they had put in place to try and address this. This strategy included the designing and issuing of long term condition annual review letters and reminder slips. These were sent and handed to patients to encourage them to attend for annual reviews. Patients were given half hour appointments for diabetic reviews and were referred to a local physical activity scheme where appropriate. This scheme supported patients with lifestyle advice. They also referred patients to diabetes education programmes and were participating in two local diabetic programmes, one of which was incentivised. Under one of these schemes the practice identified the more challenging diabetes cases and targeted them with more aggressive treatment. The other was a national diabetic audit, involving identifying pre-diabetic cases and taking steps to avoid them progressing to full diabetes, for example through lifestyle advice.

The practice told us they had seen an improvement in their performance for diabetes. For example at the time of our previous inspection on 22 September 2016 the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (measurement of average blood glucose level) was 64 mmol/mol or less in the preceding 12 months was 45% compared to the CCG average of 70% and the national average of 78%. (Data from 1 April 2015 to 31 March 2016). The practice showed us their QOF submission for the year from 1 April 2016 to 31 March 2017 which showed their achievement was now 72%. At the time of this inspection on 19 June 2017 this was unpublished data which can be verified following the publishing of the official data by NHS Digital in October 2017.

At the previous inspection on 22 September 2016 data showed the practice's rate of exception reporting for heart failure was 18% which was above the CCG average of 8% and the national average of 9%. Data from 1 April 2015 to 31 March 2016 showed the rate of exception reporting for heart failure had slightly reduced to 15%. During this inspection on 19 June 2017 the practice showed us their data which showed no exception reporting for heart failure for the year 1 April 2016 to 30 March 2017. At the time of this inspection on 19 June 2017 this was unpublished data which can be verified following the publishing of the official data by NHS Digital in October 2017.

Effective staffing

At the previous inspection on 22 September 2016 we found staff had not had training in information governance. At this inspection on 19 June 2017 we found only one member of staff had completed information governance training. Only two members of staff had received fire safety training. The provider was unable to demonstrate that any assessment of staff training needs had been undertaken.

Supporting patients to live healthier lives

Requires improvement

Are services effective?

(for example, treatment is effective)

At the previous inspection on 22 September 2016 we found the practice's uptake for the cervical screening programme was 72%, which was below the CCG and national average of 81%. At this inspection on 19 June 2017 the latest published data (1 April 2015 to 31 March 2016) showed the practice's achievement remained at 72%.

At the inspection on 22 September 2016 we found uptake rates for the childhood immunisations given were below CCG/national averages. At this inspection on 19 June 2017 we found childhood immunisation rates for the vaccinations given remained lower when compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice did not achieve the target in any of the four areas. These measures can be aggregated and scored out of 10, with the practice scoring 7.2 (compared to the national average of 9.1). (Data from 1 April 2015 to 31 March 2016).

The provider was aware of the below average figures for immunisations and cervical screening, however they believed the figures relating to childhood immunisations to be incorrect. The practice nurse, who carried out all childhood immunisations and cervical screening tests, was not available on the day of the inspection but we were able to interview them by telephone the following day. The practice nurse told us they were only aware of two patients who regularly did not attend for childhood immunisations. They were unable to explain why the published figures were much lower.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test.

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 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users by failing to: • Assess and mitigate against the risks to the health and safety of service users associated with fire, infection control, emergency and major incidents and the storage and management of medicines and prescription forms and pads. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance How the regulation was not being met: The registered person did not do all that was reasonably practicable to ensure effective systems and processes were in place, specifically by failing to: • Effectively address below average clinical performance for the care of some patient groups. • Ensuring all mandatory training was completed by all staff including fire safety and information governance.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.