Grange Street Surgery

Quality Report

2 Grange Street, St Albans, Hertfordshire.
AL3 5NF.
Tel: 01727 833550
Website: www.grangestreetsurgery.co.uk

Date of inspection visit: 17 May 2017
Date of publication: 05/06/2017

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

Are services effective?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused inspection at Grange Street Surgery on 30 September 2016. We identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided effective services. Consequently the practice was rated as requires improvement for providing effective services. The focused report from the 30 September 2016 inspection can be found by selecting the 'all reports' link for Grange Street Surgery on our website at www.cqc.org.uk.

After the focused inspection, the practice wrote to us and submitted an action plan outlining the actions they would take to meet legal requirements in relation to;

- Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

- staffing.

The area identified as requiring improvement during our inspection in September 2016 was as follows:

- Ensure that all staff employed are supported by a formal induction process, are receiving appropriate supervision and appraisal and completing the essential training relevant to their roles.

In addition, we told the provider they should:

- Ensure a plan of action to control and resolve risks identified by the health and safety risk assessment is completed.
- Ensure that a Legionella risk assessment is completed and that any issues identified are resolved.
- Ensure that the Legionella management policy is adapted to the specific needs and requirements of the practice.

We carried out an announced focused inspection on 17 May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches of regulation that we identified in our previous inspection on 30 September 2016. This report covers our findings in relation to those requirements.

Our key findings on this focused inspection were that the practice had made some improvements since our previous inspection and were now meeting the regulation that had previously been breached. Consequently the practice is now rated as good for providing effective services.

However, the practice had not taken sufficient action in some areas identified on our previous inspection and were now in breach of legal requirements in those areas. On this inspection we found:

Summary of findings

- There was a formal and documented induction programme in place for newly appointed staff that ensured they had a comprehensive understanding of practice processes and procedures, including essential training requirements.
- A system was in place to ensure staff completed the essential training relevant to their roles.
- Sufficient systems were in place to ensure all staff received regular supervision and an appropriate appraisal of their skills, abilities and development requirements.
- There were no action plans in place to control and resolve the risks identified by the health and safety and Legionella risk assessments.
- The Legionella management policy was not adapted to the specific needs and requirements of the practice.
- Staff were unclear as to who had responsibility for health and safety related issues at the practice, including managing and responding to the risk assessments.

The areas where the provider must make improvements are:

- Ensure plans of action to control and resolve the risks identified by the health and safety and Legionella risk assessments are completed.
- Ensure that the Legionella management policy is adapted to the specific needs and requirements of the practice.
- Ensure the governance arrangements in place provide staff with a clear understanding as to who is responsible for managing and responding to health and safety related issues and risks.

In addition the provider should:

- Ensure that all clinical staff are participating in the practice's programme of online essential training (e-learning).

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 effective?

Good

At our focused inspection on 30 September 2016, we identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided effective services. During our focused inspection on 17 May 2017 we found the provider had taken action to improve and the practice is rated as good for providing effective services.

- There was a formal and documented induction programme in place for newly appointed staff that ensured they had a comprehensive understanding of practice processes and procedures, including essential training requirements.
- A system was in place to ensure staff completed the essential training relevant to their roles. However, the GPs at the practice were not participating in the e-learning training.
- Sufficient systems were in place to ensure all staff received regular supervision and an appropriate appraisal of their skills, abilities and development requirements.

Are services well-led?

Requires improvement

At our focused inspection on 30 September 2016 we told the provider they should make improvements in some areas. During our focused inspection on 17 May 2017 we found the provider had not taken sufficient action in those areas and consequently the practice is rated requires improvement for being well-led.

There were some weaknesses in the governance arrangements at the practice that, although not placing patients at risk of significant harm, could be strengthened to ensure the provision of a safe work place and patient environment.

- There were no plans of action in place to control and resolve the risks identified by the health and safety and Legionella risk assessments.
- The Legionella management policy was not adapted to the specific needs and requirements of the practice.
- Staff were unclear as to who had responsibility for health and safety related issues at the practice, including managing and responding to the risk assessments.

Grange Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

This inspection was completed by a CQC lead inspector.

Background to Grange Street Surgery

Grange Street Surgery provides a range of primary medical services from its premises at 2 Grange Street, St Albans, Hertfordshire, AL3 5NF.

The practice serves a population of approximately 10,064 and is a training practice. The area served is less deprived compared to England as a whole. The practice population is predominantly white British. The practice serves an above average population of those aged from 0 to 9 years and 30 to 49 years. There is a considerably lower than average population of those aged from 15 to 29 years.

The clinical team includes two male and two female GP partners, one female salaried GP, two female trainee GPs, four practice nurses and one healthcare assistant. The team is supported by a practice manager and 17 other managerial, administration, reception and secretarial staff. The practice provides services under a General Medical Services (GMS) contract (a nationally agreed contract with NHS England).

The practice is staffed with the phone lines and doors open from 8.30am to 6.30pm Monday to Friday. There is extended opening from 7am every Tuesday and from 8.30am to 10.30am one in every four Saturdays.

Appointments are available from approximately 8.30am to 11.45am and 4pm to 6.30pm daily, with slight variations depending on the doctor and the nature of the appointment.

An out of hours service for when the practice is closed is provided by Herts Urgent Care.

Why we carried out this inspection

We undertook a focused inspection of Grange Street Surgery on 30 September 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We identified breaches of legal requirements. Improvements were needed to systems, processes and procedures to ensure the practice provided effective services. Consequently the practice was rated as requires improvement for providing effective services.

The focused report following the inspection on 30 September 2016 can be found by selecting the 'all reports' link for Grange Street Surgery on our website at www.cqc.org.uk.

We undertook an announced follow up focused inspection of Grange Street Surgery on 17 May 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

Before our inspection, we reviewed information sent to us by the provider. This told us how they had addressed the breaches of legal requirements we identified during our

Detailed findings

focused inspection on 30 September 2016. We carried out an announced focused inspection on 17 May 2017. During our inspection we spoke with a range of staff including the practice manager and members of the managerial, reception and administration team.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective staffing

At our inspection on 30 September 2016 we found that the induction programme for newly appointed staff was informal and undocumented. The induction did not provide staff with a comprehensive introduction to the practice's processes, procedures and training requirements. Some staff were not completing essential training in accordance with the practice's own protocols. The practice did not adhere to its own programme of staff appraisal. Some staff had been overdue an appraisal for a long period and one staff member had not received an appraisal in their clinical role. The senior staff we spoke with were unclear as to who was responsible for appraising the healthcare assistant. We told the provider they must make improvements.

Following our request, the provider submitted an action plan informing us of the measures they would take to make the necessary improvements. We inspected the practice again on 17 May 2017 to check the practice had taken action to improve.

During our inspection on 17 May 2017 and from our conversations with staff, our observations and our review of documentation we found the practice had taken action to improve in these areas.

- We saw there was a formal and documented induction process in place. This included providing new staff members with a staff handbook, induction protocol and induction checklist. Between them these detailed the practice's processes and procedures, the expectations of staff, the probationary period and essential training requirements among other things.
- We saw that three staff employed since 1 January 2017 had been or were going through the new induction programme. Completed or part completed induction checklists were kept in their personnel files along with other relevant induction related documentation.
- The relevant staff we spoke with told us that during their induction periods they were required to work with a more experienced member of staff (shadowing) and were regularly supervised. We saw that completed supervision (observation) records were available in their personnel files.
- Staff said they were aware of the essential training they were required to complete and of the scope of their roles and responsibilities. They told us they felt well supported through their induction.
- Since our inspection in September 2016 the practice had introduced an e-learning facility (online training). Our review of training records showed that as part of this and less than five months through a 12 month timescale, most staff had received training that included: health and safety, infection control, fire safety, safeguarding adults and children and basic life support. This was in addition to any training they'd completed in 2016 before the introduction of the new system. All staff present at the time had also received face-to-face training on basic life support provided at the practice in November 2016. However, the GPs at the practice were not participating in the e-learning training. From our conversations with senior staff we were told they completed the training in other ways and were required to demonstrate this as part of their revalidation process.
- Since our last inspection in September 2016 all staff that were overdue an appraisal at that time had received one. This included the healthcare assistant who was appraised by two of the GP partners in November 2016. In December 2016 the practice introduced a new appraisal programme to ensure that all staff received an appraisal on an annual basis. The senior staff we spoke with told us that regardless of when each staff member received their last appraisal, they would all receive one by September 2017 as part of the new programme. Our review of appraisal records including the schedule showed that of the 26 staff listed, 18 had received an appraisal as part of the new programme and the remaining staff were all scheduled to receive one by September 2017.
- The practice had also introduced a system of formal quarterly one-to-one supervision sessions. Our review of the one-to-one schedule for non-clinical staff showed that 10 of the 16 staff had completed their first session. We looked at the personnel files of two staff employed for more than six months (one clinical and one non-clinical) and saw that documented records of

Good

Are services effective?

(for example, treatment is effective)

one-to-one supervision sessions were available. All the staff we spoke with during our inspection said there had been a noticeable improvement in the approach to supervision, appraisal and training at the practice in the past six months and this was beneficial to them.

Are services well-led?

Requires improvement

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

Our findings

Governance arrangements

At our inspection on 30 September 2016 we found there was no action plan in place to respond to the risks identified and improvements required from the health and safety risk assessment. A Legionella risk assessment had not been completed at the practice (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, we saw confirmation the assessment was booked for 3 October 2016. The Legionella management policy was generic and not adapted to the specific needs and requirements of the practice. We told the provider they should make improvements.

During our inspection on 17 May 2017 and from our conversations with staff, our observations and our review of documentation we found the practice had not taken sufficient action to improve in these areas. There were some weaknesses in the governance arrangements at the practice that could be strengthened to ensure the provision of a safe work place and patient environment.

We saw the practice's overarching health and safety risk assessment from September 2016 still did not have an action plan in place to respond to the risks identified and the improvements required. However, as part of the refurbishment work completed at the practice between January 2017 and May 2017 the practice had ensured a full health and safety plan and risk assessment was available on the premises. This was provided by an external contractor.

During our inspection on 17 May 2017 we asked to see the Legionella risk assessment undertaken in October 2016. Initially, the risk assessment could not be located and none of the staff we asked could confirm if the risk assessment had been completed. However, it was located before the end of our inspection. Dated 12 October 2016, the Legionella risk assessment report rated the practice as a medium to high risk and detailed 15 actions to be implemented as a priority (within one to three months). None of the staff we spoke with were aware of the actions required and there was no action plan in place to respond to the risks identified and the improvements required.

During our inspection on 30 September 2016 we were told that the practice's Legionella management policy would be updated and made specific to the practice once the results of the Legionella risk assessment were known. During our inspection on 17 May 2017 we found the Legionella management policy was still a generic document dated July 2015 that had not been adapted to the specific needs and requirements of the practice.

With the exception of one individual, the staff we spoke with were unclear as to who had responsibility for health and safety related issues at the practice. This included who was responsible for managing the overarching health and safety risk assessment and implementing a plan of action following the Legionella risk assessment.

Despite these issues, we found the practice was making considerable progress in reorganising its practice management structure to ensure appropriate governance arrangements were in place. We were aware that the two non-clinical staff members with most of the day-to-day management and health and safety responsibilities had left the practice shortly after our last inspection on 30 September 2016. A new practice manager was now in post and four new positions had been created including two deputy managers, a finance manager and a human resources support role. Three of these individuals were in post with the remaining deputy manager due to start in July 2017. However, as all of these posts were new and the roles and responsibilities of these positions were not yet fully organised or allocated there remained weaknesses in the governance arrangements at the practice. This had led to issues relating to health and safety in particular being unidentified or unresolved.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** We found that the registered person had not fully protected people against the risk of inappropriate or unsafe care and treatment because some systems designed to mitigate the risks relating to the health and safety and welfare of patients and staff were insufficient. There were no plans of action in place to control and resolve the risks identified by the health and safety and Legionella risk assessments. The Legionella management policy was not adapted to the specific needs and requirements of the practice. Staff were unclear as to who had responsibility for health and safety related issues at the practice, including managing and responding to the risk assessments. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.