Berwick Surgery

Quality Report

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Date of inspection visit: 22 February 2017
Date of publication: 02/05/2017

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

Overall rating for this service	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
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 Berwick Surgery on 1 March 2016. The overall rating for the practice was Inadequate. The full comprehensive report on the 1 March 2016 inspection can be found by selecting the 'all reports' link for Berwick Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 22 February 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 1 March 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as Inadequate.

Our key findings were as follows:

- The practice had some systems in place to minimise risks to patient safety. However, these were not always clearly defined or embedded.
- The arrangements for managing medicines, including vaccinations were adequate to ensure patient safety.
- Staff were aware of current evidence based guidance. However not all patients had their needs assessed and treatment planned for effectively.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However they had not received training in Information Governance.
- There was very limited or no monitoring of people's outcomes of care and treatment. A higher than average number of patients with long term conditions were exception reported with limited/no efforts made to monitor this or ensure reasonable efforts were made to ensure these patients were reviewed.
- A female locum GP was available for four sessions per week.
- There was no evidence of quality improvement processes including clinical and non- clinical audits and local benchmarking.

Summary of findings

- There was an ostensive leadership structure in place however in practice this was unclear and unstable due to the imminent dissolution of the GP partnership which was responsible for the practice.

At the previous inspection we told the practice they should:

- Review facilities for disabled people and people who are hard of hearing and advertise that translation services were available.

At this inspection we found a hearing loop had now been installed. The practice had an interpreting service and we saw a sign in reception informing patients about this. Facilities for people with mobility restrictions remained limited. We were told this was due to space limitations in the building and that this would remain under review.

However, there remained areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure appropriate steps are taken to ensure the outstanding issues identified in the most recent infection control audit are addressed.
- Ensure an adequate business continuity plan was in place to be followed in the event of a major incident.
- Improve care planning processes to ensure the health, safety and welfare of patients.
- Ensure patients with long term conditions received appropriate care and treatment by taking all reasonable steps to ensure these patients were effectively identified and reviewed.
- Ensure there is a programme of quality improvement including clinical audits to improve patient outcomes.
- Ensure staff receive training on Information Governance.
- Ensure systems and processes are in place at the practice, in particular regarding vision and strategy, governance, staffing, practice policies (specifically adult safeguarding), performance awareness, continuous improvement and leadership.

In addition the provider should:

- Review and formalise the induction process.

On the basis of the ratings given to this practice at this inspection, and the concerns identified at the inspection on 1 March 2016, this practice will remain in special measures. This will be for a further period of six months. This will allow time for the new provider to address the concerns identified. We will inspect the practice again within the next six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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.

- The practice had some systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. However there was no safeguarding policy in place which related to vulnerable adults.
- The practice had adequate arrangements to respond to emergencies and major incidents. However essential information was missing from the business continuity plan.
- Some deficiencies identified in the most recent infection control audit remained unaddressed.

Are services effective?

Inadequate

The practice is rated Inadequate for providing effective services.

- Staff were aware of current evidence based guidance. However they were unable to demonstrate that patient needs were assessed and care was delivered in line with it. This was demonstrated by the lack of care plans for vulnerable patients.
- Data from the Quality and Outcomes Framework showed levels of exception reporting were above average. (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).
- There was no evidence of quality improvement including the use of clinical audits.
- The induction process for new staff was undefined and informal.
- Staff had not received mandatory training in Information Governance.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a written mission statement which was on display in the reception area. However this mission statement was not underpinned by systems and processes which were effectively managed and monitored to ensure the mission statement was achievable.

Summary of findings

- The practice did not have a clear long-term strategy and supporting business plans. There was a lack of clarity and certainty about the future leadership and direction of the practice.
- Practice specific policies were available to all staff. However there was no process in place to ensure policies were reviewed and updated with regular frequency.
- There was no evidence of quality monitoring and/or improvement.

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 resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

People with long term conditions
The provider had resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

Families, children and young people
The provider had resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

Working age people (including those recently retired and students)
The provider had resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

People whose circumstances may make them vulnerable
The provider had resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

People experiencing poor mental health (including people with dementia)
The provider had resolved some of the concerns for safety, effective and well-led identified at our inspection on 1 March 2016 which applied to everyone using this practice, including this population group. However a number of concerns remained unresolved. Therefore the population group ratings remain inadequate.

Inadequate

Berwick Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist adviser.

Background to Berwick Surgery

Berwick Surgery is based in a converted semi-detached house, located in a residential area of Rainham. The practice provides GP primary care services to approximately 4,900 people. Primary medical care is provided under a personal medical services (PMS) contract within NHS Havering Clinical Commissioning Group (CCG). The practice is registered with the Care Quality Commission (CQC) to care out the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services and family planning, diagnostic and screening procedures and surgical procedures.

There are two male GP partners. One of the senior partners is the Clinical Director for Havering CCG. The GP partners do 11 clinical sessions between them from Monday to Friday. They are supported by locum GPs who do an additional four GP sessions between Monday and Friday. The practice employs one female part time nurse prescriber and one female part time healthcare assistant. There is one practice manager and seven part time administrative staff.

The practice opens between 8.00am and 6.30pm Monday to Friday. The practice is closed between 12.00pm and 1.00pm for lunch but the telephone lines remain open for patients. Appointments are from 8.30am to 11.30am every morning and from 4.00pm to 6pm in the evening. Between 11.30am and 12.30pm, all clinical staff carry out telephone consultations. Out of hours the service is provided by a different provider between 6.30pm and 8am and can be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet.

Information taken from the Public Health England practice age distribution shows the population distribution of the practice was similar to that of other practices in England. The life expectancy of male patients was the same as the CCG and national average of 79 years. The female life expectancy at the practice was 85 years, which is higher than the CCG average of 84 years and national average of 83 years.

Information published by Public Health England rates the level of deprivation within the practice population group as seven on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

Why we carried out this inspection

We undertook a comprehensive inspection of Berwick Surgery on 1 March 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate. The full comprehensive report following the inspection on 1 March 2016 can be found by selecting the 'all reports' link for Berwick Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Berwick Surgery on 22 February 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.

Detailed findings

How we carried out this inspection

During our visit we:

- Spoke with a range of staff including GPs and practice management and spoke with patients who used the service.
- Reviewed a sample of the personal care or treatment records of patients.
- Visited all practice locations.
- 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 1 March 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of safeguarding, infection control, medicines management, staff recruitment, risk management and arrangements to deal with emergencies and major incidents were not adequate.

We saw that some improvements to these arrangements had been made when we undertook a follow up inspection on 22 February 2017. However a number of issues identified at the previous inspection had not been adequately addressed. The practice is now rated as requires improvement for providing safe services.

Overview of safety systems and process

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. At our previous inspection we found safeguarding policies were out of date and did not have the correct contact details of the safeguarding teams. At this inspection we found the practice had a child protection policy in place. This was dated October 2016. The policy identified the practice's safeguarding leads, types and signs of abuse and the processes and procedures to be followed in the event of a concern. It included website links to the relevant local safeguarding teams. We noted there was not a safeguarding policy in place for vulnerable adults.
- At the last inspection we found administration staff had not received training on adult safeguarding. At this inspection we found all staff had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to level two and all other staff to level one.
- At the last inspection we found that risk assessments for Disclosure and Barring Service (DBS) check were not in place for members of the reception team who acted as chaperone. (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 this inspection we found all staff had undergone DBS checks.
- At the last inspection we found there was no infection control protocol in place and annual infection control audits were not being undertaken. At this inspection we found all staff had received safeguarding training in November 2016. There were policies in place which included needle stick injuries and Legionella management. (
- Infection control audits had been carried out NHS England in August 2016 and December 2016. A number of issues identified in August 2016 remained in December 2016. We were told these were due to be addressed as part of the extensive renovations due to start in late February 2017. These issues included taps at hand wash basins which were not elbow or wrist operated mixer taps, taps with lime scale on them, plugs and overflows present at most handwashing sinks and textured wall paper on consultation room walls. Some of the issues identified in August 2016 had been addressed such as a legionella risk assessment had been carried out, the standard of cleaning was satisfactory and a general cleaning schedule was in place as well as a checklist for each room.
- At the previous inspection we found the fridge was overstocked with vaccines and we saw mould had grown in the fridge as well as on packaging of some vaccines. At this inspection we saw the fridge was visibly clean and all items stored in the fridge were in good condition. The fridge was cleaned regularly by the cleaner and we saw this task was on the cleaning checklist. Records showed that a monthly stock checks were carried out which included a visual check of all stock and rotation to ensure the oldest medicines were used first.
- Fridge temperatures were checked twice a day and recorded. There was a cold chain protocol in place to follow if the fridge temperatures went out of range.
- The details on sharps bins were filled in correctly and included start dates and signatures.
- Health care assistants (HCA) were trained to administer vaccines and medicines and patient specific prescriptions or directions (PSDs) from a prescriber were

produced appropriately. (A PSD is the traditional written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis). The HCA provided the GPs with a list of patients with appointments to receive vaccines that day. The GPs checked this list and signed it to confirm that they had knowledge of the patient's health, and were satisfied that the medicine to be administered served the individual needs of each patient on that list.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- A fire risk assessment had been carried out in September 2016 and regular fire drills were carried out. The majority of actions identified during the risk assessment had been completed with the remainder due to be completed as part of the renovation. Fire safety equipment such as fire extinguishers had been serviced in March 2016.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- Locum GPs were used for six sessions per week by the practice. We saw locum induction packs in place and the locums' files showed that background checks were carried out prior to them working.

Arrangements to deal with emergencies and major incidents

Practice had adequate arrangements in place to respond to emergencies and major incidents.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, the plan did not include details of the neighbouring practice whose premises could be shared in the event of an emergency. The plan did not include details of the practice's service/utilities providers or emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 1 March 2016, we rated the practice as inadequate for providing effective services as the arrangements in respect of needs assessments, management of long-term conditions, quality improvement including clinical audits and staff training needed improving.

At this inspection we found improvement had been made in staff training, however the position in respect of the other concerns identified at the previous inspection remained unresolved when we undertook a follow up inspection on 22 February 2017. The practice remains rated as inadequate for providing effective services.

Effective needs assessment

The practice was unable to demonstrate that patient needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Clinicians organised their own access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. At the last inspection we found the practice did not have a system to ensure that these guidelines were followed through risk assessments, audits or random sample checks of patient records. At this inspection we found that whilst the GPs could give examples of guidelines we did not see evidence of processes and procedures in place to ensure these were followed.
- For example, we saw from patients' records that there were no care plans in place for some vulnerable patients such as patients with dementia or for those at risk of unplanned admissions to hospital. We saw some care plans for patients receiving palliative care and some for patients with poor mental health; however these were prepared by hospitals rather than the practice itself.

Management, monitoring and improving outcomes for people

At the previous inspection we found the practice had higher than average exception reporting for some clinical indicators including chronic obstructive pulmonary disease (COPD), diabetes, cancer and chronic kidney disease (CKD). (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). At this inspection we found the overall exception reporting rate for April 2015 to March 2016 for the practice was double the CCG and national average at 21% (CCG and national average 11%). We saw there had been some improvement in the exception reporting rate for cancer from 33% in 2014/15 to 17% in 2015/16 (CCG 26%, national 25%).

For diabetes the exception reporting rate from April 2015 to March 2016 remained high at 28% (CCG 13%, national 12%) from 32% for April 2014 to March 2015. At the time of our inspection the exception reporting rate for diabetes was 6% for the period April 2016 to March 2017. The final figure would be published in late 2017.

We found exception reporting rates remained high for COPD at 29% (CCG 14%, national 13%) (April 2015 to March 2016). At the time of our inspection the exception reporting rate was already at 30% for the period April 2016 to March 2017 with the final figures to be published in late 2017.

We reviewed some patient records and saw examples where patients had been exception reported where alternative options for ensuring treatment/reviews was carried out were not considered or attempted. For example, we saw several instances where patients had been exception reported for COPD because they had undergone cataract surgery. Whilst it is appropriate to delay spirometry following cataract surgery for a period of time it is not appropriate to completely fail to carry out this lung function test for those patients without further attempt. We also saw other instances where patients had been exception reported and reasons given included the patient was "unwell" or was "unable to perform spirometry". There was no evidence of any further attempts made to carry out the test at a later date.

We raised this with the GPs who did not demonstrate any progress or particular measures put in place to address the levels of exception reporting in the period between the two inspections.

There was limited evidence of quality improvement including clinical audit:

- At the previous inspection we found there had been no clinical audits carried out in the previous two years. At this inspection we found three single cycle audits had

Inadequate

Are services effective?

(for example, treatment is effective)

been carried out (minor surgery, diabetes and record keeping). These were not full cycle audits where any improvements made were implemented and monitored. Data had been collected however there was no evidence of analysis of these results or of findings used to improve services.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment

- The practice did not have a formal induction programme for newly appointed staff. We were told new recruits did undergo an induction process but this was informal and not documented.
- Staff received training that included: safeguarding, fire safety awareness and basic life support. However there was no evidence of training on information governance.

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 1 March 2016, we rated the practice as inadequate for providing well-led services as there was no overarching governance structure. The practice's values and vision were unclear and there was no evidence of quality improvement or continuous improvement.

We issued a requirement notice in respect of these issues and found arrangements had not significantly improved when we undertook a follow up inspection of the service on 22 February 2017. The practice is still rated inadequate for being well-led.

Vision and strategy

The practice did not have a clear vision or strategy.

- The practice did have a written mission statement which was on display in the reception area. However this mission statement was not underpinned by effectively managed systems and processes to ensure the mission statement was achievable.
- The practice did not have a clear long-term strategy and supporting business plans. There was a lack of clarity and certainty about the future leadership and direction of the practice. Prior to this inspection we were made aware that the two GP partners at the practice were due to stand down as of the end of March 2017. A new provider was due to take over the practice as of April 2017. On the day of this inspection the final arrangements for this change of leadership were unclear. As such there was a lack of certainty as to the future direction of the practice.We spoke with the prospective new provider during the inspection who was able to describe their visions for the future of the practice. Staff and members of the patient participation group (PPG) we spoke with demonstrated confidence in the prospective new provider and their capacity and capability to run the practice and ensure high quality care.

Governance arrangements

The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care. Some improvements in governance had been made since our previous inspection, however some concerns remained unaddressed.

- Infection control audits had been carried out, however a number of actions identified in the audits conducted by NHS England in December and August 2016 remained outstanding. Electrical appliance testing had been carried out in March 2016. Suitable arrangements were in place for fire safety.
- All staff who carried out chaperoning had undergone a Disclosure and Barring Service (DBS) check.
- The practice had systems in place for the safe management of medicines. Health care assistants (HCA) were trained to administer vaccines and medicines and patient specific prescriptions or directions (PSDs) from a prescriber were produced appropriately. The practice had oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- We saw the fridge was visibly clean and all items stored in the fridge were in good condition.
- We found the practice still did not operate an effective programme of clinical audits. While some data collection was carried out, we saw no evidence of completed audits. There was still no quality improvement programme including continuous clinical and internal auditing to make improvements.
- Practice specific policies were available to all staff. However there was no process in place to ensure policies were reviewed and updated with regular frequency.

Leadership and culture

At the last inspection we found the leaders did not have the necessary capacity or capability to lead effectively. We did not see evidence of quality and safety as top priorities for the leadership team. At this inspection we found that whilst some improvements had been made to address the issues around safety and staff recruitment and training, the practice's strategy, values, objectives, plans and governance arrangements were unclear or inadequate. Quality and safety were not evident as a top priority for the

Are services well-led?

Inadequate

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

present leadership. This was demonstrated by the ongoing lack of any quality improvement processes since prior to the previous inspection and persistently high levels of inappropriate exception reporting.

Continuous improvement

There was little innovation or service development. There was minimal evidence of learning and reflective practice.

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 Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 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: • Take adequate steps to assess the risk of, prevent, detect and control the spread of infections. • Ensure an adequate business continuity plan was in place to be followed in the event of a major incident. • Failing to implement nationally recognised guidance about delivering safe care and treatment, specifically failing to have care plans in place as required. 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 Maternity and midwifery 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:

This section is primarily information for the provider

Requirement notices

- Take steps to improve the practice's performance in the management of long term conditions, specifically in relation to levels of exception reporting.
- Ensure there was a process of quality improvement for example completed clinical audits.
- Ensure staff received mandatory training in Information Governance.
- Take steps to improve systems or processes at the practice, in particular regarding vision and strategy, governance, practice policies, performance awareness, continuous improvement and leadership.

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