Beaconsfield Road 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
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Beaconsfield Road Surgery on 8 December 2015. Breaches of legal requirements were found during that inspection within the safe, effective and well-led domains. After the comprehensive inspection, the practice sent us an action plan detailing what they would do to meet the legal requirements in relation to the following:

- Ensure that policies and procedures are implemented to keep blank prescriptions secure at all times.
- Ensure all actions identified by infection control auditing processes are implemented including improvements to the building.
- Ensure that all policies, procedures and risk assessments in place for assessing and monitoring risks to staff, patients and visitors, including fire safety arrangements and the legionella risk assessment are signed, dated and reviewed on a regular basis and that any actions identified are implemented. In particular ensuring that regular rehearsals of fire safety and evacuation procedures are carried out and fire escape routes are assessed.
- Ensure staff undertake training to enable them to gain the knowledge required in order to fulfil the duties and responsibilities pertaining to their role, including training in the safeguarding of children and vulnerable adults and the Mental Capacity Act 2005.

We undertook a focused inspection on 26 July 2016 to check that the provider had implemented their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link on our website at www.cqc.org.uk

Our key findings across the areas we inspected were as follows:-

- Risk assessments were not always being undertaken to identify when staff required a criminal records check via the Disclosure and Barring Service.
- Recruitment checks were not always undertaken prior to a staff member commencing in employment.
- Fire safety rehearsals continued not to be carried out.

Summary of findings

- Not all clinical staff had an up to date records of safeguarding children and vulnerable adults training or training in the Mental Capacity Act 2005.
- Training records were unavailable in relation to areas such as health and safety and fire safety.
- Risk assessments such as legionella were not accessible on the day of inspection and the system for adopting relevant policies was unclear.
- Security and tracking of blank prescription pads was in place.
- Action relating to an infection control audit had been taken and further actions monitored by the practice.

The areas where the provider must make improvements are:

- Ensure that risk assessments relating to the need for a criminal records check via the Disclosure and Barring Services are undertaken prior to each new staff member commencing in post. Ensure that the risk assessment process identifies and mitigates all of the potential risks associated with this.
- Ensure that recruitment checks are consistently undertaken prior to a staff member commencing in employment and that records of this are maintained.
- Ensure that fire safety rehearsals are carried out in line with an associated risk assessment.
- Ensure all clinical staff have an up to date record of safeguarding children and vulnerable adults training and training in the Mental Capacity Act 2005.
- Ensure that training records are maintained and accessible in relation to all areas of training need for all staff within the practice.
- Ensure that all risk assessments including legionella are accessible and that a system for adopting policies and procedures within the practice is clear.

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 as requirement notices from a previous inspection had not been met.

- A risk assessment process had been implemented to assess the need for staff to receive a Disclosure and Barring Service (DBS) check. However risk assessments were not consistently undertaken and when they had been carried out not all risks were appropriately considered. This was identified as an action the provider should take following the December 2015 inspection.
- Recruitment checks were not always carried out prior to employment.
- A fire drill rehearsal had not been carried out, this was subject to a requirement notice following the December 2015 inspection.
- The practice had taken action to address issues identified as part of an infection control audit.
- Improvements had been made to the secure storage and tracking of prescriptions within the practice, including those stored in printers.

Are services effective?

Requires improvement

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

- Comprehensive training records were not available.
- The practice had focused on training in areas identified at a previous inspection such as safeguarding and Mental Capacity Act (2005). However, not all staff had completed this training, including some GPs where there was no record of safeguarding training.
- The practice had not adequately addressed the training needs of staff in line with a requirement notice issued following the December 2015 inspection.

Are services well-led?

Requires improvement

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

- Training records were not up to date and information relating to this was not easily accessible.

Summary of findings

- Risks were not always assessed and assessments were not available to view.
- There was not a systematic process for adopting policies within the practice.
- Action from a previous inspection had not been taken in a timely manner.

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

Due to the issues identified within the practice the service is rated as requires improvement for the care of older people. The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

- The practice was responsive to the needs of older people, and offered home visits and longer appointments for those with enhanced needs. They also worked closely with community nurses to share information regarding older housebound patients and ensure their access to appropriate support and care.
- The practice provided care for patients in several local care homes and provided regular visits and support for care home staff in dealing effectively with patients' needs. In one care home where they looked after a relatively large number of patients, they held a weekly ward round.
- For those older people with complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- During the early autumn additional flu vaccination clinics were held, including Saturday clinics. The percentage of people aged 65 or over who received a seasonal flu vaccine was in line with the national average.

People with long term conditions

Requires improvement

Due to the issues identified within the practice the service is rated as requires improvement for the care of people with long-term conditions. The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

- GPs and nursing staff held lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.

Summary of findings

- All of these patients had a named GP and a structured regular review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- All patients living in residential homes with a long term condition had an annual review with a nurse.
- There were a variety of clinics run for the management of specific long term conditions. For example in addition to routine diabetic clinics, one GP ran diabetic clinics with the practice nurse to manage the care of diabetic patients with complex care needs.
- An audit dated 07 October 2015 of the practice's diabetic patients showed the percentage of diabetics cared for by the practice and attaining all four recognised standards that indicated a good quality of diabetic control was over twice that of the national average achievement. This was supported within the results from the Quality and Outcomes Framework 2014 to 2015 which also showed that the practice performed better than the national average.
- Patients receiving end of life care were supported using the Gold Standards Framework which is a system designed to provide a high standard of care to patients nearing the end of their life.
- GPs held monthly meetings with the palliative care team.

Families, children and young people

Requires improvement

Due to the issues identified within the practice the service is rated as requires improvement for the care of families, children and young people. The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

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- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- The practice had identified a lead GP for the safeguarding of children and practice staff knew who the lead GP was.
- Immunisation rates for the standard childhood immunisations were mixed. For example 12 month old immunisation rates (91.1%) were in line with the clinical commissioning group (CCG) average (92.3 - 92.7%) but the five year old immunisation rates (84.4% - 92.2%) were below the CCG average (89.8% - 95.8%).

Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had a policy that if a request for an appointment was made for a child under 10 they were always seen.
- The percentage of women aged 25 or over and who had not attained the age of 65 whose notes record that a cervical screening test had been performed in the preceding five years was 93.5%. This was above the CCG 83.9% and national 81.8% averages.

Working age people (including those recently retired and students)

Requires improvement

Due to the issues identified within the practice the service is rated as requires improvement for the care of working-age people (including those recently retired and students).The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

- The practice offered extended opening hours for appointments and patients could book appointments or order repeat prescriptions online.
- Telephone consultations were available and there was a text reminder service for appointments.
- There was a full range of health promotion and screening that reflected the needs for this age group and there was accessible health promotion material available through the practice.
- The practice promoted services for the under 25's on its website and in the practice and staff had been trained to proactively offer (sexually transmitted infection) STI testing and distribute condoms to patients under the age of 25 who were sexually active.
- Health checks were available to all new patients registering with the practice.

People whose circumstances may make them vulnerable

Requires improvement

Due to the issues identified within the practice the service is rated as requires improvement for the care people whose circumstances may make them vulnerable. The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

Summary of findings

- The practice identified patients living in vulnerable circumstances and kept a register of those with a learning disability.
- They had carried out annual health checks for patients with a learning disability and supported them in developing care plans.
- Longer appointments were available to patients where needed, for example when a carer was required to attend with a patient.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients how to access various support groups and voluntary organisations.
- The practice had a carers' register and signposted carers to support services. They would proactively send new information out to carers.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours although not all reception and administration staff had completed training in the safeguarding of vulnerable adults.

People experiencing poor mental health (including people with dementia)

Requires improvement

Due to the issues identified within the practice the service is rated as requires improvement for the care people experiencing poor mental health (including people with dementia). The identified issues included poor identification and management of risks, records not being maintained or accessible, recruitment processes not being consistently followed and staff not being appropriately trained to undertake their role. However we also found that;

- Patients experiencing poor mental health had comprehensive care plans.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have had a comprehensive care plan documented in their medical records in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate was 92.5% (national average 88.47%).
- 85% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months (national average 84.01%). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

- They had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and demonstrated clear pathways of referral to mental health and drug and alcohol services.
- If a patient required urgent referral to the mental health services, the practice had clear protocols in place for urgent assessment and referral.
- The practice had arranged for a staff member to undertake the course for the Bradford Certificate in Dementia for Practitioners with a Special Interest so that they could work as part of the local memory assessment services team to aid in the diagnosis of dementia in the local area.

Beaconsfield Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 8 December 2015 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Breaches of legal requirements were found. As a result we undertook a focused inspection on 26 July 2016 to follow up on whether action had been taken to deal with the breaches.

Requires improvement

Are services safe?

Our findings

Overview of safety systems and processes

The practice did not always have clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- During the inspection on 8 December 2015 it was noted that the practice did not have a process in place to identify when staff required a Disclosure and Barring Service (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). During our inspection on 26 July 2016 we found that a risk assessment process had been developed for use within the practice. However, we found that this was not always undertaken prior to a staff member commencing in post. For example a risk assessment had not been undertaken for a new manager until they had been in post for two months and the assessment did not take into consideration that they may be alone with patients within their management capacity.A new receptionist who had commenced in post a month previously did not have a DBS check or a risk assessment in place. A risk assessment had been carried out for a member of clinical staff and the decision made to carry out a DBS check however the staff member had commenced in post prior to the check being undertaken and this had not been considered as an area of risk within the risk assessment. We were told that the DBS was being processed but there was no paperwork available.
- During inspection on 8 December 2015 we found that blank prescription forms were not handled in accordance with national guidance and were not kept securely at all times. On 26 July 2016 we saw that the practice had a system for recording the receipt and distribution of prescriptions and these were kept in a locked cupboard. Prescriptions in printers in consulting rooms were kept in locked cupboards or drawers when not in use.
- During our inspection on 8 December 2015 we found that the practice had some infection control systems in place and had undertaken an infection control audit; however an action plan developed as a result did not include restorative work to rectify issues identified in the audit. On 26 July 2016 we saw that clear action had been taken to improve some areas of infection control such as updating the flooring in treatment rooms and repairing chairs in the waiting area.
- During our inspection on 26 July we reviewed two personnel files. We found that recruitment checks were not always undertaken prior to employment. For example, we viewed the file of a member of the clinical team who had commenced in post a week before our inspection and found no record of previous employment or references. There was also no current DBS check or risk assessment carried out on this staff member.

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Monitoring risks to patients

- During our inspection on 8 December 2015 we found that the practice had assessed the risks associated with fire safety, but had not conducted a rehearsal of their fire evacuation procedures. On 26 July 2016 the practice had still not conducted a rehearsal of their fire evacuation procedures. We were told this was because not all staff had attended up to date fire safety training and the plan was for staff to be trained prior to carrying out the fire evacuation rehearsal.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective Staffing

- During our inspection on 8 December 2015 we found that staff had not always received training appropriate to their roles. This included some reception staff having not received training in safeguarding of vulnerable adults and children and some clinical staff having not received training in the Mental Capacity Act 2005. On 26 July 2016 we viewed a training matrix that showed reception staff had received training in safeguarding of vulnerable adults and children. However, there were limited records of clinical staff training in relation to safeguarding. For example, only two of five GPs had a current record of safeguarding children training and only one had a current record of safeguarding vulnerable adults training. The lead GP told us they were in the process of arranging level three safeguarding children training for all GPs, however this had not happened at the time of our inspection. We were also told that some staff were attending safeguarding training arranged by the CCG in the afternoon of the day of inspection. Training records on 26 July showed that only two out of eight clinical staff had attended training in the Mental Capacity Act 2005.
- On 26 July 2016 we found that the practice had not maintained a comprehensive training log for all areas of staff training. For example there was no record of which staff had attended annual fire training. The managers and lead GP told us they had focused on the gaps in training identified in their previous inspection and as such other areas were not up to date.

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

- During our inspection on 8 December 2015 we found that there were areas of risk that had not been identified within the practice and other areas where risks had not been adequately mitigated. For example, we saw that action had not been taken in relation to an infection control audit and that risks associated with the storage and security of prescriptions had not been identified. We also saw that a fire risk assessment had not been signed and dated and that mitigating actions such as fire evacuation rehearsals had not been carried out. On 26 July 2016 we saw that action following an infection control audit had been carried out and that prescriptions were stored securely within the practice. However, the practice had still not carried out a fire evacuation rehearsal and it was unclear how recently staff had attended fire training.
- Although a legionella risk assessment had been seen on inspection in December 2015 the practice was unable to locate it during inspection on 26 July 2016. An associated policy relating to legionella had been developed in June 2016 and adopted from another practice. The policy stated that six monthly water temperature checks were to be carried out and we saw that this had been done. However, because the practice staff were unable to locate the risk assessment it was unclear if this action was in line with the recommendations made at the time.
- On 26 July 2016 we were told that changes in practice management were still in the process of being embedded with two part time managers now in post. However, we were told that some governance processes had been impacted by changes in management since the December 2015 inspection and that some records of risk assessments and staff training information could not be located by the new staff in post.

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 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:** The registered person did not do all that was reasonably practicable to ensure that systems and processes to assess and monitor the service were effective. Risks were not adequately mitigated and records not maintained or accessible. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Maternity and midwifery services Surgical procedures 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 ensure that risks were being adequately assessed and mitigated. Fire evacuation rehearsals continued not to be undertaken within the practice. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered provider had not ensure that all persons employed in the provision of a regulated activity had received appropriate training. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had failed to ensure that recruitment checks were carried out on all new employees. This included information set out in schedule 3 of the act.

This section is primarily information for the provider

Enforcement actions

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.