# Bursledon Surgery

## Quality Report

Bursledon Surgery
The Lowford Centre
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Hampshire
SO31 8ES
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Website: www.bursledonsurgery.co.uk

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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 | Inadequate |
|---|---|
| Are services safe? | Inadequate |
| Are services effective? | Inadequate |
| Are services responsive to people's needs? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced inspection at Bursledon Surgery on 6 December 2016 to monitor whether the registered provider had met the requirements of the warning notices which were served following an announced comprehensive inspection in June 2016. The timescale given to meet the requirements was 31 October 2016. The provider submitted an action plan to demonstrate how they would become compliant with the regulations.

Two warning notices were served which related to regulations 12 Safe care and treatment and 17 Good governance of the Health and Social Care Act 2008.

**Areas which did not meet the regulations in June 2016 were:**

- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff. When incidents and complaints had been identified reviews and investigations were not thorough enough.
- The system in place for reporting, recording and monitoring significant events was not always followed. There was no structure for identifying, reporting and analysing incidents in order to learn from them and prevent them from happening again.
- There were no processes in place for receiving and responding to medicines alerts from the Medicines and Healthcare products Regulatory Agency.
- Staff had not received training which was relevant to their roles, this included safeguarding adults and children; infection control; chaperone training and basic life support.
- Staff were not clear whether there was a safeguarding policy in place and staff did not know if there was a whistle blowing policy at the practice.
- The practice was unable to demonstrate that staff who chaperoned had a Disclosure and Barring Service check or a risk assessment, to ensure they were competent and suitable to carry out this role.
- Medicines which had been opened were not dated to ensure they were not used past their expiry date.

# Summary of findings

- Patient Group Directions which had been adopted by the practice to allow nurses to administer medicines in line with legislation were out of date.
- The infection control policy was not up to date and current. The last annual infection control audit had been carried out in May 2015 and there was no record of action taken to address any improvements which may have been necessary.
- There was a lack of clarity on what duties staff and medical students were expected to perform and how they would be supported, supervised and mentored in this.
- Governance arrangements to ensure that there were sufficient numbers of staff employed and were supported to carry out their duties were not effective.
- Accurate and complete records of patient care and treatment were not consistently maintained.
- The systems for ensuring that clinical coding of patient notes had been completed were not implemented well enough to ensure that all information was captured accurately.
- The practice was unable to demonstrate how the practice aimed to improve the care of all patients with long term conditions.
- There were no process in place for staff meetings, appraisals and clinical supervision.
- Staff had limited opportunities to provide feedback on the service provided; there were no clear plans in place on how the practice would develop in the future.

**Key findings of the inspection 6 December 2016:**

- Systems in place to assess the risks to the health and safety of patients receiving care and treatment had improved in most areas. However, further work was needed to ensure that there is a clear policy for staff to know what is to be included as a significant event.
- Processes in place for Medicines and Healthcare products Regulatory Agency alerts now demonstrated that these were handled appropriately and cascaded to staff for action when needed.
- All staff had received training on safeguarding adults and children; infection control; basic life support; and chaperone training, which was recorded. Suitable arrangements were in place to show that staff that chaperoned had been appropriately checked.
- Medicines were managed in line with current guidance and there were safe systems in place to monitor expiry dates, stock levels and storage.
- Patient Group Directions which had been adopted by the practice to allow nurses to administer medicines in line with legislation were in date.
- Infection control policies and procedures were up to date and contained relevant information. The practice had carried out an infection control audit and made improvements where needed. A planned programme of audits was in place.
- Governance arrangements had been improved and there were clear roles and responsibilities for all staff. All practice policies and procedures were in the process of being reviewed.
- All staff had received an appraisal; and there were arrangements in place to provide clinical supervision and monitoring for staff as needed.
- Patients' records were maintained and contained sufficient information on care and treatment given. Staff had adequate time to complete tasks such as clinical coding and summarising of patient notes.
- The practice was able to demonstrate how it was reviewing and improving the care of patients with long term conditions.
- Minutes of meeting held showed that complaints, actions and outcomes were discussed with relevant staff members.
- Systems and processes in place had been reviewed and improved to provide opportunities for staff to feedback on service provision.

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

Importantly, the provider must:

# Summary of findings

- Monitor and improve the quality and safety of the services with regard to business resilience and continuity.

The provider should:

- Continue to manage and mitigate risks to the health and safety of service users with regard to significant events and staff are aware of what the practice considers to be a reportable significant event.

The Care Quality Commission has found that improvements have been made and the warning notices are met.

The full report published on 20 October 2016 should be read in conjunction with this report. The practice remains in special measures until a full comprehensive inspection is carried out by the Care Quality Commission. Therefore the overall rating remains inadequate.

**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?**

**Inadequate**

The practice is rated as inadequate for providing safe services until a further comprehensive inspection takes place. However, there were areas of improved practice:

- Systems in place to assess the risks to the health and safety of patients receiving care and treatment had improved in most areas. However, further work was needed to ensure that there is a clear policy for staff to know what is to be included as a significant event.
- Medicines were managed in line with current legislation.
- Suitable arrangements were in place for infection control and prevention.
- The practice had defined systems, processes and practices in place to keep patients safe and safeguarded from abuse.

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for providing effective services until a further comprehensive inspection takes place. However, there were areas of improved practice:

- Staff were provided with suitable training to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- The GP was responsible for exception reporting and records showed this was only done for repeat non-attenders or those patients where it was clinically inappropriate. The practice reported an improvement on QOF exception reporting and recent unverified figures showed that exception reporting for 2015/16 had improved as they were lower than 2014/15.

**Are services responsive to people's needs?**

**Inadequate**

The practice is rated as inadequate for providing responsive services until a further comprehensive inspection takes place. However, there were areas of improved practice:

- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

# Summary of findings

**Are services well-led?**

Inadequate

The practice is rated as inadequate for providing well led services until a further comprehensive inspection takes place. However, there were areas of improved practice:

- Systems and processes in place had been reviewed and improved to provide opportunities for staff to feedback on service provision. A range of meetings had taken place and there was a schedule of meetings to be held in the future. These included whole practice meetings; management meetings; administration meetings; and the nurses meetings had been combined with the clinical meetings to enable effective communication and regular contact between members of the clinical team.
- There was a staff structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity all of which were in the process of being reviewed.
- There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

# Bursledon 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 practice manager specialist advisor.

## Background to Bursledon Surgery

Dr Vivian Ding is a solo registered provider at Bursledon Surgery, The Lowford Centre, Portsmouth Road, Lowford, Southampton, Hampshire, SO31 8ES.

There is one female GP who is also the provider; an advanced nurse practitioner and a practice nurse as well as a health care assistant and a phlebotomist. The practice is supported by a reception and administration team and an office manager. There is an interim practice manager, with a new practice manager starting on 7 December to work three days a week.

The practice currently provides services for approximately 3,825 patients. The practice has slightly higher than average numbers of patients aged four years and under; and 30-34 years old.

The practice is a teaching practice (teaching practices take medical students and training practices have GP trainees and F2 doctors). The practice is not currently teaching any medical students. The practice is part of the NHS West Hampshire Clinical Commissioning Group (CCG). Bursledon Surgery serves the whole of Bursledon as well as the surrounding areas of Lowford, Old Netley, Butlocks Heath, Netley and Hamble-Le-Rice, Swanwick,Sarisbury Green andparts of Hedge End andSholing. The population for this practice is recorded as being in the fourth less deprived decile and are predominantly white British.

The practice is open between 8.30am and 1pm and 2pm and 6.30pm Monday to Friday. Appointments are from 8.30am to 6.30pm daily. Extended hours appointments are offered at the following times from 7.30am to 8am on Mondays and Wednesdays and 6.30pm to 7.30pm on Thursdays.

When the practice is closed patients are advised to dial 111 for the local out of hours service which is provided by West Hampshire CCG.

Regulated activities are provided from Bursledon Surgery, The Lowford Centre, Portsmouth Road, Lowford, Southampton, Hampshire, SO31 8ES which was visited during the inspection.

## Why we carried out this inspection

At the inspection carried out in June 2016, we served warning notices to address shortfalls with

Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to send a report of the changes they would make to comply with the regulation they were not meeting at that time.

We carried out this inspection to make sure that the necessary changes have been made in relation to the warning notices. We found the provider was meeting the regulation included within this report. This report should be read in conjunction with the full inspection report for Bursledon Surgery published in October 2016.

# Detailed findings

## How we carried out this inspection

We carried out an announced visit to the practice on 6 December 2016 and looked specifically at the shortfalls identified in the warning notices served to the practice after our inspection in June 2016.

On this occasion we did not review the population groups or speak with patients who used the service.

We spoke with the GP partners, the practice manager, nursing staff and reception and administration staff.

We looked at policies and procedures and inspected records related to the running of the service.

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

- We found the process for reviewing significant events had been reviewed since our last inspection. A new form had been introduced to enable better reporting of incidents and details of how these were managed. There was also a summarising sheet which gave an overview of all significant events, with outcomes and follow up actions.
- Significant events were discussed at a range of meetings, which included management meetings; whole practice meetings; administration meetings; and clinical meetings. Minutes of these meetings confirmed this. There was evidence of discussion and notes of actions that were needed; how they were to monitored; and progress on managing any significant event that had occurred.
- Staff were able to give examples of recent significant events, such as, a patient being prescribed a medicine which was not suitable due to their condition. However, there was not a clear policy held by the practice of what events would be considered significant and therefore to be recorded for reflection analysis and learning purposes. For example we were told that a patient had collapsed in the waiting room on 5 December 2016 and appropriate action had been taken, but this event was not recorded.

**Overview of safety systems and processes**

- We looked at the processes for managing Medicines and Healthcare products Regulatory Agency alerts. The practice had two email addresses where these were received. These were monitored by the management team on a daily basis, at regular intervals. When needed the interim practice manager and office manager would also monitor the emails. When an alert was received which was relevant to the practice, this was printed out and attached to their safety alert checklist, on which a record of action taken was made. Whilst actions were ongoing an alert was placed on the email to show that it was still active, this was removed when all actions had been completed.
- We found that training had been provided on safeguarding adults and children to the appropriate level; basic life support; chaperoning; and infection control.
- Safeguarding policies for children and adults had been reviewed and contained all necessary and relevant information. There were nominated safeguarding leads and contacts details for other agencies which needed to be informed of safeguarding concerns. Staff were able to describe what actions they would take if they suspected patients were at risk of harm.
- The whistle blowing policy had also been reviewed and a mini-training session had taken place on whistle blowing for all staff.
- All staff that chaperoned had an enhanced Disclosure and Barring check in place and refresher training had been provided for the staff that chaperoned.
- We reviewed the processes and policies for safe handling and management of medicines within the practice. Protocols were in place for storage of medicines and there was a nominated member of staff who was responsible for ensuring they were followed. The process included ordering; checking of orders received; safe storage, such as vaccines needing to be stored in a fridge and checking of expiry dates.
- The practice had planned to have an annual medicines audit, the first of which had been carried out on 4 December 2016 this audit covered safe storage; labelling of medicines; stock rotation; and checks of expiry dates. This included any medicines that were kept in the doctor's bag. A prescription log was in place and monitored.
- All 23 patient group directives had been reviewed to ensure they were in date, appropriately authorised and had been signed by the member of staff who would administer the medicines.
- We looked at the storage of medicines in the practice and found that all medicines were stored appropriately and within recommended temperature ranges, for those that required cold storage. Liquid medicines were dated when opened and disposed of appropriately when they were no longer effective.
- We looked at infection control processes in place. We found the infection control policy and protocols had

received a full review. Areas covered included information on minimising risk; waste control; needlestick injuries and a plan of audits and risk assessments.

- An audit of minor surgery had been completed on 30 November 2016; this showed that infection rates post procedures were low. A hand hygiene audit was planned for January 2017.
- An annual infection control audit had been carried out and areas identified for improvement had been actioned and completed. Such as, a review of cleaning standards in the practice. This included making sure cleaning schedules were in place. The practice had also liaised with the contracted cleaners to carry out a complete check of the premises. An area which required attention was high dusting, but other aspects of cleaning were satisfactory. The practice were awaiting a date for a full deep clean of the practice. Following the inspection visit the practice informed us that this would take place on 20 January 2017.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Management, monitoring and improving outcomes for people**

- We looked at how the practice was managing Quality and Outcome Framework outcomes. We found reviews for patients with long term conditions such as diabetes and COPD, a condition which causes breathing difficulties, had been scheduled. These reviews were a mix of home visits and consultations at the practice dependent on patient need.
- The GP was responsible for exception reporting and records showed this was only done for repeat non-attenders or those patients where it was clinically inappropriate. The practice reported an improvement on QOF exception reporting and recent unverified figures showed that exception reporting for 2015/16 had improved as they were lower than 2014/15.

**Effective staffing**

- Since our last inspection we found the practice had employed three more administration staff and an office manager. The practice had an interim practice manager and the permanent manager would be commencing work on 7 December 2016 and a handover period of one month was in place. The staffing structure was clear and there was a senior receptionist in place to provide additional support.
- There was a clear rota system in place and staff were provided with protected time to ensure documentation was maintained. Scanning and note summarising had improved and protocols for test results showed that these would be available in consultations when needed. There was also protected time allocated for carrying out audits. Staffing structures ensured that telephones were answered in a timely manner and this had prompted positive feedback from patients.
- Since our last inspection the practice had suspended teaching medical students whilst the practice was in special measures. The advanced nurse practitioner confirmed they no longer would prescribe medicines over the telephone and now received regular clinical supervision and mentoring from the GP. An appraisal system had been put into place and all staff had received an appraisal and were provided with the opportunity during their appraisal to discuss how the practice was run. Records we looked at confirmed this.

**Coordinating patient care and information sharing**

- We reviewed a sample of patients' records to determine their completeness. We found there was adequate detail recorded to determine what had happened in the consultations. There was a sufficient amount of information to enable other staff members to provide care and treatment and reasons for treatment decisions. The practice aimed to make further improvements by introducing templates for consultations to standardise recording processes. This would also enable staff to initial entries to provide an audit trail. Appropriate alerts were in place on patient records.
- Refresher training had been provided for members of staff who were responsible for coding patient events. An audit of coding on patient records had been carried out to identify areas where this had been missed. This work was ongoing and the practice were moving to using specific templates on their computer system to streamline the process.
- Improvements had been made in relation to patient record summarising. The practice reported that 5% of records were awaiting summarising, compared with 9% in January 2016. The advanced nurse practitioner had undertaken a piece of work on reviewing all cervical screening which had taken place to ensure they were recorded. Records confirmed that this had been completed and showed when the procedure was carried out.

Inadequate

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Listening and learning from concerns and complaints**

- Minutes of meeting held showed that complaints, actions and outcomes were discussed with relevant staff members. When needed a complaint was discussed at subsequent meetings to ensure all necessary actions had been taken.
- We found verbal and written complaints were logged and acknowledged within three days by the interim practice manager. Actions were noted and monitored to ensure the complaint was resolved to the patient's satisfaction.
- There was an example of a recent complaint where changes had been made related to a comment on NHS Choices. A patient considered their communication needs were not being met. The practice made sure that a specific alert was placed on their record to detail what assistance was required and staff were informed in a meeting of this. Staff reported that the communication needs of this patient were being met and the process was working.
- The complaint related to contraceptive prescribing had been reviewed and the recommended training for staff had been booked to take place in January 2017.

# Are services well-led?

Inadequate

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

## Our findings

**Governance arrangements**

- Since our last inspection a process of reviewing all practice policies and procedures had started, with policies identified in the warning notices being the first to be reviewed, for example, the infection control policy. Policies were available in a variety of places, either in paper or electronic formats. Work was in progress to upload all reviewed policies and procedures onto the computers shared drive for staff to access.
- We found the practice had worked on defining staff roles and responsibilities and there was a clear structure in place which detailed these. All staff had been provided with up to date job descriptions to support this work.
- The practice had a business continuity plan and disaster recovery plan in place. However, the information contained within the document was limited and did not demonstrate clearly how actions would be put into place in the event of an emergency. There was also limited information on what would happen if the premises were not available for use and the practice had to operate from another location. For example it was not clear how buddy practices would provide support.
- The GP had recently had annual leave, which was covered by a locum GP. However, on one morning cover was not available for half an hour, as the regular locum GP was unavailable, until a replacement locum GP was found.

**Seeking and acting on feedback from patients, the public and staff**

- We found systems and processes in place had been reviewed and improved since our last inspection, to provide opportunities for staff to feedback on service provision.
- A range of meetings had taken place and there was a schedule of meetings to be held in the future. These included whole practice meetings; management meetings; administration meetings; and the nurses meetings had been combined with the clinical meetings to enable effective communication and regular contact between members of the clinical team.
- Minutes of meetings confirmed that significant events; complaints; and positive and negative feedback from patients was discussed.
- Staff we spoke with said this enabled them to feel involved and part of the team. They added that they were more comfortable with raising issues and were confident these would be addressed whenever possible.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered person did not have systems or processes that were established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity with regard to business resilience and continuity.<br>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |