Grove Medical Centre

Quality Report

The Grove
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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?	**Inadequate**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Grove Medical Centre on 10 May 2016. The overall rating for the practice was requires improvement. The full comprehensive inspection report published on the 3 August 2016 can be found by selecting the 'all reports' link for Grove Medical Centre on our website at www.cqc.org.uk. We had found breaches of legal requirements and the provider was rated as requires improvement under the safe, effective and well led domains. The provider was rated good for providing caring and responsive services. The practice sent to us an action plan detailing what they would do to meet the legal requirements in relation to the following:-

- Ensuring that blank prescriptions forms used within the practice were tracked.
- Ensuring they could demonstrate an adequate method of recording significant events and had a significant event policy in place.
- Ensure all staff that had unsupervised contact with patients, and those used for chaperoning duties, had been checked by the Disclosure and Barring Service or had a risk assessment in place.
- Ensure staff had received all relevant training.
- Ensure that all recruitment checks had been undertaken prior to employing staff.

There were also areas that we found the practice should improve including:

- Actively identifying patients that had caring responsibilities within their patient list.
- Reviewing their complaints procedure to ensure information is available to escalate a complaint should a patient remain dissatisfied.
- Reviewing and updating their business continuity plan.
- Reviewing induction processes to ensure elements are appropriate to different staff groups and document that these are undertaken.
- Reviewing access to appointments in line with patient feedback.
- Ensuring all safety assessments are undertaken and reviewed as appropriate.

This inspection was an announced focused inspection carried out on 20 January 2017 to confirm that the

Summary of findings

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 10 May 2016.This report covers our findings in relation to those requirements. Although we found that the provider had made some improvements we still found areas where the provider needed to improve.

Overall the practice is still rated as requires improvement.

Our key findings were as follows:

- The provider had ensured all staff that have unsupervised contact, or undertook chaperoning duties, had a Disclosure and Barring Service check in place.
- All appropriate recruitment checks were completed and recorded prior to employment.
- The provider had reviewed their complaints procedure and now provided the appropriate signposting information to patients should they wish to escalate their complaint.
- The provider had updated their business continuity plan but this did not include contact numbers for key staff members.
- The induction process had been reviewed and documentation was seen that the induction process had been followed.
- Areas in relation to access to appointments had improved in the national patient survey feedback.
- The practice had increased the number of known carers from 135 carers to 321 carers.

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

Importantly, the provider must:

- Ensure governance arrangements for the management of risks to patients and staff such as for, safety assessments, fire risk assessment, Legionella assessment and staff training are complete and known risks are corrected as required.
- Ensure their significant event analysis procedure is complied with and enables all significant events to be managed in a timely manner..
- Ensure their recording system in place to track prescription forms used within the practice allows for the correct tracking of all prescription forms.
- Ensure all staff receive appropriate training commensurate to their role, for example, fire training, information governance and Mental Capacity Act (2005) (MCA).
- Ensure that safety assessments are undertaken as required and ensure that they formulate an action plan to address the issues that have been documented.

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

At our previous comprehensive inspection on 10 May 2016, we rated the practice as requires improvement for providing safe services as the arrangements required some improvements. Areas included, significant event reporting and investigation, the tracking of prescription forms, risk assessments not being up to date, recruitment checks not being fully adhered to and not all staff who acted as chaperones had undergone a Disclosure and Barring service check (DBS).

At this inspection, in January 2017 we found that:

- All staff who acted as a chaperone had a DBS certificate on record. 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 unsupervised contact with children or adults who may be vulnerable.
- The practice provided evidence that staff recruited following our previous inspection had all required recruitment checks undertaken and evidence was held on file.
- The practice had undertaken a fire risk assessment and a Legionella assessment following our last inspection. However, there were areas that were documented within these assessments as requiring action which were still outstanding.
- The practice had put in place a prescription form tracking system for prescriptions being delivered into the practice. However, this system did not enable the practice to ensure that prescription forms could not be used inappropriately.
- The practice now had in place a significant event policy. However, there was evidence that this policy was not being adhered to and some staff were not aware of where significant event reporting forms were held.

Are services effective?

Requires improvement

At our previous comprehensive inspection on 10 May 2016, we rated the practice as requires improvement for providing effective services as the arrangements in place to ensure all staff were adequately trained for their roles were not present. We found that concerns raised at this inspection had not been addressed appropriately and the same concerns remained.

At this inspection, in January 2017 we found that:

- The practice did not have an effective process in place to ensure all staff were adequately trained. For example,

Summary of findings

phlebotomists had not undergone training in awareness of the Mental Capacity Act 2005 or for gaining consent, no staff had undertaken information governance training and not all staff had undertaken fire safety training apart from during induction. The practice did have trained fire marshals.
- The practice did not maintain a training matrix or plan to identify training needs. Some information of training undertaken was held on the practice's payroll system but no information was kept on this system in regards to any training undertaken by GPs who kept their own records for revalidation.

Are services well-led?

Inadequate

At our previous comprehensive inspection on 10 May 2016, we rated the practice as requires improvement for providing well led services as the business continuity plan had not been reviewed since 2007, the system used to ensure all relevant staff could learn from issues arising from significant events was not sufficient. At the time of inspection the practice did not have a significant event policy and not all staff knew the location of reporting forms. The practice were not providing information detailing how patients could escalate a complaint if they remained dissatisfied.

At this inspection, in January 2017 we found

- Governance arrangements for the oversight and management of risk had not been sufficiently improved leaving a risk of potential harm to patients and staff.
- The practice had an up to date business continuity plan. This had been supplied following the previous inspection but did not include contact numbers for key members of staff.
- The practice showed evidence they were providing patients with the required information to allow them to escalate a complaint if they remained dissatisfied.
- Whilst there was a significant event policy in place, there was evidence this was not being adhered to. Three staff members we spoke with were not aware of where incident reporting forms were held. Evidence was seen where one significant event form was completed in December 2016 stating the matter was discussed at the partnership meeting in January 2017 but minutes of the practice's clinical meeting documented that there were no significant events to discuss. The practice manager informed us that the incident forms had only been given to her during the week of the inspection.
- Risk assessments that had been completed had outstanding actions remaining. This included a need for fire training for staff members and corrective pipe work to comply with the legionella risk report.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

People with long term conditions
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

Families, children and young people
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

Working age people (including those recently retired and students)
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

People whose circumstances may make them vulnerable
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

People experiencing poor mental health (including people with dementia)
The provider had not resolved all the concerns for safe, effective and well-led identified at our inspection on 10 May 2016 which applied to everyone using this practice, including this population group. Therefore the rating for this population group has not changed and remains requires improvement.

Requires improvement

Grove Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and assisted by a second CQC Inspector.

Background to Grove Medical Centre

Grove Medical Centre is located in a residential area of Egham and provides general medical services to approximately 14,000 patients.

There are three GP partners (two male and one female) and four female salaried GPs. The GPs are supported by two female practice nurses, two health care assistants, a team of receptionists, administrative staff and a practice manager.

Data available to the Care Quality Commission (CQC) shows the practice serves a higher than average number of patients who are aged between 35 and 54 years of age when compared to the national average. The number of patients aged 60 to 79 is slightly lower than average. The number of registered patients suffering income deprivation (affecting both adults and children) is below the national average.

The practice is open Monday to Friday between 8am and 6.30pm. Extended hours appointments are offered every Saturday morning from 8am to 11am with appointments available to see either a GP or a nurse. Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hour's service by calling the surgery or viewing the practice website where they were directed to contact NHS111.

The practice runs a number of services for its patients including; chronic disease management, new patient checks, smoking cessation, phlebotomy, 24 hour blood pressure monitoring, travel vaccines and advice.

Services are provided from one location. Grove Medical Centre, The Grove, Church Road, Egham, Surrey, TW20 9QN.

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS North West Surrey Clinical Commissioning Group.

Why we carried out this inspection

We undertook a comprehensive inspection of Grove Medical Centre on 10 May 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the inspection published on 3 August 2016 can be found by selecting the 'all reports' link for Grove Medical Centre on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Grove Medical Centre on 20 January 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 if the practice was now meeting legal requirements.

Detailed findings

How we carried out this inspection

We carried out a follow-up inspection of Grove Medical Centre on 20 January 2017. During our visit we:

- Spoke with a range of staff including the practice manager and three administrative staff.
- Reviewed policies and records kept by the practice in relation to significant events, chaperoning and recruitment.
- Reviewed the tracking system in place for prescription forms.
- Reviewed training information for staff.
- Reviewed safety assessments that had been undertaken by the practice.
- Reviewed the complaints procedure of the practice.

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 10 May 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of tracking prescription forms, managing significant events, ensuring chaperones had DBS checks in place, completing recruitment checks and ensuring risk assessments were undertaken, were not adequate.

Not all of these areas had improved when we undertook a follow up inspection on 20 January 2017.

Safe track record and learning

During our inspection in May 2016 we found that the provider did not have a significant events policy in place which detailed how these were to be managed within the practice. Following the inspection the practice sent us a copy of their significant event policy.

At this inspection we found that the practice had not been following their significant events policy. The policy stated that significant events should be discussed at the practice meeting following the incident. Evidence was seen that there was one incident that occurred in April 2016 with documentation showing this had not been discussed until September 2016. Additionally we were shown two significant events that had occurred in November and December 2016 which had not been discussed at any meeting as the incident reporting forms had not been given to the practice manager until shortly before our re-inspection. These delays could impact on patients through a lack of sharing learning from the occurrences and the prevention of similar occurrences in the practice.

At the previous inspection it was noted that not all staff were aware of the location of the incident reporting form for significant events. At this inspection we spoke to three members of administrative staff who did not know where this form was located.

Overview of safety systems and process

At our previous inspection it was found that not all staff who acted as chaperones had undergone a check through the Disclosure and Barring service (DBS), (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 this inspection evidence was seen that all staff who undertook chaperoning duties or may have unsupervised patient contact had a DBS certificate on file.

In May 2016 it was noted that the practice did not have a system in place for the tracking of blank prescription forms used by the practice. During this inspection we found there was a process now in place but this did not adequately track forms used in printers.

We saw evidence that showed that within one box of prescription forms, which originally contained 2,000 forms, the practice could not identify where 1,700 forms had been used. We saw 80 prescription forms in a printer within one consulting room that had not been signed out for use in their records.

It was also reported from our inspection in May 2016 that the practice had not undertaken all appropriate recruitment checks prior to employment. We inspected the recruitment file for a new member of staff at this inspection and discovered that all checks had been completed prior to employment. This included, a full works history, proof of identification and references.

Monitoring risks to patients

During the inspection of May 2016 we found there had not been a fire risk assessment of the premises since 2006 but noted that one was planned for the week following our inspection. During this inspection we found this had been undertaken. However, not all areas identified within the assessment had been acted upon. The practice had no action plan in place to undertake or document these improvements. For example, no evidence was seen during the risk assessment that the practice ensured the fire system was subject to preventative maintenance every six months as was required.

The practice had undertaken a legionella risk assessment the week prior to our last inspection (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). It was seen that there was no action plan in place for this assessment to act on the risks detailed within the assessment. For example, a leak which was documented as medium risk, and requiring action within one month, had not been addressed.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

During our previous inspection it was found that the business continuity plan in place for major incidents such as power failure or building damage had not been reviewed since 2007. A revised plan was seen dated May 2016. However, this did not contain contact numbers for key staff within the document.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 10 May 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of staff training including fire training, information governance and Mental Capacity Act (2005) (MCA) needed improving.

These arrangements had not improved when we undertook a follow up inspection on 20 January 2017. The practice is still rated as requires improvement for providing effective services.

Effective staffing

We reported, following our previous inspection, that the practice could not demonstrate how they ensured role-specific training or when staff were required to update their training. The practice did not maintain a training plan that allowed them to review training requirements for all staff. We saw evidence that some staff training that had been undertaken including safeguarding (for adults and children) and basic life support (BLS). Training gaps identified included fire training, information governance and Mental Capacity Act (2005) (MCA).

During this inspection we found that no staff had undertaken information governance training. Neither of the practice's phlebotomists had training in the Mental Capacity Act 2005 nor undergone training regarding obtaining consent, however, during interviews they had provided information that they understood how to obtain consent and what actions to take if they were unsure if this was understood.

The practice provided fire training on induction but no annual refresher training was provided for staff as advised in the fire risk assessment. Five members of staff had been trained as fire marshals and it was expected that these staff would disseminate information to other staff, there was no evidence that this had happened as there was no process in place to capture this information.

No training records were kept for GPs as they maintained their own records for revalidation purposes. Some records were kept for other staff's training within the practice's payroll system.

It was also seen during the previous inspection that the practice did not have documentation outlining an induction programmed for all newly appointed staff. Evidence was seen at this inspection that this issue had been addressed.

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 May 10 2016, we rated the practice as requires improvement for providing well-led services as not all governance arrangements in place within the practice were adequate.

We found that there had not been improvement in this area during our inspection on 20 January 2017.

Governance arrangements

We had previously reported following our inspection in May 2016 that there were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, there were areas that required improving such as, systems for documenting significant events, systems for tracking prescription forms, acting upon recommendations from risk assessments and ensuring that staff had undertaken required training.

Whilst the practice had implemented some improvements following the earlier inspection, at the January 2017 inspection, governance arrangements remained poor in some areas. For example, a significant events policy was in place however, this was not being adhered to. The document stated that there would be a Significant Event Process Log documenting date of discussion, learning outcomes and action points. We were informed by the practice manager this log was not in place. Significant issues that threatened the safe and effective delivery of care were not managed adequately. For example, two incident reporting forms from events in November and December 2016 had only been passed to the practice manager during the week of our inspection on January 20th 2017. One of these forms had been completed stating that the issue was discussed during their January meeting however, the minutes of their meeting detailed that there were no significant events to be discussed.

The governance procedure that was put in place to track prescription forms within the practice was not adequate and evidence was seen that not all prescription forms could be accounted for.

Some training, as identified by the practice, for staff had not been completed and the practice could not demonstrate that they had acted upon the recommendations documented within their own risk assessments. There were continued gaps in training that had been highlighted during our previous inspection which had not been acted upon including fire training, information governance and Mental Capacity Act 2005 (MCA) training. These were issues that had been identified during our previous inspection in May 2016 and remained outstanding. The issue regarding fire training for staff was also documented within the Fire Risk Assessment undertaken the week following our inspection.

Leadership and culture

Areas were identified where strong leadership was required to ensure an effective and consistent approach to all issues was adopted by practice management. These issues included management of significant events, staff training, tracking of prescription forms and acting upon issues identified within risk assessments. Our findings from this inspection indicated the management team lacked the capacity to oversee the changes required to meet the regulatory breaches previously identified. The lack of change in some areas therefore placed patients and staff at risk particularly in regard of health and safety.These included:

- Prescription form tracking process that did not enable prescription form tracking.
- Actions that were required following risk assessments not being undertaken.
- A significant events policy that was not being adhered to and significant delays identified during our inspection in dealing with some of these issues.
- Staff being unaware of the location of incident reporting forms.

The provider had reviewed their complaints procedure as required following our previous inspection and now provided the appropriate signposting information to patients should they wish to escalate their complaint.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The practice could not demonstrate that they had an adequate method for tracking prescription forms. The practice could not demonstrate that they had an adequate method of managing significant events. 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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: We found that the registered provider had not ensured all relevant training had been undertaken by practice staff. This was in breach of regulation 18 (2) 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 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: The practice could not demonstrate that they had an adequate system in place to oversee the assessing, monitoring and mitigation of risks relating to the health, safety and welfare of service users and others who may be at risk. This was in breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.