Little Park Surgery

Quality Report

281 Hounslow Road,
Feltham, Hounslow,
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Our previous comprehensive inspection in October 2016 found breaches of regulations relating to the safe, effective and well-led delivery of services.

Following the October 2016 inspection Little Park Surgery was rated requires improvement for the provision of safe, effective and well-led services. The practice was rated good for providing caring and responsive services. Consequently we rated all population groups as requires improvement. The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for Little Park Surgery on our website at www.cqc.org.uk.

We carried out an announced follow up focussed inspection on 14 September 2017. This inspection was

Summary of findings

undertaken to ensure improvements had been implemented and that the service was meeting regulations. During this inspection we found a number of concerns and decided to carry out a further visit to look at the full range of services at the practice. The practice was not rated during this focussed inspection.

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

- There was a lack of good governance and the practice had not dealt with some of the issues in a timely manner.
- We found additional breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always carried out consistently and effectively.
- There were inconsistent arrangements in how risks were assessed and managed. For example we found risks relating to the monitoring of fridge temperatures, safeguarding vulnerable adults and children training and management of health and safety related risk assessments.
- Staff we spoke with on the day of inspection was not aware who the safeguarding lead in the practice was.
- The practice was unable to demonstrate they always followed national guidance on infection prevention and control.
- The practice was unable to demonstrate that all appropriate recruitment checks had been undertaken prior to employment.
- Staff appraisals had not always been completed in a timely manner. However, the practice informed us after the inspection that dates were planned to complete all appraisals by October 2017. Not all staff were up to date with training relevant to their role.
- One clinical audit cycle had been completed in the last 12 months, which demonstrated quality improvement. The practice did not have a rolling programme of audits to drive and monitor improvement in patient outcomes.
- We saw evidence that the practice was encouraging patients to register for online services. For example, 12% (735) patients were registered to use online Patient Access compared to 10% (615) we found during the previous inspection in October 2016.
- The practice had reviewed the appointment booking system and increased online GPs appointments to reduce the pressure on the telephone system.
- Staff we spoke with informed us the management was approachable and always took time to listen to all members of staff.

The areas where the provider must make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

In addition the practice should:

- Implement systems to carry out a thorough periodic analysis of the significant events to identify any themes and take appropriate action.
- Develop a rolling programme of audits to ensure continuous monitoring.
- Ensure the most recent CQC rating is clearly displayed.

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?

We have not rated this domain during this follow up focussed inspection.

- At this inspection in September 2017, we found the practice had made some improvements but they had not addressed all of the issues identified during previous inspection.
- Staff we spoke with were not aware who the safeguarding lead was in the practice. Some clinical and non-clinical staff had not received safeguarding adults and children training.
- Staff we spoke with on the day of inspection were not able to find recent infection control audit and appropriate standards of cleanliness and hygiene were not always followed. For example, we noted that disposable curtains had not been changed since August 2016. Some clinical and non-clinical staff had not completed infection control training relevant to their role.
- We found concerns regarding monitoring of cleaning standards, handwashing audits, expired syringes and segregation of clinical waste into appropriate colour-coded containers.
- The practice had not carried out all required health and safety related risk assessments to monitor safety of the premises, such as control of substances hazardous to health (COSHH).
- There was an effective system in place for reporting and recording significant events. Lessons were learnt from significant events and staff we spoke to informed us that significant events were discussed during the team meetings. However, the practice had not maintained a log or carried out a periodic analysis of the significant events to identify any trends or themes.
- Emergency equipment and emergency medicines were easily accessible and securely stored.
- In addition, we identified some additional risks during this follow up inspection such as poor monitoring of medicine fridge temperatures, and a lack of Disclosure and Barring Scheme (DBS) checks or risk assessments for some clinical staff and non-clinical staff undertaking chaperoning duties.
- Electrical equipment checks were carried out to ensure they were safe to use.
- Records of hepatitis B immunisation were available for all clinical staff.

Summary of findings

Are services effective?

We have not rated this domain during this follow up focussed inspection.

- At the inspection in September 2017, we found the practice had made some improvements since our last inspection in October 2016 but these were not sufficient and further improvements were needed.
- There was limited evidence of appraisals and personal development plans for most staff. Staff we spoke with confirmed this. However, the practice had informed us after the inspection that dates were planned to complete all appraisals by October 2017.
- We checked staff training records and noted that some role specific training was not organised in a timely manner including safeguarding vulnerable adults and children, health and safety, equality and diversity, infection control, basic life support, the Mental Capacity Act 2005 and fire safety training.
- We saw evidence that the practice had completed one clinical audit cycle in the last 12 months, which demonstrated quality improvement.
- We found patients on high risk medicines were monitored effectively.

Are services well-led?

We have not rated this domain during this follow up focussed inspection.

- At this inspection in September 2017 we found the practice had made some improvements. However, the practice had not met all requirements identified in the report published in April 2017.
- We found additional breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance arrangements within the practice were not operated effectively. For example, the implementation of systems and processes to minimise the risk and spread of infection, a consistent approach to the monitoring of fridge temperatures, staff training, annual appraisals and Disclosure and Barring Service (DBS) checks were not always managed in line with national guidance.
- The practice had not carried out periodic analysis of the significant events to identify any trends or themes.
- The practice had not ensured that all relevant health and safety related risk assessments were carried out in a timely manner or undertaken by a competent assessor to ensure patients' safety.
- The practice did not have a rolling programme of audits to drive and monitor improvement in patient outcomes.

Summary of findings

- On the day of inspection, we noted that the ratings poster of previous CQC inspection was not displayed in the premises. The practice manager informed us they had displayed three ratings posters in the premises but they were not able to find two posters and one was found behind the radiator. However, the practice informed us five working days after the inspection that they had displayed the ratings poster in the premises.

Summary of findings

What people who use the service say

The most recent national GP patient survey results published on 6 July 2017 showed the practice results were comparable to the local and the national averages for most of its satisfaction scores. Three hundred and thirty-six survey forms were distributed and 125 were returned (a response rate of 37%). This represented about 2% of the practice's patient list.

- 68% of patients said they could get through easily to the practice by telephone compared to the clinical commissioning group (CCG) average of 69% and national average of 71%. This had increased 1% compared to the previous national GP patient survey results published in July 2016.
- 68% of patients described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%. This had increased 5% compared to the previous national GP patient survey results published in July 2016.
- 73% of patients said they would recommend this surgery to someone new to the area compared to the CCG average of 74% and national average of 77%.

All four patients we spoke with on the day of inspection informed us they get through to the practice by telephone and were satisfied with the service provided by the practice.

Staff we spoke with on the day of inspection informed us they had noticed improvement in telephone system due to increase in number of online GPs appointments.

We saw evidence that the practice was encouraging patients to register for online services. For example, 12% (735) patients were registered to use online Patient Access compared to 10% (615) we found during the previous inspection in October 2016.

The practice had not carried out any internal survey to evaluate patient satisfaction and was not able to provide the NHS friends and family test (FFT) results due to IT issues.

Little Park 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 advisor.

Background to Little Park Surgery

The Little Park Surgery provides GP primary care services to approximately 6,200 people living in Feltham, Hounslow. The local area is relatively diverse.

There are two GP partners, three salaried GPs and two trainee GPs at the practice. Four GPs are male and three female, who work a total of 48 sessions (including 16 sessions of trainee GPs). The practice employs two practice nurses, a health care assistant and a phlebotomist. The practice manager is supported by an assistant practice manager, a team of administrative and reception staff. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

This is a training practice, where a doctor who is training to be qualified as a GP has access to a senior GP throughout the day for support.

Services are provided from the following location which we visited during this inspection:

281 Hounslow Road,

Feltham,

Hounslow,

Middlesex,

TW13 5JG

The practice has core opening hours from 8am to 6.30pm Monday to Friday. The practice offers extended hours appointments on Monday's between 6.30pm and 8pm. The telephone line used for various enquiries is staffed throughout working hours. However, the appointment telephone line is not staffed between 11.30am and 2pm. Appointment slots are available throughout the opening hours. Longer appointments are available for patients who needed them and those with long-term conditions. This also includes appointments with a named GP or the nurse. Pre-bookable appointments could be booked up to two weeks in advance; urgent appointments were available for patients that needed them.

Why we carried out this inspection

We carried out a previous comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection took place on 12 October 2016 and we published a report setting out our judgements. These judgements identified two breaches of regulations. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time.

We carried out a follow up focussed inspection on 14 September 2017 to follow up and assess whether the necessary changes had been made, following our inspection in October 2016. We focused on the aspects of the service where we found the provider had breached regulations during our previous inspection. We followed up to make sure the necessary changes had been made.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations

Detailed findings

associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, review the breaches identified and update the ratings provided under the Care Act 2014.

How we carried out this inspection

Prior to the inspection we contacted the Hounslow Clinical Commissioning Group, NHS England area team and the local Healthwatch to seek their feedback about the service provided by Little Park Surgery. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced focused visit on 14 September 2017.

During our visit we:

- Spoke with seven staff (included a GP partner, a practice manager, a practice nurse and four non-clinical staff) and four patients who used the service.
- Collected written feedback from four members of staff.

This report should be read in conjunction with the full inspection report of CQC visit on 12 October 2016.

Are services safe?

Our findings

When we inspected the practice in October 2016 we found most staff were unclear about which documentation to use for reporting and recording significant events. The practice did not carry out a thorough analysis of the significant events to identify any trends or themes and take appropriate action. Staff were not clear about who the lead member of staff was for safeguarding. Most staff had not completed infection control training. The practice was not carrying out regular checks to ensure emergency equipment is fit for use. Electrical equipment checks were not carried out to ensure they were safe to use. The practice did not have appropriate emergency medication available such as Benzyl penicillin or Hydrocorticortisone and had not risk assessed the decision not to include them. The practice had not carried at a COSHH or legionella risk assessment.

At this inspection in September 2017 we found some improvement. However, the practice was required to make further improvement.

Safe track record and learning

We noted there was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system and also kept in a folder in reception.
- Significant events were discussed during team meetings. We reviewed records of three significant events and incidents that had occurred during the last six months. There was evidence that the practice had learned from significant events and communicated widely to support improvement. For example, we saw an analysis of a significant event regarding wrong day booked for home visit. The practice had investigated the incident and reminded all staff to follow the advice and protocol correctly.
- Significant events were saved in a folder but the practice had not maintained a log and did not carry out a thorough periodic analysis of the significant events to identify any trends or themes.

Overview of safety systems and processes

The practice had some processes and practices in place to keep patients safe and safeguarded from abuse, however improvements were required.

- Four non-clinical staff and a practice nurse we spoke with on the day of inspection were not clear about who the lead member of staff was for safeguarding. We noted some staff had not received safeguarding children and adults training relevant to their role. For example, two new trainee GPs, a practice nurse and three non-clinical staff had not completed training in safeguarding children and vulnerable adults.
- A notice in the premises advised patients that chaperones were available if required. All clinical and non-clinical staff who acted as a chaperone were trained for the role. The practice had not undertaken a risk assessment or carried out a Disclosure and Barring Scheme (DBS) check for seven non-clinical staff who was undertaking chaperoning duties. (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). We found the practice had not carried out a DBS check for a health care assistant and a phlebotomist (specially trained clinical staff who take blood samples from the patients).
- We observed that appropriate standards of cleanliness and hygiene were not always followed and some areas of the practice were not clean. For example, we found a collection of dust and dirt in some clinical and non-clinical areas. The monitoring of cleaning within the practice was not always effective and cleaning records and schedules were not available on the day of inspection to show how often the practice was cleaned. However, the practice informed us three working days after the inspection that they had put in place cleaning monitoring sheets.
- We noted the practice was not segregating clinical waste into appropriate colour-coded containers. For example, the practice was giving depot contraceptive injections which contained a hormone (chemical messengers that travel throughout the body coordinating complex processes like growth, metabolism, and fertility) and required to be disposed of in a purple container. We saw the clinical waste containers were not correctly labelled.
- We noted that disposable curtains were not changed since August 2016 and schedule was not available to show how often the fabric curtains were cleaned.

Are services safe?

- Staff we spoke with on the day of inspection was not able to find annual infection control audit. The practice was not following their internal protocol because we observed that infection control checklist (supposed to be completed quarterly) had not been completed since October 2016. Handwashing audits had not been carried out since June 2016.
- We noted three GPs (one GP partner and two new trainee GPs), a practice nurse and two non-clinical staff had not completed infection control training.
- The NHS commissioning unit had completed an audit in July 2016. We noted that the practice had not completed outstanding actions which were identified during the previous inspection (such as the need to replace the taps and carpets in the consulting rooms) due to delay in funding.
- We found expired syringes used to collect blood samples, which could contaminate blood samples and affect the accuracy of results if used unnoticed.
- Records showed fridge temperature checks were not carried out daily for both fridges used to store medicines and vaccines. We found significant gaps in fridge temperature monitoring sheets for the last two months. For example, we noted fridge temperature checks were only carried out on 13 days in August 2017 and two out of 11 working days in September 2017. The practice was unable to demonstrate that the temperatures had been checked daily and that the medicines held in fridges were therefore being maintained within relevant temperature ranges. Staff we spoke with told us there was no spot check system in place. There was a policy for ensuring that medicines were kept at the required temperatures, which also described the action to take in the event of a potential failure.
- Records of hepatitis B immunisation were available for all clinical staff.

Monitoring risks to patients

Risks to patients were assessed and well managed in some areas, however improvements were required.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy and a poster was displayed in the premises.
- An internal fire safety risk assessment had been carried out by the practice manager on 15 March 2017. We noted the practice was carrying out regular smoke alarm checks. The practice had carried out last fire drill on 11 January 2017 and fire extinguishers were checked in July 2017. The practice had electronic fire detection and alarm system installed in the premises covering all corridors and communal areas. However, we noted that the smoke alarm detectors were not installed in most of the consulting and administration rooms. The practice informed us their plans to improve disabled access through the rear fire exit had been delayed due to delay in funding.
- The safety of electrical portable equipment was assessed at the premises to ensure it was safe.
- Legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out in 2016. However, it did not include the actual date of risk assessment, validity certificate and name of assessor. There was no evidence available to demonstrate that the legionella risk assessment was carried out by a competent person. We saw the practice was carrying out regular water temperature checks as recommended in the risk assessment.
- The practice had not carried out all risk assessments required to monitor safety of the premises such as control of substances hazardous to health (COSHH) risk assessment and an asbestos survey. The practice informed us they were in the process of arranging the asbestos survey within two weeks after the inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- Most staff had received annual basic life support training with the exception of two new trainee GPs.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks, and there was evidence that these were checked regularly.
- 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, although we noted they did not have any Hydrocortisone for injections (used to treat

infections) available and there was no risk assessment as to why they were not included. However, the practice informed us after the inspection that they had ordered the Hydrocortisone on 19 September 2017.

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the practice in October 2016 we found there was limited evidence of quality improvement and the practice had not completed any audit cycles.

At this inspection in September 2017 we found some improvement. However, the practice was required to make further improvement and additional concerns were identified.

Management, monitoring and improving outcomes for people

- We saw evidence that the practice had undertaken a completed clinical audit in the last 12 months, where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, we saw evidence of one completed audit cycle relating to the diagnosis and treatment of tonsillitis. The aim of the audit was to monitor the use of antibiotics used to treat tonsillitis (inflammation of the tonsils). The practice had introduced scoring system to assist with the prescribing of antibiotics and advised all clinical staff to use appropriate Read codes to facilitate better monitoring. The practice had carried out a repeat audit after six months, which demonstrated the practice had improved the documentation of how tonsillitis was diagnosed using a scoring system along with an improvement in the correct treatment being given.
- We noted the practice did not have a rolling programme of audits to ensure continuous monitoring.
- We found patients on high risk medicines were monitored effectively.

Effective staffing

Most staff had the skills, knowledge and experience to deliver effective care and treatment. However, some staff had not received training relevant to their role and most staff had not received regular support through annual appraisals.

- There was limited evidence that the learning needs of staff were identified through a system of appraisals and reviews of practice development needs. Two practice nurses, a health care assistant, a phlebotomist and seven non-clinical staff had not received an appraisal since October 2016. The practice manager informed us that the practice had lost all previous online appraisal records due to IT issues and they had no data backup arrangements before the previous inspection visit in October 2016. The practice manager informed us they had data backup arrangements in place now. However, we found system of appraisal was not effective, there was limited evidence of ongoing support and the practice had only completed one appraisal since October 2016. Staff we spoke with on the day of inspection informed us that they had not received an appraisal for the last 18 to 24 months. However, staff informed us that the management was approachable and they were being listened to. Three working days after the inspection the practice manager provided us with the future dates which were planned to ensure all appraisals were completed by October 2017.
- Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. However, records showed that not all staff were up to date with training relevant to their role. We identified gaps in the following training: safeguarding vulnerable adults (not completed for two new trainee GPs, a practice nurse and three non-clinical staff); safeguarding children (two new trainee GPs, a practice nurse and three non-clinical staff), health and safety (two GP partners, three salaried GPs, two new trainee GPs, a practice nurse, a health care assistant and four non-clinical staff), equality and diversity (two GP partners, two new trainee GPs, a practice nurse, a health care assistant, a phlebotomist and three non-clinical staff), infection control (one GP partner, two new trainee GPs, a practice nurse and two non-clinical staff), basic life support (two new trainee GPs), Mental Capacity Act 2005 (two GP partners, two new trainee GPs, a practice nurse, a health care assistant, a phlebotomist and eight non-clinical staff) and fire safety (two GP partners and two non-clinical staff).
- The practice informed us they had provided ongoing support to trainee GPs and salaried GPs during one-to-one meetings, appraisals, coaching, mentoring, clinical supervision and facilitation and support for the revalidation of doctors.

Are services well-led?

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

Our findings

When we inspected the practice in October 2016, we found there was a lack of good governance and monitoring of specific areas required improvement. The practice did not have a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Patients found it difficult to get through to the practice by phone to make an appointment. We found some patients on high risk medicines were not monitored effectively.

At this inspection in September 2017 we found the practice had made some improvements, in particular to the monitoring of patients on high risk medicines. However, the practice had not met all requirements identified in the report published in April 2017. In addition, we found additional breaches of regulation that had not been identified by the practice prior to our inspection, which demonstrated that governance and monitoring procedures were not always carried out consistently or effectively.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which included practice's aim, values and priorities. This included providing a highest possible quality health care and promoting the importance of good health and well-being by focussing on patient's specific needs.
- We saw a mission statement was displayed in the premises and staff were aware of it.
- The practice had a business plan for 2016-2019 which reflected the vision and objectives.

Governance arrangements

Governance arrangements within the practice were not operated effectively or in a way to ensure risks were monitored to protect the safety of patients.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However, some staff had not received training relevant to their role.
- Most clinical and non-clinical staff had not received annual appraisals to enable them to carry out the duties they were employed to do. After the inspection the practice had informed us that dates were planned to complete all appraisals by October 2017.
- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas such as Disclosure and Barring Service (DBS) checks for some clinical staff and non-clinical staff undertaking chaperoning duties, infection control procedures, monitoring of fridge temperatures and periodic analysis of the significant events to identify any themes were not managed appropriately.
- The practice had not carried out all related health and safety risk assessments required to monitor safety of the premises such as control of substances hazardous to health (COSHH), asbestos survey, and there was no evidence available to demonstrate that the legionella risk assessment was carried out by a competent person.
- On the day of inspection, we noted that the ratings poster of previous CQC inspection was not displayed in the premises. The practice manager informed us they had displayed three ratings posters in the premises but they were not able to find two posters and one was found behind the radiator. However, the practice had displayed the ratings poster within five working days after the inspection.
- The practice did not have a rolling programme of audits in place to drive improvement in patient outcomes.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: The practice had failed to demonstrate good governance in accordance with the fundamental standards of care. The practice was unable to demonstrate their monitoring of medicine fridge temperatures was always effective and complete. The practice was unable to demonstrate that they always followed national guidance on infection prevention and control. The practice had not assured that all staff were aware who the safeguarding lead was in the practice. The practice could not demonstrate that all staff had received an appraisal in a timely manner and completed training relevant to their role including safeguarding adults, safeguarding children, health and safety, equality and diversity, infection control, basic life support, mental capacity act and fire safety training. The practice was unable to demonstrate that they had adequate health and safety related risk assessments and processes were in place to ensure safety of the premises and patients. Regulation 17(1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

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 registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular:

The practice had not assured that Disclosure and Barring Scheme (DBS) checks or risk assessments for all clinical staff and non-clinical staff undertaking chaperoning duties had not been carried out.

Regulation 19(1)&(2)