Westbourne Surgery

Quality Report

Westbourne Surgery
11a St James Road
Marsh
Huddersfield
West Yorkshire HD1 4QR
Tel: 01484 505007
Website: http://www.westbournesurgery.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

Are services safe?	**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 at Westbourne Surgery on 19 August 2015. The overall rating for the practice was good. However, a breach of the legal requirements was found which resulted in the practice being rated as requires improvement for providing safe services. The full comprehensive report on the August 2015 inspection can be found by selecting the 'all reports' link for Westbourne Surgery on our website at www.cqc.org.uk.

In addition to the breach of regulation, at the inspection on 19 August 2015 we also said the practice should consider the following area:

- The practice should review the provision of emergency equipment and undertake a risk assessment in regard to the decision not to have a supply of emergency oxygen or a defibrillator on the premises.

This inspection was an announced focused inspection carried out on 6 April 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breach of regulation that we identified in our previous inspection on 19 August 2015. This report covers our findings in relation to those requirements.

The practice had not made sustained improvements to meet the legal requirements in the key question of safe and remains rated as requires improvement.

Our key findings were as follows:

- The practice had not undertaken an assessment for the risk of legionella, fire safety, emergency equipment or undertaken an infection prevention and control (IPC) audit or completed a fire drill within the last 12 months. Mandatory refresher training in fire safety and IPC had not been completed by relevant staff.

The areas where the provider must make improvement are:

- The provider must assess the risks to the health and safety of service users and do all that is reasonably practicable to mitigate any such risks. Risk assessments to monitor the safety of the premises in respect of infection prevention and control (IPC) and legionella had not been completed. A supply of emergency oxygen was not held at the practice and no risk assessment had been completed to support this decision.

Summary of findings

- Ensure relevant staff update their mandatory training in respect of fire safety, fire evacuation and IPC to ensure they have the appropriate training to meet their learning needs and to cover the scope of their work.

The areas where the provider should make improvement are:

- The practice should risk assess and review the arrangements for emergency equipment as there was no defibrillator held at the practice.

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

This inspection was conducted to review issues that were found at the comprehensive inspection carried out on 19 August 2015. The issues at the previous inspection included:

- The practice had not undertaken an assessment for the risk of legionella, undertaken an IPC audit or completed a fire drill within the last 12 months. Mandatory refresher training in fire safety and IPC had not been completed by relevant staff.
- We also told the practice they should review the arrangements for emergency equipment as there was no defibrillator or supply of emergency oxygen held at the practice and there was no risk assessment made in regard to this.

At this inspection in April 2017 we found:

- The provider had initially implemented improvements; however we saw that these had not been sustained. For example, annual risk assessments and training that had been completed following our earlier inspection were now overdue and no plans were in place to repeat them.
- The provider had not undertaken a risk assessment in regard to the provision of emergency oxygen.
- The provider had not undertaken a risk assessment in regard to the provision of a defibrillator at the location.
- The provider told us they did not have a defibrillator or supply of oxygen for use in the event of an emergency.

Westbourne Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector.

Background to Westbourne Surgery

Westbourne Surgery, St James Road, Marsh, Huddersfield, HD1 4QR, provides services for 3,746 patients in the area of Marsh on the outskirts of Huddersfield.

Westbourne Surgery is situated within the Greater Huddersfield Clinical Commissioning group (CCG) and provides primary medical services under the terms of a general medical services (GMS) contract. This is a contract between general practices and NHS England for delivering services to the local community.

The practice population experiences average levels of deprivation and the age profile is similar to other GP providers in the area.

There are two GPs at the practice; one male and one female. The practice is undergoing a period of transition within the partnership. We have advised the provider to make the appropriate applications to reflect these changes to us without delay.

The practice has a practice nurse who works 21 hours a week and the clinical team is supported by a practice manager and a team of administrative staff.

The practice is open between 8am and 6pm Monday and Friday, 7.30am to 6pm on Tuesday, 8am to 12.30pm on Wednesday and 7am to 6pm on Thursday. Appointments are available throughout the day with extended hours available from 7am on Thursday for patients that find it difficult to access the surgery during the usual working day. The practice is closed on a Wednesday afternoon and patients are directed to the out-of-hours service. This service is provided by an external contractor, Local Care Direct. Patients are also advised of the NHS 111 service.

Why we carried out this inspection

We undertook a comprehensive inspection of Westbourne Surgery on 19 August 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated overall as good. However a breach of the regulations was found. The full comprehensive report following the inspection in August 2015 can be found by selecting the 'all reports' link for Westbourne Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Westbourne Surgery on 6 April 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out a focused follow up inspection of Westbourne Surgery on 6 April 2017.

During our visit we:

- Spoke with the practice manager and reviewed documentation held by the provider.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 19 August 2015, we rated the practice as requires improvement for providing safe services. The arrangements in respect of the monitoring, management and mitigation of risks to the health and safety of service users were not sufficient. We found that the practice had not undertaken an assessment for the risk of legionella, undertaken an infection, prevention and control (IPC) audit or completed a fire drill within the last 12 months. Mandatory refresher training in fire safety and IPC had not been completed by relevant staff.

We also told the practice they should review the arrangements for emergency equipment as there was no defibrillator or supply of emergency oxygen held at the practice and there was no risk assessment made in regard to this.

During our follow up inspection on 6 April 2017 we saw that some improvements had been made immediately following our earlier inspection, however they had not been sustained. The practice continues to be rated as requires improvement for providing safe services.

Overview of safety systems and process

- The practice had not undertaken, within the last 12 months, risk assessments to monitor the safety of the premises in respect of IPC and legionella. (Legionella is a bacterium which can contaminate water systems in buildings).
- Mandatory annual refresher training in respect of fire safety, fire evacuation and IPC was overdue.
- The provider did not have defibrillator and had not undertaken a risk assessment in regard to this.
- The provider did not have a supply of emergency oxygen at the practice and there was no risk assessment made in regard to this.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not assessed the risks to the health and safety of service users or done all that was reasonably practicable to mitigate any such risks. Risk assessments to monitor the safety of the premises in respect of infection prevention and control (IPC) and legionella had not been completed. A supply of emergency oxygen was not held at the practice and no risk assessment had been completed to support this decision. Relevant staff had not updated their mandatory training in respect of fire safety, fire evacuation and IPC to ensure they had the appropriate training to meet their learning needs and to cover the scope of their work. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.