North Camp Surgery

Quality Report

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Farnborough
Hampshire
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced focussed, follow up inspection of North Camp Surgery, Queens Road, Farnborough, Hampshire GU14 6DH on 15 September 2015.

Our previous inspection in May 2015 had found the practice was requires improvement overall. Due to breaches of regulations relating to safe delivery of services and services being well-led. The practice was good for Effective, Caring and Responsive services.

From the inspection 15 September 2015 the practice is still rated as requires improvement overall. With requires improvement for the provision of safe and effective services. The practice is rated as inadequate for well-led services. The practice remains rated as good for the provision of caring and responsive services. In addition we had received information of concern from NHS England (national commissioning board and contract holder for GP practices) in relation to patients being placed at risk. These concerns referred to inconsistent patient record keeping and a high turnover of staff.

Key findings include:

- The practice was not operating safe systems in relation to the recruitment of staff between May 2015-August 2015.
- There was an inconsistent application of current clinical guidelines documented within patient records.
- There was a lack of governance and management of the practice by those with the authority to make decisions.

However we found the practice had made improvements since our last inspection in May 2015. Specifically the practice was:

- Monitoring hygiene and infection control, including a system of audit, identifying and assessing any risk of legionella.
- Managing risk, assessments were in place and up to date for health and safety such as assessments relating to the premises and equipment.
- Providing appropriate staff with chaperone training and the practice provided a chaperone service for patients in a timely way that does not delay any assessment or treatment needed.
- Ensuring all new staff was performing their roles as needed and supported to have further development.

Summary of findings

- Ensuring the practice had arrangements to deal with emergencies with a revised and updated business continuity plan and an automated external defibrillator (AED) in place.
- Securely handling blank prescription forms consistently in accordance with national guidance.

There were areas of practice where the provider needs to make improvements. Importantly, the provider must:

- Ensure all patient records are accurate and up to date.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure there is clear leadership structure, sufficient leadership capacity and formal governance arrangements.

Where a practice is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected within six months after the report is published. If after re-inspection it has failed to make sufficient improvement and is still rated as inadequate for any key questions or population group we will place into special measures. Being placed into special measures represents a decision by CQC that a practice has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

In June 2015 the practice produced written evidence and whilst on inspection we saw they had addressed several issues surrounding infection control and timely access to chaperones that we judged a breach of regulation at our inspection of 11 May 2015.

The practice had taken action on matters relating to implementing issues identified from infection control audits. This had improved the way they managed this aspect of their service.

The practice had arranged and ensured key members of staff complete chaperone training. We saw background checks had been completed for these members of staff.

However, the practice had failed to take heed to the Care Quality Commission (CQC) report detailing a breach of regulation with regards recruitment. Although the practice had recently revisited the recruitment process, there was evidence that recruitment checks were not fully completed and there were limited records of Disclosure and Barring Service checks on staff having been carried out.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services as there are areas where it should make improvements.

Following concerns raised by whistle-blowers and NHS England Wessex referring to inconsistent patient record keeping we found potential risks in patient records that we judged a breach of regulation.

Specifically, patient records were not written and managed in way that ensured they were accurate and complete. We also found records were not being consistently recorded and separate information was kept on paper and on the computer system.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

The delivery of high quality care is not assured by the leadership or governance in place.

Summary of findings

The practice had experienced an unprecedented amount of change in the last year, including four different practice managers and losing several key members of clinical and administration staff. Some staff told us there was a lack of visible leadership from the GP Partners, neither of which were at the practice on the day of inspection.

Following the last comprehensive inspection undertaken by us in May 2015, we saw some governance arrangements had been reviewed. Following our inspection the practice was issued with a Care Quality Commission report which highlighted four regulatory breaches relating to infection control, chaperoning, recruitment and governance. We found the practice had paid heed to the report compiled by The Commission, and had taken action as required with regards to infection control and chaperoning. However, actions relating to recruitment and governance had not been completed.

Staff told us and it was evident to the inspection team that the salaried GP and newly appointed practice manager were working towards developing a team where there was good leadership and a culture that was open. Staff we spoke with recognised the endeavour of the salaried GP and practice manager and were keen to be part of the new developments.

North Camp Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a second CQC Inspector and a specialist GP advisor.

Background to North Camp Surgery

North Camp Surgery, 2 Queens Road, Farnborough, Hampshire, GU14 6DH is a converted dwelling that was extensively extended in 2001. The practice is located on the outskirts of Farnborough. The practice covers a diverse community incorporating a large proportion of ethnic minorities, including people of Nepalese decent. Within the area there are pockets of deprivation. A number of people working for the armed forces are registered with the practice. The practice is on the ground floor with disabled access.

Care and treatment is provided by four GPs, comprising of two male partners, a salaried female GP and a male locum GP.

At the time of our inspection, one of the partners was not working any sessions as a GP and the other partner had reduced the number of weekly sessions down to three.

The practice has around 4,600 patients and operated under a personal medical services (PMS) agreement. The practice manager started working at the practice in August 2015 and the practice had recently employed new administration and reception staff.

Over the previous year the practice has seen a significant amount of change, instability and a lack of clear leadership and management.

The practice offered a proportion of pre-bookable appointments available four weeks in advance. Book-on-the-day appointments were available on a first come basis. Patients could ring from 8.00am for morning appointments and 2.00pm for afternoon appointments. The practice also provided telephone consultations. GP surgeries ran Monday to Friday from 8.30am until midday and from 2.30pm until 6.00pm. The practice had two telephone lines which helped to make it easier for patients to contact the practice. There were extended hours on Tuesdays until 7.30pm and once a month on a Saturday. Out of Hours urgent medical care was provided by Frimley Out of Hour's service when the practice was closed.

At the time of our visit the practice had been required by NHS England to not carry out any immunisations until the outcome of an investigation. This investigation had been completed and the practice was being supported by North East Hampshire and Farnham CCG to recommence the provision of immunisations within the practice.

Why we carried out this inspection

We carried out this inspection on 15 September 2015 to follow up and assess whether the necessary changes had been made following our inspection on 11 May 2015. 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.

Detailed findings

Additionally, we carried out this inspection in response to concerns raised by whistle-blowers and NHS England. These concerns referred to inconsistent patient record keeping and a high turnover of staff.

We focused on the aspects of the service where we found the provider had breached regulations during our previous inspection and the areas of concerns raised to us by NHS England.

This report should be read in conjunction with the full comprehensive inspection report of our inspection conducted in May, 2015, published in July 2015.

How we carried out this inspection

Before visiting, we reviewed information sent to us by the provider. This told us how they had addressed the breaches of regulations identified during the comprehensive inspection. During our visit, we spoke with staff that were on duty including a GP, practice manager, health care assistant, prescription clerk and two members of the reception team.

We reviewed information, documents and records kept at the practice including a range of policies and procedures the service used to govern their activities.

We inspected the premises to look at the cleanliness and the arrangements in place to manage risks associated with healthcare related infections.

We spoke with five patients during the visit to obtain their views on the service they received.

We spoke to NHS England and received information from them in relation to their formal meetings with the provider to monitor delivery of the service.

Neither of the two GP Partners were present on the day of inspection. Following the inspection there was email contact with the two GP Partners instigated by the Inspection team which confirmed intentions to change the day to day to management of the practice as part of succession planning.

Requires improvement

Are services safe?

Our findings

Cleanliness and infection control.

Following the comprehensive inspection in May 2015, the practice sent us an action plan and provided evidence showing the improvements made in relation to cleanliness and infection control.

At the last inspection, we found that there was no formal training programme for staff regarding hygiene and infection control and staff told us they had not received any recent training. There was no hygiene and infection control audit undertaken to ensure all relevant guidance was followed or areas of risk identified. We also found there were minimal records and cleaning schedules and no records in relation to control of substances hazardous to health (COSHH).

During this inspection in September 2015 we saw training schedules for specific staff groups and individual staff training had been completed. This demonstrated that the practice had reviewed the staff training programme and records showed that all staff working in the practice had received appropriate hygiene and infection control training.

We saw a completed infection control audit from June 2015 and actions for improvements identified were recorded as completed within set timescales. We saw a revised infection control policy and supporting procedures including cleaning schedules and COSHH records. The practice manager advised these documents were available for staff to refer to and enabled them to plan and implement measures to control infection.

Reliable safety systems and processes including safeguarding.

At the last inspection we found the practice had robust safeguarding systems in place.

At the time of our last inspection, the practice offered patients the services of a chaperone during examinations if required. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.

We saw evidence and staff confirmed to us that since our last inspection staff had been trained to become chaperones. The practice now provided a chaperone service for patients in a timely way that does not delay any assessment or treatment needed.

Staffing and recruitment.

At the last inspection in May 2015 appropriate recruitment checks were not always completed before new and locum staff commenced employment.

Following our last inspection we received an action plan from the provider informing us of the action they had taken to meet regulation.

At the inspection on 15 September 2015 we reviewed a sample of staff files including newly recruited members of staff. The newly appointed practice manager was aware that between May 2015 and August 2015, appropriate background checks had not been completed and the practice had not followed their recruitment policy.

The practice manager provided evidence of a reinforced and revised recruitment policy. This set out the standards the practice would follow when recruiting all staff. We also saw a standardised list had been developed to help ensure all relevant checks and information was obtained during the recruitment process.

We saw evidence that practice manager had taken appropriate action and implemented control processes to ensure all staff were subject to suitable checks and arranged for all practice staff to have a full background (DBS) check. This included a check that employment histories were full and that any gaps were accounted for.

On the day of inspection we witnessed a member of staff have a pre-arranged meeting with the practice manager to provide the documents for their DBS check. We saw confirmation that other members of staff had been contacted and a meeting arranged to provide all required documents post-recruitment.

Arrangements to deal with emergencies and major incidents.

At the last inspection in May 2015 we had concerns how the practice would deal with emergencies or a major incident. Specifically, the practice had a business continuity plan that was last updated in 2007.

Requires improvement

Are services safe?

This plan records what the service would do in an emergency to ensure that their patients are still able to receive a service. The plan had not been updated since 2007 and on inspection the plan was found to have out of date telephone contact numbers.

During the inspection in September 2015 we were presented with an updated business continuity plan. All staff knew where this plan was located and we saw the plan detailed how the practice would manage a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather and access to the building. We checked the document also contained relevant up-to-date contact details for staff to refer to.

For example, contact details of a heating company to contact if the heating system failed.

The practice had assessed the need for emergency equipment within the practice following the previous inspection. The practice now had an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed it was checked regularly. Staff provided us with an example where they had responded appropriately to an emergency at the practice which had resulted in a positive outcome for the patient.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in May 2015 the practice was rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Most staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for some staff and were in development for new staff. The staff worked with multidisciplinary teams.

Effective needs assessment.

Following concerns raised by NHS England, during our inspection in September 2015 the GP specialist advisor reviewed a sample of 25 patient medical records. This review of records referred to care and treatment between 11th May 2015 and 15th September 2015.

We found an inconsistency in patient medical records and how they were managed within the practice. For example, one of the GPs record keeping was poor with inadequate medical history recorded, minimal examination findings documented and lack of structure to the records.

We reviewed eight patient medical records completed by this GP, seven of the eight records contained examples of a lack of cohesion. For example insufficient documentation, elements of records were missing, records contained various spelling and grammar mistakes and we saw limited chronological order which did not demonstrate continuity of care and response to treatment.

Patient medical records are a fundamental part of a GP's duties in providing patient care. Patient medical records form a permanent account of a patient's health and wellbeing. Clarity, accuracy and precision are paramount for effective communication between healthcare professionals and patients.

We saw limited maintenance of good medical records, and could not be assured that a patient's assessed needs were met comprehensively.

Another GP had variable record keeping. For example, some records were of a good standard but other records featured minimal recording. We saw several consultations had a blank record with no care or treatment discussions documented.

We were told this GP used a combination of written and computerised records for each patient. However, we found the information was not recorded in a consistent manner. Some information was kept on the written file and other information was stored on the computer system. All of the patient's notes were not accessible in one place.

If these GPs had to go on an extended period of leave then other GPs including locum GPs could not rely on the information on the computer being accurate and up to date.

We did however see and review a further two GPs notes which were of a high standard, documented, structured and recorded in accordance to national guidance.

Following the inspection we have been sent information that two of the GPs whose clinical records we reviewed as poor will attend an appropriate workshop on the understanding of the importance of medical records. This workshop aims to enhance skills in making and keeping quality medical records.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy.

There was a lack of current engagement from the two GPs who are the partners and registered manager of the practice, with regard to the vision and strategy for the practice.

Staff told us despite the changes and instability the practice staff retained its vision and values; being a personal, friendly, patient centred practice. This was reflected in staff and patient feedback. Staff we spoke with gave examples of how knowing their patients, enabled them to provide effective care and treatment which met patients' individual needs.

On the day of inspection we were told of the intentions to change the day to day to management of the practice as part of succession planning. This included the open discussion of the future retirement of one of the GP Partners who was also the Registered Manager. At the time of our inspection the registered manager was not involved in the day to day running of the practice.

A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

We were told there was an arrangement for the salaried GP who had been at the practice for seven years to join the partnership soon and in time become the principal GP Partner and also take over the role of the Registered Manager.

Neither of the GP Partners was present at the practice on the day of inspection but confirmed these plans in writing following a request from Care Quality Commission post inspection.

Governance arrangements.

At the last inspection in May 2015 we had concerns regarding governance arrangements within the practice. We found that infection control monitoring procedures had not been recorded. Criminal records checks during the recruitment process had not been recorded. We also found that policies had not been updated regularly for example the business continuity plan had out of date contact numbers and locations.

Following the last inspection we received an action plan from the provider telling us the action they would take to become compliant. We received confirmation that a nominated person responsible was now a named lead for infection control and health and safety matters.

The named lead for infection control had a system in place to ensure that regular infection control monitoring was in place for clinical and non-clinical aspects of the practice. We saw evidence that infection control audits had been carried out, the last audit completed in June 2015.

We also saw an updated business continuity plan. This plan records what the service will do in an emergency to ensure that their patients are still able to receive a service. This plan had updated contact details and the details of how the practice would continue to work from if there was a disruption to their service.

However, the practice had failed to complete all required recruitment checks and continued to not follow their recruitment policy.

The concerns highlighted on the day of this inspection, in relation to governance systems and risk, suggested the governance and management responsibilities of the practice were not effective.

The salaried GP took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. However, we identified evidence which demonstrated how the governance arrangements and their purpose were ineffective and unclear. The poor governance arrangements did not identify the risks of clinical records by two GPs. There were continued breaches in the same regulations and the registered manager and GP partners were not engaged in the inspection process.

Leadership, openness and transparency.

We found that the practice had experienced an unprecedented amount of change in the last year. Including four different practice managers and losing several key members of clinical and administration staff.

Are services well-led?

Inadequate

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

The practice manager was relatively new in post and expressed a commitment to make improvements. However, it was evident that the GP partners were not leading the process to implement change and make necessary improvements.

We saw the salaried GP and newly appointed practice manager were working towards developing a team where there was good leadership and a culture that was open. Staff we spoke with recognised the endeavour of the salaried GP and practice manager and were keen to be part of the new developments.

They all told us that felt valued, supported and knew who to go to in the practice with any concerns. They showed optimism for the future management style and leadership.

Staff told us prior to the employment of the practice manager they did not always feel involved in discussions about how to run the practice and how to develop the practice. Staff said they were unsure of what was happening within the practice and commented they felt their concerns were not being addressed by the GP partners.

Staff explained that team meetings had not been held regularly. However, following the recruitment of the practice manager there was a programme of team meetings arranged and clear lines of communication devised for members of staff unable to attend these meetings.

There was a pre-arranged team meeting on the day of inspection, however this was cancelled and rearranged for the following day to accommodate our inspection.

Neither of the two GP Partners were present at the practice on the day of inspection and made no contact with the inspection team in the days following the inspection. However CQC contacted the two partners and they have since confirmed our findings on inspection that there are intentions to change the day to day to management of the practice as part of succession planning.

This has been shared with staff and is part of the discussion for the vision and values for the future. The lead partner acknowledged that the positive contribution of the practice manager and the salaried GP during a time of change for the practice.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(c) The provider did not maintain securely, accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider had not ensured there was clear leadership structure, sufficient leadership capacity and formal governance arrangements. This was a breach of Regulation 17(1) and 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in Regulation 19(1)(b). The provider had not ensured that staff including locums providing care or treatment to service users had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. This was a breach of Regulation 19(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.