Burnham Surgery

Quality Report

Foundry Lane
Burnham On Crouch
Essex, CM0 8SJ
Tel: 01621 782054
Website: www.burnhamsurgery.co.uk

Date of inspection visit: 11 May 2016
Date of publication: 28/06/2016

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

We carried out an unannounced focused inspection at Burnham Surgery on 11 May 2016. This inspection was carried out in response to risks identified at a previous comprehensive inspection on 31 March 2016.

Following our initial inspection, the practice was rated as inadequate overall, inadequate for providing safe, effective and well-led services and as requires improvement for providing caring and responsive services. In response to these concerns we requested an action plan from the provider detailing how and when these risks would be reduced.

The unannounced inspection was carried out to ensure these specific risks were being addressed and to monitor the progress being made by the provider.

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

Summary of findings

- Practice policies and procedure were being reviewed and updated as required.
- A system for recording significant events had been implemented, although these were not always completed in a timely manner and learning outcomes were not shared with all staff.
- A system for acknowledging and sharing safety alerts and new clinical guidance had been implemented.
- Non-clinical chaperones were not being used until Disclosure and Barring Service (DBS) checks had been completed. Clinical staff had now received these checks.
- Staff training had been undertaken to ensure all staff had appropriate safeguarding training, awareness regarding the Quality and Outcomes Framework as well as additional computer skills training.
- A risk assessment regarding infection control had been carried out to address our immediate concerns but was incomplete to ensure all risks were addressed.
- Since our last inspection advice and quotations had been sought to address the concerns regarding legionella and other risk assessments including health and safety had been carried out but were incomplete.
- Consent was no longer being sought by non-clinical staff. Most clinical staff sought and recorded consent appropriately although there was some evidence of consent not being recorded.
- Patient referrals were often incomplete and lacked details of an examination or patient history.
- There was no robust system in place to ensure patients receving high risk medicines had the appropriate blood tests prior to receiving repeat prescriptions.
- There was no programme of clinical audits to drive improvement in patient outcomes.
- There was no multi-disciplinary care taking place, although staff were attempting to arrange meetings to discuss this.
- We were made aware of two GP partners tendering their resignation. There was a lack of leadership from a partnership level, although other staff were working towards addressing our concerns and to drive improvement.

The areas where the provider must make improvements are:

- Record and respond to significant events in a timely way and share learning outcomes.
- Implement a system of multidisciplinary care.
- Complete risk assessments for infection control and health and safety and address concerns raised and continue to address the risk of legionella.
- Carry out clinical audits and re-audits to improve patient outcomes.
- Implement a robust system for the repeat prescribing of high risk medicines.
- Demonstrate effective leadership to ensure patient care continues during a period of transition and a change of partners.

In addition the provider should:

- Ensure consent is sought and recorded in line with practice policies.
- Continue to review and update procedures and guidance.

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

Burnham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Burnham Surgery

Burnham Surgery is located centrally in the village of Burnham On Crouch, Essex. It is in close proximity to the train station and has parking available. The practice is located in a privately owned purpose built building which, at the time of our inspection, was undergoing some building work.

The practice had a smaller than average population aged 0 to 44 years old and a larger than average population aged 45 to 85+ years old.

There are three GP partners, one female and two male, a male salaried GP and two regular locums. There is a nurse practitioner, three nurses and two healthcare assistants. There is a practice manager, an assistant practice manager and a team of reception and administrative staff. We were informed on the day of our inspection that two GP partners had tended their resignation.

The practice offers a dispensing service; this is managed by a community pharmacy.

The practice is open between 8am and 6.30pm Monday to Friday and offers extended hours on Saturdays between 9am and 11.30am.

When the surgery is closed a recorded message directs patients to the out of hour's services they can access by calling 111.

Burnham Surgery was inspected on 31 March 2016, at which time we identified a number of risks. We issued the practice with a letter of intent and requested an action plan detailing how and when actions would be taken to address these risks.

We carried out an unannounced, focused inspection in response to this and to ensure the action plan was being implemented.

Why we carried out this inspection

We carried out an unannounced, focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

How we carried out this inspection

On 11 May 2016 we carried out an unannounced, focused inspection at Burnham Surgery approximately six weeks after our comprehensive inspection on 31 March 2016. Following our original inspection, we wrote to the practice highlighting our concerns regarding areas of risk we had identified. We requested an immediate action plan detailing how and when actions would be taken to reduce these risks. In order to ensure this action plan was being implemented we returned to Burnham Surgery to carry out an unannounced focused inspection.

Detailed findings

On the day of our unannounced inspection we focused only on the areas of risk we were most concerned about. We spoke with staff.

During our visit we:

- Spoke with a range of staff including two GPs, an advanced nurse practitioner, a practice nurse, the practice manager, assistant practice manager and other non-clinical staff.
- Reviewed a sample of the personal care or treatment records of patients.

Are services safe?

Our findings

Safe track record and learning

Work was in progress to improve the system in place for reporting and recording significant events.

- Staff were aware of how to identify and report a significant event but told us they did not receive any feedback or learning outcomes.
- We viewed records of significant events, a suitable recording form was being used to record information but not all significant events were being dealt with in a timely manner.
- There was still insufficient documented evidence of actions being taken in response to significant events or evidence of learning outcomes being shared with staff or external organisations.

The practice had implemented a system for sharing patient safety and medicines alerts, and new guidance; this was printed and shared with staff who signed to acknowledge them.

Overview of safety systems and processes

The practice had implemented some systems to improve patient safety since the last inspection but there were areas where further improvements were required.

- Staff had received recent training in safeguarding, including a GP who was now level three trained, a health care assistant who had received level two training and non-clinical staff who had all received level one safeguarding training.
- GPs had received some training regarding the use of the practice computer system and could now use the system more effectively to identify patients who were vulnerable.
- Non-clinical staff were no longer being used as chaperones as they had not received a Disclosure and Barring Service (DBS) check. (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).
- Despite the practice encouraging their cleaning company to improve the service provided, they had not ensured appropriate standards of cleanliness and hygiene. There were areas in the waiting room that were still dirty. The cleaning cupboard had been organised but cleaning items such as cloths and mops were not colour coded to prevent cross-contamination.
- The advanced nurse practitioner was the infection control clinical lead. Staff acknowledged they still required infection control training. An audit had been carried out but this was incomplete and did not acknowledge the areas for improvement or demonstrate actions taken.
- The arrangements for managing medicines in the practice did not ensure patients were kept safe. There were no robust procedures in place to ensure the safe handling of repeat prescriptions of high risk medicines. We viewed patient records which highlighted the need for blood tests prior to a repeat prescription, however these tests were not being undertaken and prescriptions were being issued without effective reviews.
- Following our last inspection, appropriate checks through the Disclosure and Barring Service had been carried out for all clinical staff.
- The storage of liquid nitrogen for the use of cryotherapy had been made safe and appropriate signage was in place.

Monitoring risks to patients

Risks to patients were not consistently assessed or well managed.

- At our last inspection, we highlighted that a legionella risk assessment had been carried out but not actioned to address the areas of high risk identified. Since out visit, quotes for remedial work had been obtained and was due to be carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Risk assessments for infection control and health and safety had been carried out but were incomplete and therefore did not address areas of concern.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had implemented a system of distributing information regarding current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. This information was disseminated by the practice manager and clinicians signed to acknowledge this information.

We found some records suggesting that some care was not based on current guidance. For example, we saw records suggesting cryotherapy had been carried out in cases which were unsuitable for this treatment.

Management, monitoring and improving outcomes for people

Some non-clinical staff had recently attended a course regarding the Quality and Outcomes Framework (QOF) to encourage a better understanding of the practice performance.

There was no evidence of quality improvement including clinical audit. There was a lack of understanding of the purpose of on-going clinical audit. There was no indication that areas for improvement had been identified through audit or that action had been taken to achieve such improvement. We discussed this with staff who were keen to implement an audit programme to demonstrate improvement in patient outcomes.

We reviewed the practice register for patients with dementia. Out of five records we reviewed, three of these had up to date care plans and reviews in place. We also reviewed the practice register for patients suffering from poor mental health. It was unclear what the criteria for these patients was as many of the patients were not suffering from mental health problems or had not received any treatment for over 12 months.

Effective staffing

Some additional training had taken place since our last inspection, including safeguarding training and training for GPs regarding the computer system. There was still no robust system in place to monitor the training needs of staff and areas such as infection control still needed addressing.

There were on-going discussions regarding the recruitment of GPs due to the recent decisions taken by two partners to leave the practice.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. However this information was not always being appropriately updated or used to ensure patient safety. For example, we reviewed patient referrals that had been made without an examination or detailed patient history and we saw high risk medicines being re-issued without checking blood tests had been carried out as per the patient notes.

There was still a lack of multidisciplinary care; a meeting due to take place had been cancelled. A non-clinical member of staff had identified patients with potential palliative care needs but these had not been actioned and were awaiting discussion. We reviewed records of recent deaths and found some of these to be palliative patients who had not been identified by the practice.

Consent to care and treatment

Following our last inspection, non-clinical staff were no longer seeking consent from patients prior to their consultations. Consent forms for procedures such as coil fitting and joint injections were in place and could be found on the patient records. However, we reviewed patient records for cryotherapy procedures and found some records had no signed consent form and another that had a consent form signed by a different patient.

We also viewed records of patients receiving cryotherapy for inappropriate diagnoses, which were later changed and cryotherapy carried out.

Are services caring?

Our findings

We did not inspect any key lines of enquiry under the caring domain.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect any key lines of enquiry under the responsive domain.

Are services well-led?

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

Our findings

On the day of our unannounced inspection, we were informed that two GP partners has notified the practice of their intention to leave. Since our last inspection a new salaried GP had been recruited and was in talks to become a partner. The practice were aware that this change would leave them without a female GP and they intended to try to recruit one in their place. .

There was improvement in the practice management team with the addition of an assistant practice manager. Due to the transitional phase in the partnership, there was still limited engagement between GPs and other staff.

Governance arrangements

The practice management team were working to improve the governance arrangements and were drafting new policies. There were still limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. These included risks identified at our inspection on 31 March 2016.

Due to a lack of understanding of the use and purpose of audits, there was no programme of continuous clinical and internal audit used to monitor quality and to make improvements. However staff were keen to learn and told us they would aim to carry out clinical audits in the future.

The staffing structure was still unclear due to the transition the practice were going through. There were changes of lead roles, of which not all staff were aware. There was still a lack of communication as not all staff were aware of why meetings were being cancelled.

Leadership and culture

The partner GPs were not demonstrating experience, capacity and capability to run the practice and ensure high quality care. We were told of several, recent disagreements and tension between the GP partners. Although we were told that this partnership was due to change and staff felt this would improve, the current leadership was not effective..

There had been a recent practice and nurse meeting and there was a timetable of future meetings. However, both meetings detailed in the practice's action plan, scheduled for the day of our inspection, had been cancelled.

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 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not done all that was practicable to offer a multidisciplinary approach to patients with complex needs. The provider had not ensured that patient referrals were appropriately documented. This was in breach of regulation 9 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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured that consent was always sought and recorded in line with practice policies. This was in breach of regulation 11 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was practicable to minimise the risks associated with infection control or the prescribing of high risk medicines. This was in breach of regulation 12 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. There was insufficient governance in place to assess or monitor risks to patient safety. Significant events were not always being identified, recorded or shared to encourage learning or improve patient outcomes. There was no continuous programme of clinical audit to drive improvement in patient outcomes. There was a lack of leadership in place to ensure good practice. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.