Poole Road Medical CentrePoole Road Medical Centre

Quality Report

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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.

Summary of findings

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Summary of findings

Overall summary

Poole Road Medical Centre provides a general practice (GP) surgery accommodated in an older converted building in Bournemouth. The practice currently has about 8250 patients on its list.

Poole Road Medical Centre is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, family planning, surgical procedures and treatment of disease, disorder and / or injury.

The practice is open between 8:00am and 6:30pm for telephone calls and between 8:15am and 6:30pm for physical access on Monday to Friday. The practice offers early morning appointments each week on a Tuesday and Saturday appointments once a month.

The majority of patients we spoke with during our inspection told us that they were happy with the treatment that they received.

We saw the practice was provided in a clean and hygienic environment, and there were effective systems in place to ensure that patients received safe care.

We found the practice was effective in meeting the wide ranging needs of its patients and the varying levels of demand that were placed on it. The practice was well-led and responsive to the needs of the diverse patient group attending the practice.

There were some examples of good practice, where the service had 'gone the extra mile' to meet the needs of its patients which could be shared with other services. These included the walk-in service that had been developed to respond to patients' need and the use of a 'care of' address for homeless patients.

Unfortunately, the practice was not following some of its own policies and this led to an issue with the safe recruitment of some staff.

Patients received a caring service and the majority of patients we spoke with told us they were satisfied with the healthcare they received. We saw patients being treated with sensitivity by reception staff, and most patients we spoke with confirmed the reception staff were polite and respectful. Some patients commented on the lack of privacy afforded in the reception area and said they had sometimes not been treated respectfully by reception staff.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Staff were aware of policies and procedures for reporting for safeguarding children at risk of harm.

We found that the recruitment of some clinical staff meant there was a risk that the practice could not be sure that these staff was suitable to work with vulnerable patients and children.

Are services effective?

Overall the practice was effective. The practice effectively managed the demand for the practice and feedback from patients was generally positive about the service they received. Patients needs were suitably assessed and care and treatment was delivered in line with current legislation and best medical practice. Audits of various aspects of the practice, including minor surgery were undertaken at regular intervals. The practice worked with other health and social care services to ensure the needs of their patients were met.

Are services caring?

Overall the practice was caring. Most of the patients we spoke with were complimentary of the care and service that staff provided, and care was provided with respect to patients' privacy and dignity.

Are services responsive to people's needs?

Overall the practice was responsive to patients. The practice obtained and acted on patient feedback and the practice learned from patients experiences to improve the quality of care.

Are services well-led?

There were governance structures in place and the culture within the practice was open and transparent. Risks to the effective delivery of service were assessed to some degree and there were suitable business continuity plans in place. However, not all quality assurance areas were assessed and monitored such as recruitment practices and language barriers to reduce risks to patients.

Summary of findings

The six population groups and what we found

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

Older people
The practice told us that they had a significant population of vulnerable older patients and that they responded to their changing needs and worked with partner agencies such as residential and nursing care homes, and district nurses to ensure patient needs were safely met. For example, the practice told us they had implemented a community phlebotomy service for older patients to enable older patients with mobility issues to access this service at home.

People with long-term conditions
The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE).

Mothers, babies, children and young people
The practice ran a number of clinics including family planning, child health surveillance, baby clinics, maternity and immunisation clinics to ensure the needs of Mothers, babies, children and young people were safely met.

The working-age population and those recently retired
Patients of working age received a less accessible service because they were not aware of the facility to obtain booked appointments. However, the practice offered an extensive walk-in service and patients were able to see a GP of their choice.

People in vulnerable circumstances who may have poor access to primary care
The practice had a large transient population who they had tailored some aspects of the service for. This meant that vulnerable patients received quick access to GPs and medical treatment. The practice operated an extensive walk-in service and patients could choose which GP they wished to see. The practice told us that there was an average wait of seventy minutes. Patients we spoke with confirmed this and added that they were given a choice of seeing any GP or their own GP. They said that reception staff made the waiting times for each option clear to them to ensure they could make an informed choice.

People experiencing poor mental health
The practice provided services for patients experiencing poor mental health and had a volunteer counsellor whom they were able

to refer patients with mild emotional/mental health issues to. The practice worked with statutory specialist health care services such as community mental health teams, and voluntary services to ensure patients received appropriate support.	

Summary of findings

What people who use the service say

Most of the patients we spoke with during the inspection were satisfied with the service they received. Patients told us they were mostly happy with the medical care at the practice. We received a number of compliments about the GPs.

Most patients were complimentary about the reception staff. A small number of patients commented that a some reception staff were not always polite. Two patients also told us about a lack of privacy and confidentiality in the reception area.

There were varied opinions regarding the walk-in service and the availability of booked appointments. Some patients told us they were very happy with the walk-in service because of the accessibility to GPs. Some patients preferred to book an appointment. In general the patients we spoke with told us it was either more difficult to book an appointment or that they were not aware that they could book an appointment to see a GP in advance.

Areas for improvement

Action the service MUST take to improve

The practice manager confirmed that the practice sometimes used locum GPs to cover annual leave and other periods when the regular GPs were not at work. We checked five recruitment files for locum GPs the practice had used and found significant omissions in the recruitment process. This meant the practice was unable to demonstrate that appropriate checks for locum GPs were undertaken.

Action the service COULD take to improve

- Records did not demonstrate that staff had received an annual appraisal or how learning from clinical audits was shared. There was one incident that had not been recorded as significant event and this meant the practice could not demonstrate their learning.
- The practice did not have robust systems in place to ensure patients whose first language was not English received an effective and safe service and ensure staff had access to the practice complaints leaflet. This meant there was a risk patients may not receive appropriate treatment, and if patients were unhappy about the service, staff may not be able to support them to make a complaint.
- Staff were not informed about the private areas available for breast feeding.

Good practice

Our inspection team highlighted the following areas of good practice:

- The walk-in service was valued by patients as GPs were easily accessible for advice and treatment. The practice operated an extensive walk-in service and patients could choose which GP they wished to see. The practice told us that there was an average wait of seventy minutes. Patients we spoke with confirmed this and added that they were given a choice of seeing any GP or their own GP. They said that reception staff made the waiting times for each option clear to them to ensure they could make an informed choice. This meant that vulnerable patients received quick access to GPs and medical treatment.
- The practice had a significant population of patients with no fixed abode. They supported patients by having a 'care of' address. This meant that homeless patients could receive information from hospitals and other healthcare providers via the practice.

Poole Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included another CQC inspector and a specialist advisor in clinical governance.

Background to Poole Road Medical Centre

Poole Road Medical Centre provides a general practice surgery accommodated in an older converted building in Bournemouth. The practice currently has about 8250 patients on its list.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, family planning, surgical procedures and treatment of disease, disorder and / or injury.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.
This practice had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information about the GP service and asked other organisations to share their information about the practice. These included organisations such as the local Healthwatch, NHS England and Clinical Commissioning Group. We carried out an announced visit on the 28 May 2014.

During our visit we spoke with a range of staff, including the practice manager, senior GP (registered manager), GP's, registered nurses, receptionists and other administrative staff.

We also spoke with patients who used the practice and members of the patient participation group.

We also looked at how well services are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Are services safe?

Summary of findings

Staff were aware of policies and procedures for reporting for safeguarding children at risk of harm.

We found that the recruitment of some clinical staff meant there was a risk that the practice could not be sure that these staff was suitable to work with vulnerable patients and children.

Our findings

We spoke with 17 patients (including four members of the Patient Participation Group - PPG) who were using the practice on the day of our inspection. The majority of comments we received were positive and patients did not raise any concerns about patient safety. We also spoke with nine members of staff including the registered manager.

Safe Patient Care

The registered manager told us that repeat prescriptions were regularly reviewed to ensure they remained the most appropriate and safe treatment for the patient.

The practice told us they checked the premises on a regular basis to ensure it was safe for patients. We did not note any issues with the layout, cleanliness and maintenance of facilities and buildings. We saw the lift was in working order, the décor intact, and safety notices such as those for fire exits were prominently displayed. A health and safety policy was in place and regular checks were undertaken on the equipment used in the practice to ensure it was operating correctly.

Learning from Incidents

Records showed that the practice generally recorded significant events. However, on review of the significant events log we found the practice did not have an auditable system in place which demonstrated learning to improve the safety of services for patients. We also saw one example where we noted a significant event had occurred but had not been logged, investigated or learned from as a significant event. This meant that the practice did not have a robust system in place to enable them to learn from incidents.

Safeguarding

The practice had policies and procedures in place for safeguarding children and vulnerable adults. These were up to date. They set out how staff should respond when they suspected a child or vulnerable adult was at risk of harm. They contained contact details of agencies to report concerns to or which could give further advice about managing a concern.

The practice had two GPs who had received in-depth childrens safeguarding training which enabled the practice to provide a resource for other GPs. Non clinical staff had completed some online childrens safeguarding training.

Are services safe?

The practice held a child protection meeting every other month. The lead safeguarding GP told us about some of the changes the service had made as a result of learning. These included trying to ensure a whole family would be registered under the care of one GP, and greater awareness of other agency child protection contacts. This meant that information could be shared quickly and effectively.

We saw the practice had a chaperone policy and posters advertising the availability of chaperones were situated in clinical rooms. A chaperone is a person who, with their consent, accompanies another person or child during their consultation or treatment.

The practice told us that two GPs had completed safeguarding adults training.

Monitoring Safety & Responding to Risk

Senior staff told us that the practice did not have an organisational risk register but they showed us risk assessments relating to different aspects of the building.

The practice told us that they faxed special patients notes, for example where patients were receiving end of life care, to the local out of hours service. However, the practice did not have a safe haven fax process in place. This meant there was a risk that patient information might not have been received by the intended recipient.

There were arrangements in place to deal with foreseeable emergencies. We noted that all the staff had up-to-date training in basic life support.

There was a full range of emergency equipment in place, including automated external defibrillators, oxygen, intravenous fluids and emergency drugs. We saw notices clearly displayed in the practice showing where these were located. Staff told us they knew where they were kept.

Medicines Management

Appropriate arrangements were in not fully in place in relation to the management of medicines at the practice on the day of the inspection. There were regular reviews of the prescriptions of patients with long term conditions. We checked the emergency drug kit and found that all drugs were in date. The vaccinations were stored in suitable fridges. All the drugs and vaccines that we checked were within their expiry date. The practice maintained a log of temperature checks on the fridge. The records we checked showed all instances of temperature being within the correct range. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably.

Cleanliness & Infection Control

The practice had an infection control policy and had completed an audit of infection control in 2014 which had not identified any significant issues. We observed that the practice was clean and none of the patients we spoke with raised any concerns about cleanliness and infection control. This meant patients were protected against the risks of cross infection.

Staffing & Recruitment

The practice had a range of staffing and recruitment policies that were easy to access and understand. A significant number of policies had not been reviewed in accordance with the practice guidelines which places patients at risk.

The practice manager confirmed that the practice sometimes used locum GPs to cover annual leave and other periods when the regular GPs were not at work. We checked five recruitment files for locum GPs the practice had used and found significant omissions. This meant the practice was unable to demonstrate that they had undertaken satisfactory checks for locum GPs, and could not be sure that these clinicians were suitable to work with vulnerable adults and children.

Dealing with Emergencies

Most staff had up to date training in basic life support to enable them to assist a patient in the event of a medical emergency. The practice had panic alarms in each clinical room to enable staff to quickly summon support. The practice told us about a medical emergency that had occurred at the practice shortly before the inspection, which they felt they had managed well. This showed that there systems for managing medical emergencies were safe and effective.

The practice manager told us they had health and safety policies in place and a range of current risk assessments. We saw records of some regular health and safety audits, such as the weekly fire alarm test. The practice manager told us about other audits but said these were not formally recorded. The practice manager showed us the

emergency system staff used to inform others that they required immediate assistance. This showed there were arrangements to ensure the environment and facilities were suitable and safe for patients.

Equipment

The practice kept records of all equipment and logged when it needed to be tested or serviced. Records showed this been undertaken. Staff confirmed they had adequate supplies of equipment at all times. This meant equipment used for patient care and treatment was safe.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice was effective. The practice effectively managed the demand for the practice and feedback from patients was generally positive about the service they received. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best medical practice. Audits of various aspects of the practice, including minor surgery were undertaken at regular intervals. The practice worked with other health and social care services to ensure the needs of their patients were met.

Our findings

We spoke with 17 patients (including four members of the Patient Participation Group - PPG) who were using the practice on the day of our inspection.

Promoting best practice

The practice had an addictions policy and GPs we spoke with told us that they would discuss this with patients where this was appropriate. A GP explained a recent audit to demonstrate how the practice was prescribing older patients sedatives in line with national guidance. This showed the practice used best practice guidance to inform their prescribing.

GPs told us about how they sought consent including where patients might lack capacity, and decisions may need to have been made in their best interests. GPs described the mental capacity assessments they had undertaken and explained how they referred to specialist services such as the community mental health teams for psychiatry support where this was required. This meant that care and treatment was provided in line with best practice guidance.

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular meetings where clinical and business issues relevant to patient care were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of patients. Staff were aware of procedures to follow to ensure that that patients on the individual disease registers associated with the Quality and Outcomes Framework (QOF) register were contacted and recalled at suitable intervals. The practice told us they had hot topics medical education sessions to ensure clinicians were kept updated on best practice and latest research covering a wide range of medical areas relevant to a GP.

Management, monitoring and improving outcomes for people

The practice had a computerised patient record system which prompted clinicians to enter clinical data completely and correctly, alerting them when important data was missing. Clinicians were able to highlight particular clinical risks or other concerns which were recorded. This meant that staff could ensure they treated patients safely and effectively.

Are services effective?

(for example, treatment is effective)

Staffing

Staff we spoke with told us they felt supported by the management team and able to develop their skills. Reception staff told us they had received an induction and were supported to observe other staff to build up their confidence.

The practice had a staff handbook. This ensured staff were aware of their responsibilities and provided them with essential information they required to safely undertake their role.

The practice had a training schedule matrix which clearly identified staff learning needs. This demonstrated that staff had received training in areas such as health and safety, confidentiality, and information technology. We noted that not all staff had received training in fire safety and conflict resolution; however we saw evidence that this training had been booked.

Working with other services

We noted that partner health care agencies such as health visitors and district nurses were based at the practice. Staff told us that this improved communication and joint working.

GPs talked about end of life care and partnership working with other agencies to ensure patients' needs were proactively met. They were able to talk about examples where patients had chosen end of life care in their own homes, and how the practice had worked with other organisations to ensure the patients' wishes were met. GPs were aware of referral arrangements to specialist services such as the care of children or young people with complex healthcare needs. This meant patients received effective care and treatment.

Health, promotion and prevention

We saw there was an on- site pharmacy that operated the same opening hours as the practice. This meant patients could easily obtain their prescribed medicines.

Patients had access to general information about their health and about services available at the practice. There was a range of health promotion and information leaflets and posters on display in the waiting rooms. This included a noticeboard with information about services for patients who had caring responsibilities. The practice also had a staff member who took a lead role for carer information.

We noted the practice offered a variety of clinics for patients with long-term conditions including asthma, circulation and diabetes clinics.

Are services caring?

Summary of findings

Overall the practice was caring. Most of the patients we spoke with were complimentary of the care and service that staff provided, and care was provided with respect to patients' privacy and dignity.

Our findings

We spoke with 17 patients (including four members of the Patient Participation Group - PPG) who were using the practice on the day of our inspection.

Respect, dignity, compassion and empathy

The practice accommodated the needs of disabled patients. We saw that the ground floor of the building was wheelchair accessible and that there was a lift to enable patients to access the first floor. The front door was wide enough for wheelchairs and there was a toilet adapted for patients with mobility needs.

We saw that there was a small reception area where patients privacy when talking with the receptionists could be compromised. The practice showed how they had tried to overcome this with a barrier to encourage distance between the reception desk and queuing patients, and a private room patients could use if they wanted to discuss something confidentially. Receptionists we spoke with confirmed how they spoke discreetly with patients to maintain their confidentiality. We observed throughout our visit that staff spoke politely with patients using the practice.

We noted that the majority of patient telephone calls were received by staff in a private office. This meant that patients confidentiality was respected. We also saw that confidential paper records were stored in lockable cabinets and that the practice had a clear desk policy which meant confidential documentation was not left unsecured.

Throughout the inspection we noted that staff knocked at clinic doors before entering and consulting rooms were equipped with curtains around examination couches, to give privacy during examinations.

The practice manager told us there were private areas available for breast feeding. However, one patient we spoke with told us they had not been able to breast feed their baby during a visit to the practice because staff had told them there was not a suitable room to use.

Involvement in decisions and consent

Patients told us they were able to express their views and felt involved in making decisions about their care and treatment.

Information about services at the practice was contained in the practice leaflet and on the website which included

Are services caring?

details of opening times and information about common ailments and actions patients could take. However, neither the leaflet nor website was available in accessible formats including different languages on the day of the inspection. The practice manager told us that the practice had a significant proportion of patients whose first language was not English. The practice confirmed that the practice had access to online and telephone interpreting and translation facilities. The practice informed us that a new website had been developed that would offer a translation service for patients. We also noted that the majority of information posters displayed throughout the building were in English. A GP confirmed there was a translation service but told us they rarely used this. They said that most patients who required communication support brought a friend or relative to their appointment. This could lead to an increased risk that GPs may not be given the correct information, and/or patients may not have fully understood what was going to happen to them during their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the practice was responsive to patients.

The practice obtained and acted on patient feedback and the practice learned from patients experiences to improve the quality of care.

Our findings

We spoke with 17 patients (including four members of the Patient Participation Group - PPG) who were using the practice on the day of our inspection.

Responding to and meeting people's needs

The practice told us how the practice population had significantly increased over a short number of years. They explained that this was a result of a local increase in hotels, retirement complexes and care home businesses. They told us about some of the actions they had taken to respond to the increasing population which included extending the building and changing access arrangements to the GPs.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

Patients were able to choose the local hospital to have further treatment. GPs told us they discussed the different hospital options with patients in order to support them to make an informed choice.

GPs told us that they had a Spanish and Portuguese speaking GP who was able to converse with those patients to enable language barriers to be reduced.

The practice had a significant population of patients with no fixed abode. They supported patients by having a 'care of' address. This meant that homeless patients could receive information from hospitals and other healthcare providers via the practice. They were also aware of local housing options such as homeless shelters and guided patients to these services. This meant vulnerable patients could access healthcare services more easily.

The practice told us that they had a significant population of vulnerable older patients and that they responded to their changing needs and worked with partner agencies such as care homes and district nurses to ensure patients' needs were safely met. For example, the practice told us they had implemented a community phlebotomy service for some patients to enable older patients with mobility issues to access this service at home. They were aware of

Are services responsive to people's needs?

(for example, to feedback?)

referral processes for patients experiencing memory issues, and voluntary services such as memory cafes operating in the local area. This meant that patients were able to access services that could enhance their health and well-being.

The practice felt they had effective relationships with commissioners and other stakeholders to ensure they provided responsive and integrated care. They were mindful of the gender of their workforce and ensured there were both male and female clinicians available to ensure patients could have the choice of a male or female GP. This meant sensitive conditions could be dealt with appropriately.

Access to the service

The practice operated a walk-in service from 8:30 – 10:20am and any patient presenting between these times would be seen by a GP. Patients could choose which GP they wished to see and the practice told us that there was an average wait of seventy minutes. Patients we spoke with confirmed this and added that they were given a choice of seeing any GP or their own GP. They said that reception staff made the waiting times for each option clear to them to ensure they could make an informed choice. We noted there was a water cooler provided to ensure patients could access refreshments during their wait to see a GP. In addition to the morning walk-in service the practice offered pre-booked and emergency afternoon surgeries.

The practice told us patients could book appointments and repeat prescriptions online. This enabled patients to access the practice online at times that were convenient to the patient.

Concerns and complaints

The practice had a complaints policy which included clear guidelines for staff. The practice also had complaints leaflet for patients; however how to make a complaint was not publicised within the practice to help patients understand what to do. The practice manager told us that reception staff would provide patients with a leaflet upon request. We asked a receptionist how they supported patients to make a complaint. They told us that they would ask patients to write to the practice. They told us they did not have any complaints leaflets. This meant there was a risk that patients would not know how to raise concerns or make a complaint.

Are services well-led?

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

Summary of findings

There were governance structures in place and the culture within the practice was open and transparent. Risks to the effective delivery of service were assessed to some degree and there were suitable business continuity plans in place. However, not all quality assurance areas were assessed and monitored such as recruitment practices and language barriers to reduce risks to patients.

Our findings

We spoke with 17 patients (including four members of the Patient Participation Group - PPG) who were using the practice on the day of our inspection.

Leadership and culture

GPs told us they felt there was an open culture at the practice and the GPs had effective open communication with each other. Staff told us they felt confident about approaching GPs and the practices management team to discuss any concerns.

The practice did not have a formal mission statement; however it was evident from our discussions with staff that the practice saw itself as striving to provide better services for their patients.

Governance arrangements

Discussions with GPs showed that the practice had a system in place to follow up on medicines alerts and an audit in place to check and monitor patients who chose to continue using specific medicines. This meant there were systems in place to ensure that patients received safe and effective treatment.

The practice had completed a joint injection audit and the results of this were discussed with the other GPs. The practice had also completed an audit that explored the use of sedative medicines and this had led to some changes within the practice. We saw a good example of an effective audit of minor surgery. The audit set out to confirm good medical care in respect of consent, as well as detailing any post-operative infections, other complications or cases where the final diagnosis made on the basis of specimens submitted to the laboratory turned out to be different from the initial clinical diagnosis. The incidence of issues was low and where the audit pointed towards a procedure change this was actioned and the confirmation of change recorded. However, staff told us that there were no dedicated meetings to discuss audits and learning was therefore more difficult to disseminate within the clinical team.

Systems to monitor and improve quality and improvement

The practice had a nominated GP as their audit lead, and that an improved IT system enabled GPs to perform easier searches for themes, trends and audits.

Are services well-led?

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

Patient experience and involvement

The practice had a Patient Participation Group, to enable it to engage with a cross-section of the practice population and obtain patient views. We spoke with four members of the Patient Participation Group, who mainly expressed positive views about services provided and said that the practice listened to their views. We saw that the practice had completed a recent survey with the Patient Participation Group and records showed where they had made changes in order to improve the practice as a result of the feedback. This meant that the practice was responsive to patient views and incorporated them into the way the practice was run.

Staff engagement and involvement

The staff we spoke with told us they could speak with the practice manager about any queries or concerns they had about the practice. Staff commented they felt listened to and that they could discuss ideas to improve the practice. This meant there were effective systems in place to enable staff to comment on how the practice was run.

Learning and improvement

We looked at five randomly selected staff training files. We found that two of the five files did not contain an annual appraisal and that although the other three staff had received an appraisal this did not appear to have occurred on an annual basis. We discussed this with a senior member of staff and they confirmed that this was not an area of strength for the practice. However, the staff we spoke with about their appraisal described it as a positive learning experience. We also noted that clinical staff had personal development plans in place. This meant systems were not in place to ensure all staff were fully appraised and competent to carry out their role.

Identification and management of risk

The practice told us about a number of risk assessments they completed such as fire, health and safety and the control of substances hazardous to health (COSHH). However, not all quality assurance areas were assessed and monitored such as recruitment practices and language barriers to reduce risks to patients.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice told us that they had a significant population of vulnerable older patients and that they responded to their changing needs and worked with partner agencies such as residential and nursing care homes, and district nurses to ensure patient needs were safely met. For example, the practice told us they had implemented a community phlebotomy service for older patients to enable older patients with mobility issues to access this service at home.

Our findings

The practice was aware of referral processes for patients experiencing memory issues, and voluntary services such as memory cafes operating in the local area.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE).

Our findings

We noted the practice offered a variety of clinics for patients with long-term conditions including asthma, circulation and diabetes clinics. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of patients. Staff were aware of procedures to follow to ensure that that patients on the individual disease registers associated with the Quality and Outcomes Framework (QOF) register were contacted and recalled at suitable intervals.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice ran a number of clinics including family planning, child health surveillance, baby clinics, maternity and immunisation clinics to ensure the needs of Mothers, babies, children and young people were safely met.

Our findings

The practice told us they were in the process of implementing a children's clinic within the walk in service. This was to enable children to be seen earlier and avoid absence from school.

The practice was also meeting with local schools to improve communication about children who were subject to safeguarding.

The practice told us they had produced specific guidance for parents whose children are first attending school on minor illnesses which included advice on home medicine remedies and when their child needed to see a GP.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Patients of working age received a less accessible service because they were not aware of the facility to obtain booked appointments. However, the practice offered an extensive walk-in service and patients were able to see a GP of their choice.

Our findings

People of working age received a less accessible service because patients using the walk-in service were not made fully aware of the facility to book appointments at a time that fitted in with their working hours. This meant that some patients had to take time off work in order to see their GP when this might not have been necessary.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice had a large transient population who they had tailored some aspects of the service for. This meant that vulnerable patients received quick access to GPs and medical treatment. The practice operated an extensive walk-in service and patients could choose which GP they wished to see. The practice told us that there was an average wait of seventy minutes. Patients we spoke with confirmed this and added that they were given a choice of seeing any GP or their own GP. They said that reception staff made the waiting times for each option clear to them to ensure they could make an informed choice.

Our findings

The practice had a significant population of patients with no fixed abode. They supported patients by having a 'care of' address. This meant that homeless patients could receive information from hospitals and other healthcare providers via the practice. This meant that patients who were homeless could have their healthcare needs met.

They were also aware of local housing options such as homeless shelters and guided patients these services.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice provided services for patients experiencing poor mental health and had a volunteer counsellor whom they were able to refer patients with mild emotional/mental health issues to. The practice worked with statutory specialist health care services such as community mental health teams, and voluntary services to ensure patients received appropriate support.

Our findings

A GP explained a recent audit to demonstrate how the practice was prescribing older patients with mental health issues sedatives in line with national guidance. This showed the practice used best practice guidance to inform their prescribing.

GPs told us about how they sought consent including where patients might lack capacity, and decisions may need to have been made in their best interests. GPs described the mental capacity assessments they had undertaken and explained how they referred to specialist services such as the community mental health teams for psychiatry support where this was required. This meant that care and treatment was provided in line with best practice guidance.

The practice was aware of referral processes for patients experiencing memory issues, and voluntary services such as memory cafes operating in the local area. This meant that patients were able to access services that could enhance their health and well-being.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Records showed that recruitment checks had not been fully completed for locum GPs. This meant that that information specified in Schedule 3 to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was not available in respect of all persons employed for the carrying on of a regulated activity. Regulation 21(b)