The Marine and Oakridge Partnership

Quality Report

29 Belle Vue Road,
Southbourne,
Bournemouth,
BH6 3DB
Tel: 01202 425588
Website: www marineandoakrige.nhs.uk

Date of inspection visit: 2 June 2014
Date of publication: 03/10/2014

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

Contents

Summary of findings

Overall summary

The Marine and Oakridge Partnership 29 Belle Vue Road, Southbourne, Bournemouth BH6 is located in the Bournemouth area of Dorset. There is a high proportion of people aged between 20 to 39, and 80 years living in the Bournemouth area. The main population of patients using the Marine and Oakridge practice are over 85 years and some of these patients have long term conditions such as heart conditions.

There are 10,170 patients registered at the practice. Eight GP partners, practice nurses, health care assistants, practice management team and administration staff support patients. A GP partner was a member of the East Bournemouth Clinical Commissioning Group (CCG).

This practice is registered with CQC to provide diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder, or injury.

We spoke to patients and their carers. We reviewed written feedback from five patients, which was provided on comments cards in advance of the inspection. All patients provided positive feedback about the practice and staff. We reviewed the results of the 01/01/2013 – 30/09/2013 patient survey. This showed patients were consistently pleased with the service they had received.

We found effective chaperone (a member of staff supporting a patient during intimate examinations) and safeguarding vulnerable adults and children policies, which supported the needs of young people in the practice.

Patients were able contact the practice during opening hours and have a telephone consultation with a GP.

Patients in vulnerable circumstances were supported by staff who had a good understanding of their needs.

Patients with medical conditions or symptoms related to the misuse of alcohol and drugs visited the practice and were referred to external organisations for additional support.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The practice the practice was safe. There were effective infection control and medicines management policies, procedures, and we found these were in line with national guidance. The staff worked closely with the local authority safeguarding team and there were robust internal processes to safeguard vulnerable children and adults from abuse.

Are services effective?
The practice was effective. Patients received care and treatment that was effective and they benefitted from a stable staff team. Patients care and treatment was coordinated and provided by staff who were competent and skilled. Patients had access to health promotion information and specialist clinics.

Are services caring?
The practice was caring. Patients said the staff were caring and they were treated with respect. They told us they felt informed about the care and treatment and were involved in the decisions about their treatment plans. The staff knew patients had to give their consent before any care or treatment was provided. We saw the staff use a friendly and respectful manner towards patients.

Are services responsive to people's needs?
The service was responsive. Services were organised to meet patients needs. Patients found making appointments easy and felt confident to approach staff with their concerns. The practice had extended opening on Mondays and core hours at all other times which gave access to patients in the working age population group. Patients had access to the online complaints procedure and in the practice. The complaints procedure on display in the waiting area was small and easily missed. Patients may not know the practice has a system for giving feedback about the care and treatment they receive.

Are services well-led?
The practice was well led. Staff were clear about what decisions they were required to make within their areas of responsibility. The GP partners and practice management had formed a strong leadership team with a clear vision and purpose.

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
Patients were supported to access services and were referred for specialist care where appropriate. Patients registered at the practice and living in residential and nursing establishments had home visits.

People with long-term conditions
Patients with long-term conditions were seen at the practice and supported to manage their health, care and treatment. Clinicians in the practice signposted these patients to local support groups.

Mothers, babies, children and young people
The practice had effective chaperone (a member of staff who supports a patient during intimate examinations) and safeguarding vulnerable children policies, which supported the needs of young people in the practice.

The working-age population and those recently retired
Patients who contacted the practice were able to have a telephone consultation with a GP. Extended hours from 7:00 am on Mondays gave patients in the working age category better access to GP consultation. Patient in this category were referred to other health care centres for blood tests to reduce their waiting time for these tests.

People in vulnerable circumstances who may have poor access to primary care
Patients in vulnerable circumstances had their needs met by staff who had a good understanding of their needs. For example, staff attended training to understand the needs of patients with learning disabilities.

People experiencing poor mental health
Patients with medical conditions or symptoms related to the misuse of alcohol and drugs visited the practice and were referred to external support groups for additional support.

Summary of findings

What people who use the service say

We spoke with eight patients and a further five patients provided written feedback through comments cards in advance of our inspection visit. The feedback we received from patients was positive. We were told the practice was always clean, comfortable and the environment was safe.

Patients told us the staff had a caring attitude towards them and toward the people involved in their care. They were treated with respect and confidentially was protected.

Patients told us they felt well informed about their care and treatment during consultations and were involved in the decisions about their care. They told us appointments were easy to make but they rarely saw the same GP. We were also told emergency appointments were available on the same day.

Areas for improvement

Action the service MUST take to improve

- Risk assessments must be undertaken to identify whether staff require a criminal records check via the Disclosure and Barring Service to ensure that patients are not at risk from staff who are not suitable to work with vulnerable patients

Action the service COULD take to improve

- The complaints procedure on display in the reception area should be fully visible to all patients so that they are aware of the procedure for making complaints.

Good practice

- Checks for host families offering accommodation to overseas student's pilot was taking place between practice staff, safeguarding teams and the local Clinical Commission Group (CCG).
- Homeless patients were given a summary of their consultation in the event they needed access to other health services.

The Marine and Oakridge Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP and practice manager specialist. The team included one CQC inspectors and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from similar service.

Background to The Marine and Oakridge Partnership

The Marine and Oakridge partnership is located in the Bournemouth area of Dorset. The practice is a purpose built building providing easy access to patients with a disability, those with pushchairs and young children. A local pharmacy was situated at the front of the building and other services using the building included counselling services, community nurses and health visitors used the building.

Marine is the main practice while Oakridge is a branch practice and owned by eight GP partners.

The patients we spoke with gave positive feedback about the practice and staff. We reviewed the results of the 01/01/2013 – 30/09/2013 patient survey. This showed patients were consistently pleased with the service they received.

Staff told us the registered manager and practice managers were supportive. They described an open culture where staff felt able to approach the management team with concerns.

Marine Surgery 29 Belle Vue Road, Southbourne, Bournemouth BH6 3DB and

Oakridge Surgery 1206 Christchurch Road Boscombe East Bournemouth BH7 6DY.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we had received from the practice and asked NHS Dorset Clinical Commission Group , NHS England and Healthwatch to share their information about the service. We carried out an announced visit on 2 June 2014 between 9:30 and 5:30 PM. During our visit, we spoke with a range of staff including practice nurses, healthcare assistants and the GPs. We also spoke to secretaries, reception, and administrative staff.

Detailed findings

We spoke with eight patients and a further five patients gave us feedback through comment cards. We observed how people were being cared for and reviewed personal care or treatment records of patients

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?

The inspection team always looks at the following six population areas at each inspection:

•Vulnerable older people (over 75s)

•People with long term conditions

•Mothers, children and young people

•Working age population and those recently retired

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

•People experiencing a mental health problem.

Are services safe?

Summary of findings

The practice was safe. There were effective infection control and medicines management policies, procedures, and we found these were in line with national guidance. The staff worked closely with the local authority safeguarding team and there were robust internal processes to safeguard vulnerable children and adults from abuse.

Our findings

Safe Patient Care

Patients received safe care Clinical meetings were held regularly to update policies, share information and cascade training. We saw from the minutes of the clinical meetings with GPs, discussions about referral patterns had taken place, and appropriate action plans developed.

Learning from Incidents

Systems were in place to identify and prevent risk. We looked at the records of clinical incidents and near misses, we saw they were analysed and action plans developed. For example, how the practice ensured result results was passed to GP. Members of staff gave us examples of continuous learning from incidents. Practice systems were reviewed to improve patient care when trends were identified. For example, the procedure in place for receiving, recording and passing tests results to GPs.

Safeguarding

Staff knew the actions they needed to take to protect patients including children from abuse. Safeguarding adults and children procedures were on display in the consulting room and reception area telling staff and patients the types of abuse and who to contact if they suspect abuse. Staff gave us examples of when they had raised concerns about children to the local authority. The staff we spoke with had attended safeguarding training. Time for the training was protected to ensure staff were up to date with current safeguarding procedures.

A safeguarding lead was appointed and their role included cascading training to staff. We were told the local authority safeguarding adults and children team were available to discuss concerns and suggest actions to be taken. The practice staff took safeguarding patients seriously to ensure appropriate action taken.

Monitoring Safety and Responding to risk

Safety alerts from external agencies were acted upon. Staff were expected to read the information and sign to indicate their understanding. Risk assessments were developed to assess the risk to patients and staff to then taken action to lower the levels of risk and ensure safe patient care. For

Are services safe?

example, fire risk assessments were undertaken with a fire officer; safe systems were in place to detect and respond to fire. Staff attended fire drills to ensure they knew the evacuation procedures in the event of a fire at the practice.

Medicines Management

Staff we spoke with were familiar with medicine the protocols. The practice nurse monitored all emergency drugs. There was a supply of drugs appropriate to manage adverse reactions to treatments. We found all drugs and stored vaccines were within expiry date and there were appropriate stock levels. We checked the refrigerators, which were used for storing vaccines and other medication. The refrigerators were kept locked and temperatures were monitored. We sampled temperature recording of these refrigerators and found that they had been operating at a safe temperature during the previous four weeks. The medicines stored were safe for the patients who needed them.

Cleanliness and Infection control

During the inspection, we observed the premises were clean and tidy. The practice had comprehensive infection control policies and procedures in place. These included, protocols for hand hygiene, waste disposal and sharps and needle stick injuries. The practice nurse was appointed as the infection control lead and carried out regular infection control audits. For example, curved blinds were assessed for the risk of strangulation in September 2013 and the actions were to remove the cords to prevent strangulation. Risks were assessed to detect and prevent the spread of infections. For example, hand basin taps and wash hand basins had been replaced to reduce the risk of legionella. Cleaning rotas were in place for each room and staff signed the schedule to confirm the task was completed. The risk of infection to patients was reduced.

Staffing and Recruitment

Recruitment and selection procedures were in place to appoint the right staff for the post advertised. One practice manager told us a recruitment agency was used to select suitable candidates for interviews. Candidates for all job vacancies were expected to provide their curriculum vitae (CV) at the interview stage. Other checks included references from previous employer and proof of identity. The practice manager was provided with relevant details about the candidates training and employment history and suitability to perform their role. Staff were not required to disclose criminal backgrounds in their CV or before their disclosure and barring service (DBS) checks were requested. The integrity of new staff was not checked. We saw DBS checks were undertaken for clinical staff. However, risk assessments were not undertaken to assess the potential risk to patients from non-clinical staff who may not be suitable to work with vulnerable patients.

Dealing with Emergencies

Business continuity plans had been developed to manage emergencies that could interrupt the smooth running of the practice. Staff received training on the evacuations procedures to maintain patient safety. We saw plans of actions to be taken in the event of fire, flood, or power failure.

Equipment

Emergency equipment was available for staff to use in the event of an emergency. The practice had access to resuscitation equipment including oxygen and a defibrillator. We saw the equipment was checked regularly and was in date at the time of visit.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Patients received care and treatment that was effective and they benefitted from a stable staff team. Patients care and treatment was coordinated and provided by staff who were competent and skilled. Patients had access to health promotion information and specialist clinics.

Our findings

Promoting Best Practice

Patients care, treatment, and support was in line with recognised guidance standards and good practice. Minutes of clinical meetings showed National Institute for Health Care and Excellence NICE guidance was an agenda item. The records we looked at confirmed good practice guidance was discussed at clinical meetings and action taken. Patients benefited from best practice guidance.

Staff demonstrated a sound knowledge of the Mental Capacity Act (MCA) 2005 and its relevance to general practice. The staff we spoke with told us they had attended MCA training. Clinical staff told us mental capacity assessments were carried out by the GP over several visits to establish the need for a Lasting Power of Attorney (LPA). We were told information on the person with legal rights to make decision about the patient was shared with the practice staff. GPs told us they provided coordinated care for long term conditions and palliative care. For example, multi-disciplinary meetings were held to discuss the palliative patients registered at the practice. GPs were able to support patients with the management of long term conditions. A GP partner with safeguarding lead responsibilities told us staff had a good understanding of the Mental Capacity Act 2005 (MCA). We were provided with an example when patients capacity was assessed and multidisciplinary meetings held to make best interest decisions.

Management, Monitoring and Improving outcomes for people

Patients benefited from to improved standards of care and treatment. The practice participated in benchmarking programmes nationally and locally. This included Quality and Outcomes Framework (QOF); The QOF was introduced in 2004 as part of the general medical services contract and was a voluntary scheme for GP practices in the UK. The QOF helped practices compare the delivery and quality of care they provide against the achievements of previous years. The practice had a QOF score of 99.4 % for 2012/13 an above average score in the NHS Dorset CCG.

Are services effective?

(for example, treatment is effective)

The clinical staff we spoke with knew the areas of lower achievements, which included hospital referrals and repeat prescribing. We saw documented actions plans to improve the achievements. For example, high level of referrals in areas such as cardiology.

Staffing

Staff were appropriately trained and competent to safely carry out their roles and responsibilities. They were able to monitor and adapt treatment to patients with long term conditions. A record of the in-house training provided to all staff was maintained to ensure the staff team attended essential training and updates. Non-clinical staff told us there was statutory training in fire safety, safeguarding, dealing with difficult patients and communication. Clinical staff attended training which ensured they had up to date knowledge and skills. For example, clinical staff had attended chronic obstructive pulmonary disease (COPD) and diabetes training.

We were told appraisals were undertaken annually and action plans were developed for personal development and further training. Staff told us the appraisal system identified training needs. Clinical staff told us they had one to one time to discuss their performance, duties and responsibilities with their line manager. For example, practice nurses had clinical meetings with the senior practice nurse.

The induction programme in place prepared new staff for the role they were to perform. We looked at the induction programme and a member of non-clinical staff told us their induction took six weeks to complete and covered all aspects of the role they were to undertake.

Working with other services

Patients received coordinated care and treatment. They were supported to access other health and social care services. For example, bereavement services. We saw records of multi-disciplinary meetings, joint meetings with the clinical commission group (CCG) and other clinical meetings where relevant information was shared with GP partners. We saw records of meetings with intermediate care where decisions to undertake joint visits was reached for patients moving to nursing or residential care. A GP partner told us referrals for specialist minor surgery were accepted from other local GP practices and were undertaken at the practice. We were told the community nursing team was based at the practice and there was daily contact with health visitors, district nurses, and community matrons. . Another GP partner told us they arranged for coordinated care to patients with long-term conditions and for palliative care.

Health, Promotion and Prevention

Useful health promotion information was available to patients in the reception area. In the reception area, there was information that signposted patients to other organisations. For example, carers support groups, medical information and the new appointment system. Patients were offered specialist clinics for diabetes and respiratory conditions where health promotion discussions were part of their treatment plan.

Are services caring?

Summary of findings

The practice was caring. Patients said the staff were caring and they were treated with respect. They told us they felt informed about the care and treatment and were involved in the decisions about their treatment plans. The staff knew patients had to give their consent before any care or treatment was provided. We saw the staff use a friendly and respectful manner towards patients.

Our findings

Respect, Dignity, Compassion and Empathy

Patients received their care and treatment in a way that respected their rights. Patients said the staff had a caring attitude towards them and their carers. They told us consultations were in private. Their medical conditions and treatment was explained to them during their consultations.

Patients told us their confidentiality was respected and said it was paramount at the practice. . Staff told us they had received confidentiality training and had signed the policy to show their understanding. Clinical and non-clinical staff showed a sound knowledge of their responsibilities towards maintaining patient confidentiality. We were given examples to show how confidentially was managed at the practice. For example, not leaving test samples visible to other patients, password protected systems, and ensuring letters to patients were correctly addressed. The environment was adapted to ensure telephone conversations were not overhead in the reception area.

Steps were taken to communicate with patients living with sensory loss. A loop system was used for patients with hearing loss and large print and a magnifying plastic was used for patients with sight impairments. Interpreters were used for patients who needed support with understanding English.

Involvement in Decisions and Consent

Patients we spoke with said they were involved in making decisions about their care. They felt well informed about their treatment when they left the practice. Staff knew patients had to give their consent before care or treatment was provided.

The practice staff knew how to support patients to make informed decisions about their care and treatment. Staff knew children aged 16 years and under were able to consent to some medical treatments and procedures. For example, contraception, without the need for parental permission or knowledge. GPs supported patients over 85 years and palliative patients to make decisions about their end of life care. For example to make decisions about their treatment in the event of cardio pulmonary arrest.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive. Services were organised to meet patients needs. Patients found making appointments easy and felt confident to approach staff with their concerns. The practice had extended opening on Mondays and core hours at all other times which gave access to patients in the working age population group. Patients had access to the online complaints procedure and in the practice. The complaints procedure on display in the waiting area was small and easily missed. Patients may not know the practice has a system for giving feedback about the care and treatment they receive.

Our findings

Responding to and meeting patients needs

Core services such as general management of health conditions and health promotion were provided to the main patient population group registered at the practice. The population of patients over 65 years registered at the practice was greater than the national average. A member of staff told us GPs ensured patients had a choice of hospital for appointments. For example, older patients preferred their hospital admissions to be in areas closer to their families.

The practice staff helped people to manage their conditions. A GP partner told us patient care was key to the values of the practice. We were told weekly practice meetings were held to discuss treatment plans to improve patient care. Older adults had access to screening services to detect and monitor the symptoms of certain long-term conditions such as heart disease.

Facilities and equipment ensured patients had access to all parts of the practice. We saw staff were able to engage with patients at eye level because there was level access into the practice and the reception desk was lower at one end for patients using wheelchairs.

The staff were able to understand the needs of patients in vulnerable circumstances. Training was provided to ensure staff had insight into the needs of patients in vulnerable circumstances. For example, all staff accessed on-line training to meet the needs of people with learning disabilities.

Access to the service

Patients told us booking appointments was easy but they were not always able to see the GP of their choice. The practice manager told us a new system for booking appointments was recently introduced to meet patient demand. Patients were able to contact the practice and have their needs considered by a GP. The GP then advised the patient on any follow up action, which may include a consultation visits with them on the same day. Patients we spoke with told us they were able to book an emergency appointment for the same day.

We found the system for repeat prescribing robust. Staff told us the system was reviewed annually and all staff attended prescribing courses. The patients we spoke

Are services responsive to people's needs?

(for example, to feedback?)

with told us their medicine reviews were to change from six monthly to annual. The practice manager told us medicine reviews were dependant on the needs of the patient and their medical conditions. Patients knew requests for repeat prescriptions were only accepted by post, online or through the chemist. Out of Hours (OOH), arrangements were advertised on the practice website and on display in the reception area. Patients had access to a GP at all times of the day and night. Recorded messages were left on the practice telephone answering service telling patients who to contact in the event of an emergency.

Concerns and complaints

Patients knew the procedure for making complaints and felt confident to approach staff and raise their concerns with them. The staff we spoke showed a sound knowledge of the complaints procedure. We looked at the records of the three most recent complaints, which demonstrated the practice manager had followed the procedure.

The complaints procedure was on display in the reception area of the practice and on the website. We noted the procedure was in small print and easily missed by patients who may have wanted to provide feedback about their experiences to the staff. Patients may not know a procedure for making complaints was in place.

Complaints received were analysed to identify patterns and trends and were appropriately used for learning. Complaints received at the practice were well documented and we saw policy changes had been made from the complaints analysis. For example, how urgent information was passed to the duty GPs.

Are services well-led?

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

Summary of findings

The practice was well led. Staff were clear about what decisions they were required to make within their areas of responsibility. The GP partners and practice management had formed a strong leadership team with a clear vision and purpose.

Our findings

Leadership and Culture

A GP partner told us the practice's core value was joint working. We were told the new appointment system was a response to meeting the demands of the patient population. Future plans included identifying ways to improve and develop services. We saw team days had been held to discuss the needs of the practice and to set the values.

Governance arrangements

Staff told us there were good working relationships; they were involved in practice strategy, and direction plans. There was a strong GP partner team with clear allocation of responsibilities. For example, partners were assigned with key areas, which included safeguarding and prescribing. The practice managers were able to demonstrate the use of data, audits and benchmarking information on how they minimised risks. Decisions about the practice were made through partner meetings. For example, feedback from patients about appointments. Multi-disciplinary meetings were monthly and included clinical governance and clinical management.

Patients benefited from consistent care and treatment because decisions and actions were made within a framework of policies and procedures The range of procedures we looked at were accessible and included chaperone (a member of staff supporting a patient during intimate examinations), confidentiality, and infection control. Staff were aware of Gillick competence principles (patients 16 and under were able to consent to medical treatment for example contraception, without the need for parental permission or knowledge).

Staff Engagement and Involvement:

Staff told us there was excellent communication with the whole staff team. We saw that staff had a good understanding of the need to recognise and act on the views of patients and their carers. Whistleblowing policies procedures ensured staff knew they were expected to report poor practice they may have witnessed by other staff. Staff knew they could direct their concerns to any member of the leadership team. Team meetings were organised at all levels where discussion about the quality of services to patients was reviewed.

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 results for the national GP patient survey 2013 were consistent with the Clinical Commissioning Group and national average. The practice survey identified that most patients went to accident and emergencies if they needed medical advice but only 5% went to the pharmacist for advice. A practice manager told us this information was to be used to direct patient to other organisation for advice if they had minor ailments. We received positive feedback about the practice from 13 patients including feedback from five patients through comment cards.

A virtual Patient Participation Group (PPG) was created where on-line consultations about the services offered at the practice took place with practice staff and a selected group of patients. A member of the PPG told us practice staff sought feedback from the group. We were told their feedback was actioned by the practice staff and centred on direct access to GPs by telephone consultations.

Learning and improvement

The staff were adequately supervised, competent, and qualified to meet their needs. The practice continuously strived to learn and improve high quality care. There was evidence of recognised and appropriate meetings within the practice. For Example, partner, staff team, and clinical staff meetings. Performance management and appraisal were routinely undertaken for clinical and non-clinical staff. We saw evidence of this.

Identification & Management of Risk

The practice had a robust system to evaluate patient complaints and significant clinical events. Risk assessments were undertaken to identify the risks to patients and staff. Where risks were identified, action plans were developed. We saw a range of risk assessments, which included infection control, car parking, and fire.

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

Patients were supported to access services and were referred for specialist care where appropriate. Patients registered at the practice and living in residential and nursing establishments had home visits so patients who were not able to visit the practice had their medical conditions monitored by a GP.

Our findings

Caring:

Patients living in care homes received care and treatment from the practice. GPs made weekly visits to care homes. They supported elderly patients to reach decisions about their end of life wishes and ensured the appropriate consent forms were signed. The wishes of these patients' wishes were documented for staff to follow when the patient reached the end of their life.

Effective:

Patients were referred for specialist appointments. Staff told us referrals were made to asthma clinics and for mental health support. Where appropriate patients capacity was assessed to establish whether they required support from others in relation to decisions about their finances and treatment of their behalf.

Patient with palliative care needs were registered at the practice. Palliative patients received coordinated care from the same GP and their care and treatment was discussed at GP partner meetings.

Responsive:

There were specialist clinics in house for long term conditions. These clinics provided support to manage the patients specific medical condition including health promotions. For example, smoking cessation advice.

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

Patients with long-term conditions were seen at the practice and supported to manage their health, care and treatment. Clinicians in the practice signposted these patients to local support groups.

Our findings

Caring:

Specialist nurses supported patients with long term condition such as diabetes and respiratory disease by offering them advice, education and treatment through specialist clinics.

Effective:

Patients with long term conditions had ongoing support to manage their conditions. Patients over 85 years with long term conditions such as circulatory disease were supported by the practice. We saw ongoing monitoring and proactive care to ensure patients medical conditions were reviewed at appropriate intervals.

Responsive:

Patients with long term conditions had ongoing support to manage their conditions. Clinics for patients with long-term conditions were arranged to ensure patients had all aspects of their care and treatment provided in clinics for their conditions. For example, circulatory disease, HIV and Aids and palliative care.

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 had effective chaperone (a member of staff supporting a patient during intimate examinations) and safeguarding vulnerable children policies, which supported the needs of young people in the practice.

Our findings

Safe:

Safeguarding children and adults was important to the practice. There was a safeguarding lead. Staff knew the types of abuse, and the actions they needed to take if they suspected abuse. Information about patients identified at risk or families with concerns was reviewed and discussed at practice meetings.

Caring:

Vulnerable patients or anyone who required support during their consultations with a clinician could be supported by trained chaperones

Effective:

Children and young patients were treated in an age appropriate way. The practice consent policy offered advice and guidance to staff in relation to obtaining consent from children who had the capacity to make informed decisions about their care and treatment. Patients benefited from staff who knew how to respect their rights.

Additional services were arranged at the practice for mothers and baby. Practice nurses managed mother and baby clinics where information, guidance, and health checks were available.

There was a full programme of immunisations for children and young patients.

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

Patients who contacted the practice were able to have a telephone consultation with a GP. Extended hours from 7:00 am on Mondays gave patients in the working age category better access to GP consultation. Patient in this category were referred to other health care centres for blood tests to reduce their waiting time for these tests.

Our findings

Caring:

The appointment system was recently reviewed to ensure that it met the demands of the patients registered at the practice. Patients were able to contact the practice to discuss their medical condition with the GP during opening hours and when it was convenient to them. The GP would then advise the patient on any follow up action such as visiting the practice or collecting repeat prescriptions.

At the time of our inspection, patients were referred to other health care centres and hospitals for blood tests and to reduce the waiting times. A review of phlebotomist (a medical technician who takes blood samples from patients and performs basic laboratory tasks) hours was in progress An increase in the phlebotomist hours would reduce the waiting times for patients needing blood tests at the practice.

Responsive:

A senior partner told us the new appointment system was key to improving services for patients. Extended hours were available from 7:00am and audits of the appointment system showed telephone consultations was popular with working patients.

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

Patients in vulnerable circumstances had their needs met by staff who had a good understanding of their needs. For example, staff attended training to understand the needs of patients with learning disabilities.

Our findings

Caring:

Staff attended training to increase their awareness of the needs of vulnerable patients. For example, staff attended training to support them to meet the needs of patients with learning disabilities.

Responsive:

Patients with no fixed address were seen at the practice. Staff told us these patients were seen if an appointment was requested but rarely requested one. We were told a summary of their consultation was provided to the patient and their consent to share information with other practitioners was sought at the end of the consultation. Patients with no fixed address could provide information about their medical conditions to other healthcare providers in an emergency of if they moved locations.

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

Patients with medical conditions or symptoms related to the misuse of alcohol and drugs visited the practice and were referred to external support groups for additional support.

Our findings

Responsive:

The new system of telephone consultations meant patients with changing mental health needs were able to access support promptly when required

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	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 requirements relating to workers. People who use services and others were not protected against the risks associated with employing staff who had not been checked or had a risk assessment to ensure they were safe to work with vulnerable people. Regulation 21 (a) (i).

Regulated activity	Regulation
Surgical procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 requirements relating to workers. People who use services and others were not protected against the risks associated with employing staff who had not been checked or had a risk assessment to ensure they were safe to work with vulnerable people. Regulation 21 (a) (i).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 requirements relating to workers. People who use services and others were not protected against the risks associated with employing staff who had not been checked or had a risk assessment to ensure they were safe to work with vulnerable people. Regulation 21 (a) (i).