The Hadleigh Practice

Quality Report

Hadleigh House
20 Kirkway
Broadstone
Dorset
BH18 8EE
Tel: 01202 69226801202 692268
Website: www.thehadleighpractice.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a focused inspection of The Hadleigh Practice on 15 November 2016 to check whether the practice had made the improvements in providing care and services that were safe, effective and well-led. The practice was able to demonstrate that they had made the required improvements to meet the regulations. The practice is now rated as good for safe, effective and well-led services. The overall rating for the practice is now good.

We had previously carried out an announced comprehensive inspection at The Hadleigh Practice on 25 April 2016 when we rated the practice as requires improvement overall. The practice was rated as good for being caring and responsive and requires improvement for safe, effective and well-led. This was because blank prescriptions were not safely tracked by the practice and the practice had not acted on the recommendations of infection control audits. There were also gaps in the training which the practice considered necessary for staff and the security of clinical areas. During the 25 April 2016 inspection we found that fridge temperatures were being recorded, however when temperatures went out of the safe range for the storage of vaccines, this was not consistently acted upon. We also found that governance systems to adequately manage risks to patients and staff were not consistently followed through. Following our last inspection, we asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time. We received this on 22 August 2016. We revisited the practice on 15 November 2016 to check the improvements had been made.

Our key findings across the areas we inspected on 15 November 2016 were as follows:

- There was an effective system in place for reporting and recording of significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained in order to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The premises and equipment used by the practice were clean and secure.
- There were effective governance arrangements in place in order to monitor the quality and performance of the practice.

Summary of findings

This report should be read in conjunction with the full inspection report, which can be found at www.cqc.org.uk/

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is now rated as good for providing safe services. We found during this inspection that action had been taken by the provider and improvements had been made.

- There was an effective system in place for reporting and recording significant events. All staff were open and transparent and fully committed to reporting incidents and near misses.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is now rated as good for providing effective services. We found during this inspection that action had been taken by the provider and improvements had been made.

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff were supported to deliver effective care and treatment, through meaningful and timely supervisions and appraisals.

Are services well-led?

Good

The practice is now rated as good for being well-led. We found during this inspection that action had been taken by the provider and improvements had been made.

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective.

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	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

The Hadleigh Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector.

Background to The Hadleigh Practice

The Hadleigh Practice is located at Hadleigh House, 20 Kirkway, Broadstone, Dorset BH18 8EE. The practice is purpose built and based in an urban area of Poole. The practice provides services to patients living in the Broadstone and Corfe Mullen areas of East Dorset.

The practice provides services under a NHS Personal Medical Services contract and is part of NHS Dorset Clinical Commissioning Group (CCG). The practice has approximately 20,000 patients registered and is situated in an area of low deprivation and low unemployment compared to the averages for England. The practice population has a higher proportion of older patients and a lower proportion of working aged patients compared to the averages for England. A total of 52% of patients registered at the practice have a long-standing health condition compared to the national average of 54%.

The Hadleigh Practice has a branch surgery three miles away at Hadleigh Lodge, 216a Wareham Rd, Corfe Mullen, Wimborne BH21 3LN. The management of both locations is organised at The Hadleigh Practice, and staff work across both sites. Patients are able to make appointments at both locations. We did not visit the branch surgery as part of this inspection.

The practice has six male GP partners, three female GP partners and three male partners as well as one male and four female salaried GPs. Together, the GPs provide care equivalent to approximately 12 full time GPs over approximately 100 sessions per week across both sites. The GPs are supported by one full-time Nurse Practitioner, who is a non-medical prescriber. Six practice nurses and four health care assistants also provide a range of services to patients. Together the nurses are equivalent to just over six full time nurses. The clinical team are supported by a management team andsecretarial and administrative staff. The practice is a training practice for doctors training to be GPs and a teaching practice for medical students. At the time of our inspection, there were four GP registrars (trainee GPs) who were supported by the practice.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available between 8.30am and 12pm and again from 2pm to 6.30pm daily. Extended hours appointments are offered every Monday, Tuesday and Wednesday between 6.30pm and 8pm and twice a month on Saturdays from 8am until 12pm. The practice telephone lines and reception desk are open between 8am and 6.30pm. The Hadleigh Practice has opted out of providing out-of-hours services to their own patients and refers them to the out of hour's service via the NHS 111 service, or to the nurse-led Minor Injuries Unit in Wimborne, four miles away. Patients are advised of the out of hours arrangements via the practice website, and information displayed within the practice.

The practice offers a range of additional in-house services to patients including antenatal care, midwifery, ophthalmology, travel advice, cryotherapy, physiotherapy, sexual health services, joint injections and minor skin operations. The practice offers online facilities for booking of appointments and for requesting prescriptions.

On this inspection, we visited The Hadleigh Practice located at:

Hadleigh House

Detailed findings

20 Kirkway

Broadstone

Dorset

BH18 8EE

We previously inspected The Hadleigh Practice on 25 April 2016. Following this inspection, the practice was given an overall rating of Requires Improvement. A copy of the report detailing our findings can be found at www.cqc.org.uk

Why we carried out this inspection

We carried out an announced inspection of The Hadleigh Practice on 25 April 2016 where we rated the practice as requires improvement overall. Specifically, the practice was rated as good for responsive and caring and requires improvement for the areas of being safe, effective and well-led.

As a result of the inspection in April 2016, the provider was found to be in breach of regulations 12, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that blank prescriptions were not safely tracked by the practice and there was a lack of systems to adequately monitor the temperatures of fridges used for the storage of vaccines. Infection control procedures were not fully implemented and there was not sufficient security for clinical areas. There were also gaps in the training the practice considered necessary for staff. We also found a lack of governance systems to adequately manage risks to the practice, patients and staff.

The provider sent us an action plan in August 2016 detailing the changes they would make to comply with the regulations they were not meeting at that time.

How we carried out this inspection

We revisited The Hadleigh Practice as part of this inspection. We carried out a focused inspection based on the evidence observed during our visit and on information the practice provided to us prior to and during the inspection.

A CQC inspector visited the practice on 15 November 2016 to check the necessary changes had been made.

Good

Are services safe?

Our findings

Overview of safety systems and processes

At our last inspection, we found that blank prescription forms were not tracked to record how they were distributed within the practice. This was not in accordance with national guidance so that prescription usage can be identified when required.

On 15 November 2016, we found that the practice had updated the protocol for prescription security in August 2016. The protocol detailed which staff would have responsibility for actions to protect the security of prescriptions. Prescriptions were logged at the time of issue to each clinician. We found that prescriptions were stored securely when not in use, including at the end of each day. Blank prescription stationery was removed from printers in clinical rooms at the end of each day and stored securely. Clinical rooms were locked when not in use. We saw evidence that the practice had booked a contractor to install key pad entry door locks to clinical areas in December 2016. Staff we spoke to could explain the process for the safe tracking of prescriptions clearly. A member of the leadership team carried out 'spot checks' and a three monthly review of stock to ensure the process for safe storage was followed correctly.

At our last inspection, we found that the recommendations of infection control audits were not consistently followed. Non-clinical staff had not received regular annual training in infection control, which the practice considered to be mandatory. Monthly checks of the practice for infection control risks were conducted however; these were not always acted upon. We found the disposable curtains in clinical areas had not been replaced since July 2015. Guidance recommends that disposable curtains should be changed every six months.

On 15 November 2016, we found that all staff had received infection control training. All curtains in clinical rooms had been changed and were dated from May 2016 to August 2016. The practice kept a record and monitored when each curtain set required replacement; the next replacement was due to take place on the 24 November 2016. The practice kept a spare set of curtains in case of damage or obvious contamination that occurred prior to the date the curtains were due to be replaced.

Monitoring risks to patients

At our last inspection in April 2016, we found that vaccines were not consistently stored within

the correct temperature range. Temperature readings of fridges that store vaccines were taken and recorded on a daily basis. However, on more than one occasion, high readings (in excess of 8°C) and low readings (below 2°C) were recorded in one of the fridges without a satisfactory explanation or check to establish if this was an ongoing problem. The practice had a cold chain policy dated August 2015 which detailed how vaccines should be stored and managed. The policy stated that a cold chain audit would be conducted on an annual basis to review systems and processes for vaccines. However we found that this had not been conducted and practice staff had no knowledge of the audit. This meant the practice could not be reassured that vaccines were stored safely and were effective.

At our inspection on the 15 November 2016, we found that the practice had an effective system for the safe storage of vaccines. The practice had updated its cold chain policy in October 2016. This clearly stated the responsibilities and actions required from staff as well as the contact details for vaccine manufacturers in the event they needed to be contacted. We reviewed the twice daily temperature records for three fridges and found these to have been maintained in the correct temperature range. When a fridge was found to be out of temperature range, a reason for this was documented and immediately investigated to ensure this was not an on-going problem (acceptable reasons include stock taking or a busy vaccination clinic). The protocol stated what actions staff would need to take in the event of the fridge being out of temperature range. All fridges had been maintained and calibrated appropriately. We checked random vaccines in each of the fridges and found them to be in date, stored appropriately and fit for use. The lead nurse conducted three monthly audits on the storage of vaccines. The audit detailed the number of cold chain incidents, stock levels, general condition of the fridge and a summary of the temperature history of the fridges. This was feedback to the practice leadership team. The leadership team also conducted 'spot checks' of fridges to check the protocol was being followed correctly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective Staffing

At out last inspection on 25 April 2016, we found there were gaps in staff training. Not all staff had undertaken the training the practice considered to be mandatory for staff to enable them to carry out their role safely and effectively. We found not all staff had undertaken training in basic life support, infection prevention control, fire safety and safeguarding at the frequency the practice specified. For example, of 24 reception staff, 12 had undertaken infection prevention control training. Not all staff had received an annual appraisal.

At our inspection in November 2016, we found that the practice had updated their training policy in September 2016. This clearly stated the training required for staff and the frequency with which this must occur. The practice had sought guidance from their local medical council regarding what training would be most appropriate for staff. Training for all staff included basic life support, safe-guarding adults and children, health and safety, information governance, infection control, fire safety and manual handling. Training was offered via an on-line training package and staff were given protected time to complete training at work, or were recompensed if they chose to undertake training in their own time. The importance of undertaking and completing training had been highlighted to staff by the practice leadership. We reviewed the training records for all staff and found that all staff had completed the training considered to be mandatory by the practice at the required frequency. The leadership in the practice reviewed the training status of all staff on a monthly basis to ensure training remained up to date.

The practice leadership had a system to ensure all staff received an annual appraisal, and when the next appraisal was scheduled. We found that all staff had received an appraisal, with the exception of two staff who were on long-term absence.

At our inspection in November 2016, the practice also shared with us the progress they had made to other areas following our last inspection:

- The ophthalmology service offered by the practice continued to expand. Since our inspection in April 2016, the practice has accepted referrals from a local hospital. We saw unverified data that showed the number of referrals dealt with by the service had increased by 11%. In 2015-16, an additional 106 patients were seen and treated locally by the service.
- In Autumn 2016, the practice decided to offer 'walk-in' flu vaccination clinics. This meant that patients did not have to pre-book appointments to receive the vaccine. We saw positive feedback from patients regarding the new system. The practice showed us data, which has not been externally verified, which shows the practice had so far vaccinated 71% of at risk patients with several clinics still to run. This compared favourably to a figure of 66% for the 2014-2015 flu season.

Are services well-led?

Good

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

Our findings

Governance arrangements

At our last inspection on 25 April 2016, we found that significant events were reported and investigated, however, actions from meetings where significant events were discussed were not always clearly documented. Details of the actions needed the personnel who had responsibility for these actions and the time frame for these to take place were not recorded. This meant the practice could not be assured that learning from significant events was implemented so improvements were made to care of patients.

On 15 November 2016, we found that the practice had an effective system in place to investigate and learn from significant events. The practice had updated the significant event protocol in October 2016. The significant event reporting form had been updated in October 2016 so immediate actions following the event were clearly documented. The practice held a formal significant event meeting every quarter which was attended by all GPs and representatives from the management, nursing, reception and administration teams. Staff who were external to the practice were also invited if the meeting had relevance to them, for example, health visitors or community nurses. At each meeting, actions from previous significant events were reviewed to ensure these had been completed. Each new significant event was presented as a detailed case, and required actions and learning points identified. Learning was shared to staff through the team representatives, verbal updates from management and via a significant events bulletin. All staff were required to confirm they had received, read and understood the contents of the significant events bulletin. The practice management kept a summary of the actions required from significant events and monitored these to ensure progress and completion. An annual significant event meeting was planned to analyse significant events for trends.

At our last inspection in April 2016, we found that personal staff information was not kept securely. Staff information was held in a room that was accessible to the public. A sign on the door advised that the door should be kept closed at all times, however, on inspection we observed the door to be open at times. The practice could not therefore be reassured that unauthorised access to the room was prevented.

At our inspection on 15 November 2016, we found that the practice had an effective system to manage security. Staff information was kept securely. A key pad entry lock had been fitted to the door of the room where this information was held, which limited access to authorised personnel. We found the lock to be in good working order. The practice had also been successful at receiving funding to upgrade all of the locks to clinical areas. We saw evidence that locks to clinical areas would be replaced by key pad entry locks in December 2016. In addition, the practice had updated its Information Governance Policy in August 2016. This detailed the responsibilities of all staff.

At our inspection in November 2016, the practice also shared with us the progress they had made to other areas following our last inspection:

- The practice had designed a new system to support the handling and investigation of complaints. The practice added a summary record for each complaint it received. This ensured that the theme of the complaint was captured and that each action was clearly documented. This meant the practice had a clear audit trail with regard to each complaint.
- The practice identified that they wanted to increase the number of health checks offered to patients who were also carers. A new invitation letter to patients on the carers register had been designed to offer a physical health and well-being check, as well as ensure up to date records regarding carers were kept. The letter will be sent to patients in December 2016.