Southbourne Surgery

Quality Report

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Date of inspection visit: 21 May 2015
Date of publication: 01/10/2015

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Southbourne Surgery on 21 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice inadequate for providing safe services and required improvement for providing well-led services. The practice required improvement for providing services for the population groups of older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). The practice was rated good for providing effective, caring and responsive services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents, however there were no minutes of practice meetings available to show that learning from incidents was discussed with staff.
- The practice used innovative and proactive methods to improve patient outcomes, working with other providers to share best practice, for example, they were part of a project that looked at care to their most vulnerable patients using a multi-disciplinary approach.
- Patients were very happy with the care they received and said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice held a flu vaccination day on a Saturday that raised patient awareness and encouraged patients to get vaccinated. Patients also had their pulse checked and GPs had identified at least one patient who needed treatment for atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).

Summary of findings

- Extended hours surgeries are offered daily between 7.30am and 8am and these appointments are pre-bookable for patients who are unable to attend during routine surgery hours due to other commitments.

The areas where the provider must make improvements are:

- Ensure that policies and procedures relating to health and safety are updated and implemented with risks being identified, documented and managed, including managing risks from fire.
- Ensure that Patient Group Directions are implemented; ensure that emergency medicines are available and that procedures are in place to check emergency medicines are in date for use and that there is a record of these checks available.
- Ensure that a chaperoning policy is in place, and that staff are provided with effective training and guidance on chaperoning procedures to safeguard patients.
- Ensure that policies and procedures for infection control and legionella management are implemented and audited.
- Ensure that all equipment used has appropriate maintenance checks and is suitable for use.
- Ensure that staff are trained to support patients in the use of equipment such as the stair lift.

In addition the provider should:

- Ensure that practice meetings are documented and include analysis of significant events and any lessons learned.
- Equipment such as couches should be identified and replaced when no longer suitable for use
- Provide staff with documented policies and procedures regarding consent to care and treatment.
- Provide updated information for patients about how to make a complaint.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns and to report accidents and near misses. Incidents were reviewed and information was shared at GP meetings but minutes of meetings were not available to evidence that significant events were discussed with other staff groups. Risks to vulnerable patients were identified and managed but the practice did not have documented processes in place to assess other risks, such as those relating to equipment and premises. Some policies and procedures relating to health and safety and infection control had not been updated or implemented.

Are services effective?

Good

The practice is rated good for providing effective services. Data from the Quality and Outcomes Framework for period 2014-2015 indicated that the practice was meeting patient's needs. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned using a multi-disciplinary approach when required. Staff had received clinical training appropriate to their roles and staff had appraisals and development plans in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that the patients rated the practice higher than others for all aspects of care by GPs and nurses. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the support services available, especially information for carers, was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group by attending meetings. Whilst some patients commented that they found it difficult to make appointments with a named GP, there was continuity of care and patients were seen on the same day if their need was urgent. Information about how to complain was available to patients and the practice responded appropriately to complaints received. Some information available to patients about how to make a complaint to other organisations was out of date and referred to organisations that were no longer operational.

Summary of findings

Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and strategy that all staff were aware of but these were not clearly documented. There was a leadership structure and staff felt supported by management and were clear about whom to approach if they had concerns. The practice had a range policies and procedures but some of these needed to be reviewed and had not been fully implemented. The practice said they held clinical meetings and staff meetings but there were no records available for any meetings that had taken place in the last two years. Staff received inductions and received appraisals annually.

Requires improvement

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

Requires improvement

The practice is rated as requires improvement for the care of older people. This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. Nationally reported data shows that outcomes for patients were good for conditions commonly found in older people. The practice had a nominated GP who led on elderly care and provided care to patients in 27 care homes and four nursing homes. GPs visited care homes and nursing homes to provide annual reviews, medication reviews and care plan reviews. Care homes had a separate contact number for urgent clinical enquiries. The practice was a pilot practice for a virtual ward project that aimed to improve coordination of care for older patients identified as at risk of unplanned hospital admissions.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. GP's had lead roles on chronic disease management and were supported by nurse led clinics in asthma and diabetes. Patients had a structured annual review to check that their health and medication needs were being met. Home visits were available when needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. There were systems in place to identify young people who were at risk, for example, young carers were recorded on a register of vulnerable patients. Staff worked with other services to review care to children who had a high number of A&E attendances. Immunisation rates were higher than the Clinical Commissioning Group averages for all childhood immunisations. Staff told us that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and there was a specific notice board to provide health advice to patients with children. Children who were ill were seen on the same day and the practice worked jointly with health visitors and community midwives.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working age people (including those recently retired and students. This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. The practice offered appointments from 7.30am to 6.30pm to meet the needs of the working age population. The practice offered online services such as appointment booking and ordering repeat prescriptions. The practice offered a range of health screening and family planning services that reflected the needs of this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. The practice held a register of patients living in vulnerable circumstances and patients were identified as vulnerable on the practice's electronic record system. The register included patients with learning disabilities, who received an annual health check. The practice provided care to homeless patients, who were living at a temporary housing project. The practice worked with multi-disciplinary teams to co-ordinate the care provided to vulnerable patients, including patients at risk from domestic violence. The practice had information available about support groups and voluntary organisations, including those to support carers. There was a safeguarding lead and staff had received level 1 training in safeguarding children and had received in-house training in safeguarding vulnerable adults, however all GPs had not been trained to the correct level in safeguarding children.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). This is because the service is rated as inadequate for providing safe services and requires improvement for providing well-led services to all population groups. Data from the Quality Outcomes Framework for 2013/ 2014 indicated that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the record in the preceding 12 months was lower than the national average. 2014/ 2015 data also indicated that targets relating to mental health had not been met. The practice provided care to 52 patients who lived in a supported living complex for people experiencing poor mental

Summary of findings

health, including depression, substance misuse and schizophrenia. Multi-disciplinary team meetings were held every five weeks. The practice worked with Southbourne and Christchurch Community Mental Health Teams and made urgent referrals to the duty worker at the Community Mental Team when required.

Summary of findings

What people who use the service say

The practice had participated in the national Friends and Family test. We saw eight responses to the tests and all of the responses indicated that the patient would recommend the practice to their friends and family. The practice had not completed a satisfaction survey in the last 12 months.

We reviewed data from the National GP patient survey and found that the practice scored higher than the national average in almost all areas reviewed by the survey. Patients were particularly happy with the care provided to them by GPs and nurses.

There were 4 reviews of the practice on the NHS Choices website since 2010, of which 3 commented on the high quality service at the practice.

We received 24 comments cards from patients who use the service. The cards had been left in the waiting room in the two weeks preceding our inspection. All of the 24 cards were positive and patients commented on the good services provided by the practice and the high quality care provided by staff. Patient comments indicated that staff were helpful, professional, provided good treatment and that the practice was clean and safe. Patients felt involved in their care and told us they were treated with dignity and respect. One comment card indicated that it was difficult to book an appointment.

There was information about the patient participation group (PPG) on the practice website. A patient from the PPG told us they used to meet regularly and had arranged for a suggestions box to be put into the practice. We spoke to a member of the PPG who told us that the group had declined in numbers, they were looking to recruit new members and that staff at the practice were always polite and courteous.

We spoke to seven patients during our visit. Patients told us that they were happy with the care provided by GPs and nurses and that staff listened to them and involved them in their care. They told us that care was not rushed. Three patients indicated that they sometimes have to wait for an appointment with the GP of their choice but if they needed urgent treatment they could get an appointment on the same day and we were told that children were prioritised and given appointments on the same day. Patients with whom we spoke knew how to complain about the practice if they needed to.

A patient told us that a GP visited them at home even though did not ask for the home visit. They felt the GPs actions had prevented them being admitted to hospital on that occasion.

Areas for improvement

Action the service MUST take to improve

- Ensure that policies and procedures relating to health and safety are updated and implemented with risks being identified, documented and managed, including managing risks from fire.
- Ensure that Patient Group Directions are implemented; ensure that emergency medicines are available and that procedures are in place to check emergency medicines are in date for use and that there is a record of these checks available.
- Ensure that a chaperoning policy is in place, and that staff are provided with effective guidance on chaperoning procedures to safeguard patients.
- Ensure that policies and procedures for infection control and legionella management are implemented and audited.
- Ensure that all equipment used has appropriate maintenance checks and is suitable for use.
- Ensure that staff are trained to support patients in the use of equipment such as stair lifts.

Action the service SHOULD take to improve

- Ensure that practice meetings are documented and include analysis of significant events and any lessons learned.
- Equipment such as couches should be identified and replaced when no longer in use.

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- Provide staff with documented policies and procedures regarding consent to care and treatment.
- Provide updated information for patients about how to make a complaint.

Southbourne Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a second CQC inspector and a specialist advisor in practice management.

Background to Southbourne Surgery

The practice provides treatment to 8718 patients and is located at 17 Beaufort Road, Southbourne, Bournemouth, Dorset, BH6 5BF.

The practice operates from purpose built premises that are approximately 20 years old. The practice has seven consultation rooms, a treatment room, a triage room and a small examination room.

The practice has five GP partners and a GP registrar who is a qualified doctor training to become a GP through a period of working and training in a practice. Also there is a foundation doctor (FY2) who is a grade of medical practitioner undertaking the Foundation Programme. A two-year, general postgraduate medical training programme which forms the bridge between medical school and general practice training. Five out of the seven doctors are female and two are male.

There is a practice manager, assistant practice manager, four practice nurses, a healthcare assistant, and reception and administrations staff.

The district nursing team and health visitors are based in the building and the practice has access to community midwives. A community physiotherapist works at the practice to treat patients from the practice and patients from other nearby practices.

The practice has a General Medical Services contract (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract).

There are 1749 patients over the age of 65 and the practice has a high number of patients with long-term conditions.

The practice is open between 7.30am and 6.30pm Monday to Friday. Extended hours surgeries are offered daily between 7.30 am and 8am and these appointments are pre-bookable for patients who are unable to attend during routine surgery hours due to other commitments.

When the practice is closed patients are advised to access a 111 service, with out of hours care provided by South West Ambulance Service.

The provider is registered to provide the regulated activities of surgical procedures, diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services and family planning at the location.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received information from other organisations such as NHS England, Healthwatch and Dorset Clinical Commissioning Group. Prior to the inspection, we asked patients to share their views by completing comments cards for us to review.

We carried out an announced visit on 21 May 2015. During our visit we spoke with a range of staff including GPs, the practice manager, practice nurses, healthcare assistants, receptionists and administration staff. During the visit we observed how people were being cared for and talked with patients and family members. We reviewed the premises to see if they were safe and accessible. We reviewed documentation, policies and procedures. We reviewed incidents and complaints to see if they had been investigated and acted upon.

We asked the following five questions:

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

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

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

On completion of the inspection we reviewed our findings and summarised them as part of this report.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. The practice reported incidents and national patient safety alerts as well as comments and complaints received from patients. The practice had a nominated lead for health and safety and we saw that incidents had been reported and action had been taken as a result.

We looked at safety records, incident records, policies and procedures. We were shown evidence that a new health and safety pack had been ordered as the practice had identified this as an area for improvement.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 13 significant events that had occurred over the last three years. Each of the 13 significant events had been discussed with the individuals involved and we were told that the event was discussed at doctors meetings and that information was disseminated to all staff. However when asked for an example of the minutes of the meetings we were only shown one set of minutes from a meeting in 2012, where a significant event had been discussed.

National patient safety alerts were passed to practice staff for action. Alerts were dated, signed and had action taken annotated on them prior to filing. We saw an e-mail that had been sent to all GPs and nursing staff on 29 January 2015 about an alert raised by NHS England. They had received alerts regarding scarlet fever and Ebola. A copy of alerts relating to patients was held at reception.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received training in safeguarding children to level one and had completed learning in safeguarding adults provided by the practice lead. Reception staff told us that they had completed safeguarding training on-line and that and received reminders about the types and signs of abuse.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained to level three in safeguarding children and had completed e-learning on adult safeguarding. Staff knew who the safeguarding lead was and identified that they would report any safeguarding concerns to the named lead.

The practice system highlighted vulnerable patients using an alert system, including those adults and children at risk from domestic violence. The system linked children with their parents and alerted staff to review vulnerable children if information was received about the parents. Children who did not attend outpatient appointments were followed up and discussed with the health visitor.

The safeguarding lead attended serious case review meetings and shared information from these meetings with other GPs. The feedback from a serious case review in April 2014 was discussed with GPs at an educational meeting on 9 June 2014. We saw a certificate for training provided at this meeting, which included neglect, the threshold for referrals, domestic violence and feedback from serious case reviews.

Telephone numbers for local safeguarding teams were displayed in consulting rooms and there was a link on desktops to the local safeguarding board website, including diagnostic advice, safeguarding tools and guidance about information sharing. There was active engagement in local safeguarding procedures and effective working with other organisations. The safeguarding lead shared an example of child who had a high level of A&E attendances and how they had worked jointly with health visitors and the child protection officer.

There was no chaperone policy and there were no signs in reception and no information on the practice website that indicated patients could request a chaperone, however there were signs in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and healthcare professionals during a medical examination procedure). All nursing staff, including health care assistants, acted as a chaperone. We were told that reception staff would be asked to chaperone if nursing staff were not available. Staff carrying out chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who

may be vulnerable). We were also told that chaperones had been instructed to remain outside the curtain during examinations. This did not ensure that patients or GPs were protected as chaperones were not witness to the examination. There was no written protocol to guide staff for their role as chaperone.

Medicines management

We checked medicines stored in treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Fridge temperatures were checked and recorded on a daily basis. There were systems in place, including weekly stock reviews, to ensure that medicines were within their expiry date and suitable for use.

There were systems in place for the management of prescriptions and repeat prescriptions could be ordered electronically. All prescriptions were reviewed and signed by a GP prior to issue. A record was held of all prescriptions sent directly to the pharmacy and a signature was obtained for each prescription to confirm their receipt by the pharmacist. Blank prescriptions were tracked through the practice and stored in an unlocked cupboard in a locked room.

We reviewed a prescribing audit that demonstrated an improvement in prescribing across a broad spectrum of medicines but a GP told us that the rates of hypnotics issued at the practice were higher than average and that they were under review . We were told that medication was discussed at staff meetings and saw GPs learning record indicating that the medicines lead had provided training to staff on 26 February 2014.

We were told that the nurses used Patient Group Directions (PGDs) to administer vaccines in line with legal requirements and national guidance; however PGDs were not in place. We saw that the practice had started to rectify this situation but were given conflicting information that prescriptions were generated for all vaccinations given and these were signed by a GP after the vaccination had been given or that the GP declared in the Red Book (child's health record) that the child was fit for the immunisations. The procedure for administering vaccinations was not clear and Patient Group Directions were not in place at the time of our visit for vaccinations given.

The EMIS computer system included a system for highlighting drug alerts. When an alert was received from the Medicines and Healthcare Products Regulatory Agency, it was passed to a named GP who was the lead on medicines management. The GP actioned the alert, recorded information on the computer system and highlighted information to colleagues. We reviewed a medication alert and saw that the practice had reviewed all patient records and taken appropriate action to reduce the risk to patients.

The register of significant events identified two incidents regarding the management of medicines in 2014. We saw that the record had identified learning outcomes from the incidents but there were no records to show how that learning outcomes had been shared.

Cleanliness and infection control

We observed the premise to be clean and tidy. A cleaning contract was in place and there was a daily cleaning list for the cleaning of the treatment rooms. We were told that if there were any concerns regarding contract cleaning these were discussed with the company by telephone. Patients told us that they found the practice clean and tidy and had no concerns about cleanliness and infection control.

An infection control policy and supporting policies, including hand hygiene were in place but had no date for review on them. Infection control procedures did not identify how staff would comply with the Code of practice on the prevention and control of infections, for example, there was no annual infection control statement. The infection control policy identified that infection control audits should be completed annually but there were no completed audits or documented checks in place. There was a separate policy for the safe use of sharps but the policy did not indicate action to be taken in the event of a sharps injury. we were told this information was available on the practice computer system.

The practice identified a lead for infection control but there was no record that the lead had undertaken further training to enable them to provide advice on practice infection control and carry out staff training. Training records indicated that infection control training had been provided to four staff in the last three years.

Notices about hand hygiene were displayed in staff and patients' toilets. Hand washing sinks with liquid hand soap, hand gel and paper towels were available in treatment rooms. Hand sanitiser was at the entrance to the building. Toilets had separate bins to dispose of general waste,

sanitary waste and nappies. Examination rooms contained disposable cleaning wipes, gloves, orange bags used to dispose of healthcare waste, sharps bins, hand gel and paper towels. Floors in clinical areas were wipe clean and sealed at the edges. Carpets were clean and in good repair. Disposable curtains were in place and had been changed on 19 April 2015. Disposable instruments were used for minor surgical procedures. We saw two consulting rooms, where examination couches had been covered with a disposable cover. The fabric that covered the couch was split and the disposable cover was permeable. This meant that the couch was not protected from spillages and was an infection control risk.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). There was a legionella risk assessment dated 2009 but no checks had been completed on water systems. The risk assessment we were shown referred to another medical practice.

Equipment

There was equipment in place to carry out diagnostic examinations and treatments. We saw equipment logs and maintenance records that indicated that equipment had been tested and maintained in January 2015. All portable electrical equipment was routinely tested and displayed stickers indicating that the last testing date was May 2015.

The practice had an electrocardiogram (ECG) machine that had been tested by an external organisation but had been declared faulty. We found the machine was still in use. A member of staff told us that the ECG trace was not always clear to read and the test sometimes had to be repeated. The practice could not be assured that the reading they received was accurate. GPs checked all ECG results before the patient left the practice. We were advised that the ECG machine had later been withdrawn from service. We found equipment to monitor blood pressure that was due for testing in January 2015 and testing had not been done.

Staffing and recruitment

The practice had a very thorough recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed three staff files and they contained evidence that appropriate recruitment checks had been undertaken prior to employment, for example, proof of photographic identification, references, checks with the appropriate professional body and checks through the Disclosure and Barring Service checks for clinical staff.

The practice identified that in the past two years, two GPs had been on maternity leave in each year and one GP had been on long term sick leave. We were told that they were currently understaffed by eight GP sessions per week due to two GPs having left the practice but had recruited a new partner to start work at the practice in the near future. The practice used locum staff that were booked through an agency, known to the practice and supported by a GP partner. GP partners reviewed blood tests and referrals for locum staff and reviewed their clinical practice. We saw a folder that provided information for locum staff but some information in the folder was out of date and new information had not been added to the file since August 2013.

Administration staff told us that they worked together to manage holidays in order to ensure the practice had cover at all times.

Monitoring safety and responding to risk

The practice had a range of systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Checks were completed on medicines management, staffing, dealing with emergencies and equipment. A Health and Safety policy was available in the staff handbook but the policy had not been updated since 2008. Staff told us they had received training in health and safety in 2014. Some staff had received on line and in house training in Health and Safety but this was not recorded on the staff training matrix, which indicated that only one member of staff had received Health and Safety training in the last three years. A health and safety policy was in the staff handbook had not been updated since 2008. There was some Health and Safety information displayed to staff and there was a nominated lead for health and safety. We were shown evidence that the practice had recognised this as an area of weakness and had ordered a new health and safety information pack.

The practice did not have risk assessments or a risk register in place. There were two stair lifts in place and patients had to position themselves onto another seat on a half landing in order to access the first floor. There was a sign that

indicated that patients used the stair lift at their own risk but could obtain assistance from staff. Use of the stair lift had not been risk assessed and some staff had not received training to assist people in using the stair lift.

There were systems in place to support patients who became acutely ill. Children and adults who required emergency appointments were seen on the same day and GPs carried out home visits if patients could not access the surgery. Antenatal support was available for patients with Bournemouth midwives and this included assessment of reduced foetal movement and provided support to patients who had experienced a miscarriage. The practice worked with Southbourne and Christchurch Community Mental Health Teams and urgent referrals were seen by the duty worker from the Community Mental Health Team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff told us that they received training in medical emergencies annually and we saw evidence that training had been provided in cardiopulmonary resuscitation in October and November 2014. Emergency equipment was available, including access to oxygen and an automated external defibrillator (used in cardiac emergencies). The kit contained an algorithm (flow chart) on how to manage anaphylactic reactions in children and adults and there was a separate meningitis kit and a guide for the management of meningococcal sepsis. We looked at a report for a significant event that had occurred in May 2015, where a patient had collapsed. The report indicated that staff had acted appropriately and in line with their training. Staff told us that staff had worked together to ensure the privacy and dignity of the patient and the defibrillator was used with a positive outcome. The practice concluded that whilst training was effective, more scenario based training would be beneficial.

Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew their location. The National Resuscitation Council Guidelines in primary care were available and the emergency kit was checked monthly by the nurse. Documented checks indicated that the kit had not been checked in February 2015. There was a system in place for re-ordering medicines that were near their expiry date but we found a benzylpenicillin injection (a penicillin injection that is used to treat infections such as meningitis) had expired in February 2015. A protocol for the management of emergency medication was available which identified a lead for the management of emergency medicines however the medicines listed on the protocol did not match medicines available in the medicines box. The practice did not have any Glyceryl Trinitrate spray and Glucogel stored with the emergency kit but this we were told that this was stored in a treatment room and would need to be accessed separately in an emergency. The practice held other emergency medicines as part of the emergency kit that did not appear on the emergency medicines protocol and was not on the emergency medicines checklist.

There was a business continuity plan to deal with the range of emergencies that may impact on the daily operation of the practice. There was a fire policy available but a fire evacuation drill had not been undertaken. The fire assembly point was signposted and fire-fighting equipment was tested in November 2014. The practice did not have staff trained to act as fire wardens.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with could outline the rationale for their approach to treatment. They were familiar with best practice guidance and guidance from the National Institute for Health and Care Excellence (NICE). GPs attended an update course that covered changing guidance and cascaded information to colleagues. Guidance was available on computer desk tops; a GP had a link to NICE guidance on their mobile phone and received guidance updates. NICE guidance was discussed at hospital based educational sessions and guidance was disseminated to nurses by the practice manager or senior nurse.

Staff carried out assessments on patients in line with national and local guidelines. GPs explained that care was planned to meet identified needs and patients were reviewed at required intervals to ensure that their treatment remained effective, for example, patients with diabetes had regular health checks, however the data from the Quality and Outcomes Framework (QOF) for 2013/ 2014 indicated that the practice indicators for the management of diabetes were lower than the national average in all areas. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The percentage of patients with diabetes on the register, who had a record of an albumin: creatinine ratio test in the preceding 12 months was 76.65% compared to the national average of 85.97% (This test is used to screen for the early detection of kidney disease occurring as a complication of diabetes). Patients who needed to be reviewed for diabetes in their own home were reviewed by the GP as there were no community nurses that were trained to carry out reviews. There was some improvement in QOF data for diabetes management in 2014/ 2015.

The GPs led in specialist areas such as accident and emergency admissions, elderly care, diabetes, endocrinology, asthma, dermatology, women's health, cerebrovascular disease, coronary heart disease, minor surgery and safeguarding. Practice nurses supported GPs in work with the management of asthma, chronic obstructive pulmonary disease (COPD) and diabetes (COPD is a name given for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease). Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Nurses told us that they would ask GPs to review patients straight away if they were concerned about the patient. GPs had a one hour educational meeting each month which covered a range of educational topics including discussing current clinical cases and we were told that this information was recorded in individual learning records. Meetings were not minuted but a summary of the meeting was recorded on a spreadsheet however this record did not include details of the cases discussed.

The practice identified patients that were at a high risk of admission into hospital and were vulnerable using a virtual patient ward. (Virtual wards aim to prevent unplanned admissions by using the systems of a hospital ward to provide multidisciplinary case management in the community and for people being cared for stay in their own homes throughout their illness). Multi-disciplinary meetings and multi-disciplinary care plans were documented in patient records and shared with emergency services. If patients were discharged from hospital, the discharge letter was passed to the named GP, who would review their medication and contact the patient to review their care needs.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of the patient's age, gender, race and culture as appropriate. A GP discussed ensuring equality of access to care.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. This included family planning, minor surgery and medicines management. Procedures were audited to ensure that GPs were providing contraceptive implants and the insertion of intrauterine contraceptive devices (IUCDs) in line with their registration and NICE guidance. The family planning lead provided a record of implants and IUCDs fitted, confirmed that there were no complications and

Good

Are services effective?

(for example, treatment is effective)

provided evidence that both GPs who fitted the implants and IUCDs had received appropriate up to date training. The family planning lead attended update training on an annual basis.

A GP carried out minor surgery in accordance with NICE guidelines. If needed patients could be fast tracked to hospital for assessment and treatment. We reviewed an audit on minor surgical procedures that had been undertaken between 1 April 2013 and 31 March 2014. The practice completed 74 minor surgical procedures, and biopsy samples were sent to the laboratory for testing to see if they were malignant or to identify what the tissue was made up of. Reports were received regarding all samples that were sent for testing. There were three post procedure wound infections recorded, were patients excision wounds had become infected post-operatively. A second audit cycle was undertaken between 1 April 2014 and 31 March 2015. This audit cycle confirmed that 63 minor surgical procedures were undertaken. The practice had also received histology reports for all samples sent for testing but one histology record had been received but had not been recorded in the patient's notes. There had been an increase in the number of patients who had obtained an infection post-operatively to four patients The practice had identified learning from the audit to ensure that all histology reports were recorded in the patient's records and to ensure that infection and complication rates do not rise further. However, there was no further information or trends analysis regarding complication and infection rates and no specific actions as to how these could be reduced.

We saw that QOF data for 2013/ 2014 indicated that the number of Cephalosporin's and Quinolones (types of antibiotics) prescribed was slightly higher than the national average. This had led to an audit of antibiotic prescribing which was completed in February 2015. This audit reviewed GP prescribing and their adherence to the antibiotic prescribing formulary. The audit was completed over two cycles and linked the prescription to the diagnostic condition to be treated to identify concordance with prescribing guidance.

The practice used information collected for the QOF to monitor outcomes for patients; 2013/2014 indicated that the practice obtained 84.3% of the total points available. This was lower than that the national average of 94.2%. Data for 2013/ 2014 indicted the following:

- The percentage of patients with hypertension having regular blood pressure tests was lower than the national average.
- The number of patients with mental health related illness who did not have a record of alcohol consumption in the preceding 12 months was significantly lower than the national average.
- QOF indicators for the management of patients with dementia were higher than the national average.
- Vaccinations for children were higher than the national average across all areas
- The percentage of women aged 25 or over and who have not attained the age of 65 whose notes recorded that a cervical screening test had been performed in the preceding 5 years was higher than the national average.

The practice was aware of areas where performance was not in line with national figures and had taken action to rectify this, resulting in a higher level of QOF points being attained in the last year. In 2014/ 2015 the practice had obtained 96.2% of the total QOF points available.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. We spoke to trainee GP who told us they had an allocated trainer for each session, have additional time to see patients and felt that their level of supervision was appropriate. Staff spoke positively about the culture of the practice around improving outcomes for patients and told us that they were well supported by GPs but nurses did not attend clinical meetings.

Data for 2013/ 2014 indicated that the prescribing rates for some types of antibiotics which were slightly higher than the national average this had led to an audit being undertaken. GPs were also aware that the number of hypnotics prescribed was slightly higher than the national average and had agreed to review this at the next clinical meetings. Repeat prescribing was done in accordance with national guidelines and the computer system alerted staff if a patient who had requested a repeat prescription had not been reviewed by the GP. The IT system also identified alerts relating to medicines. We saw that after an alert had been received, the GP lead for medicines had reviewed patient records and taken appropriate action by entering the alert onto the computer system. A GP told us that

Good

Are services effective?

(for example, treatment is effective)

multi-disciplinary care plans that were in place for the most vulnerable patients also led to regular reviews of their medication and had improved the work of the community matron.

The virtual ward project included reviewing patients who received end of life care at multi-disciplinary team meetings. Patients had a multi-disciplinary care plan in place that included any do not resuscitate orders; this information was shared with emergency services and out of hours services. Care provided to patients who were receiving end of life care was recorded and available for analysis.

The practice had lists of patients with learning disabilities and patients with long term conditions, who received regular reviews by nurses and GPs. Patients with long-term conditions, such as diabetes and COPD who could not attend the practice, was reviewed by the GP in their homes.

The practice had a nominated GP who led on elderly care and provided care to patients in 27 residential care homes and four nursing homes. GPs visited care homes and nursing homes to provide annual reviews, medication reviews and care plan reviews. Care homes had a separate contact number for urgent clinical enquiries and this meant that staff could contact the practice directly for clinical advice without having to go through the appointments system

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending some mandatory training courses such as annual basic life support and GPs were working towards completing safeguarding children training to level 3 but health and safety training for some staff was not recorded as being undertaken.

We noted a good skill mix amongst the GPs who had specific training to lead in areas such as family planning, minor surgery and emergency care. A GP told us that he worked in the accident and emergency department at the local hospital for one session each week in order to keep his skills in emergency medicines updated. GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff undertook annual appraisals that identified learning needs. We reviewed staff files for a member of staff who had their probationary period extended for three months and an additional training plan put in place. The practice was a training practice and a trainee doctor was allocated longer appointments with patients and was supported by a senior GP, whom they could go to for advice.

Staff had job descriptions outlining their roles and responsibilities and they had been given additional training to fulfil these duties, for example nurses had completed training in vaccinations and cytology and those who had been given additional roles in the management of diseases such as asthma, diabetes and chronic obstructive pulmonary disease had additional qualifications or training for that role.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood tests, X ray results and letters from the local hospital including discharge summaries, out of hours GP services and the 111 service both electronically and by post. They were passed to the named GP for review on the day that they were received. A GP told us that the longest that results would wait for action was over the weekend and if the results were urgent then they would request that they were telephoned through, even if they were clear. In the case of a significantly abnormal result the hospital laboratory would always telephone the practice to alert them to take immediate action.

Discharge summaries were received by the GP, who completed a medication review. The GPs used an electronic tasking system to identify any actions required. Staff we spoke with understood their roles and felt that the system worked well. There were no instances identified within the last year where results or discharge summaries were not followed up.

Emergency admission rates for the practice were lower than the national average at 6.28 emergency cancer admissions per 100 patients on the disease register compared to the national average of 7.4. The number of emergency admissions for 19 ambulatory care sensitive

conditions per 1,000 of the population was 11.6 compared to the national average of 13.6 (ambulatory care sensitive conditions are conditions for which effective management and treatment should prevent admission to hospital). The practice had a process in place to follow up patients discharged form hospital to review their care.

Multi-disciplinary team meetings were attended by care home staff, social workers, district nurses and palliative care nurses. Systems were in place to review children on the at risk register and patients who were at risk of domestic violence, multi-disciplinary team meetings were held.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a system in place to share multi-disciplinary care plans and records for patients' palliative care with emergency services. Information about patients' do not resuscitate status was also shared with the out of hours care provider.

The practice had systems in place to refer patients to hospital and referral letters were actioned by medical secretaries. Patients used the choose and book system to book all appointments.

The practice used the practice computer system to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were trained to use the system and training was provided as part of the induction process. The system enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that care records had been audited to assess the completeness of the records and records for locum staff, including referral letters were audited.

Consent to care and treatment

We found that clinical staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. A GP told us that they had received training in the Mental Capacity Act and had a link to the Mental Capacity Act toolkit on their computer desktop. Staff discussed how they had used the best interest process to support a patient to make a lasting power of attorney decision. The practice manager had completed mental capacity act training on 29 February 2012 and other staff had completed this as part of the safeguarding training.

Patients who were vulnerable, including those with learning disabilities, were supported to make decisions through the use of care plans, which they were involved in agreeing. Care plans were reviewed at multi-disciplinary meetings that were held every five weeks or if a patient had been discharged from hospital. When interviewed staff gave examples of how a patient's best interest was taken into account if a patient did not have capacity to make a decision and discussed a patient where the best interest process had been used to admit a patient into hospital.

Staff demonstrated a clear understanding of the Gillick competency test (these are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The practice had a template to record consent around Gillick competence.

The practice did not have a specific policy for documenting consent but there was a consent form available for recording consent for specific intervention, for example, minor surgical procedures. The consent form included information about relevant risks, benefits and possible complications of the procedure. A patient's verbal consent was documented in the electronic patient record. Nurses told us that they recorded consent to immunisations, ear syringing and cytology on the electronic patient record and they verbally obtained consent for taking blood tests.

The practice had not needed to use restraint. Staff discussed examples of two patients in nursing homes that had deprivation of liberty safeguards in place as the nursing home had a locked door. GPs said that patients having an intrauterine contraceptive device (IUCD) attended an advance appointment to discuss consent, risks and contraindications of the intervention, which was recorded on the electronic patient record.

Health promotion and prevention

It was practice policy to offer an annual health check to all patients over the age of 75 years and patients who have not been seen by a GP in the last three years. The practice offered chlamydia screening, smoking cessation and weight loss management advice to patients. A GP told us

Good

Are services effective?

(for example, treatment is effective)

that patients were signposted to a counselling and psychology service and that they supported patients by seeing them more frequently until the intervention had started.

Data from the QOF for the period 2013 to 2014 indicated that that 61.16% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption documented in the preceding 12 months. This was low compared with the national average of 88.65%. We spoke to a GP who told us that they did record this information opportunistically, noting there were other patient concerns that needed to be addressed within that consultation. The percentage of patients with physical and/ or a mental health condition whose notes recorded smoking status in the preceding 12 months was 96.68% compared to the national average of 95.29%.

The practice offered a full range of immunisations for children, in line with current national guidance. Last year's performance was above average for the majority of childhood immunisations but the rates for flu vaccination below the national average, for example,

- Childhood immunisations rates for vaccinations given to children under two years ranged from 94.7% to 99.1% and five year olds from 91.9% to 98.2%. These were all above national averages.
- Flu vaccination rates for the over 65 year olds were 67.22% compared to the national average of 73.24% and rates for patients at were risk 38.77% compared to the national average of 52.29%

The practice had held a flu day on a Saturday that raised patient awareness and encouraged patients to get vaccinated. Patients had their pulses checked and GPs had identified some atrial fibrillation. Nurses visited nursing homes to give flu vaccinations to residents. Patients under 65 years were targeted for vaccinations on risk and were contacted by the assistant practice manager.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey published on 8 January 2015. This contained data collected from January to March 2014 and July to September 2014 and 108 responses were received. The practice had not completed their own independent patient satisfaction survey in 2014.

The evidence from the satisfaction survey showed that patients were very extremely satisfied with how they were treated and that they were treated with care and concern. For example data from the survey identified that the percentage of patients who rated the overall experience of the surgery as good was 89.4% compared to the CCG average of 89.1% and the national average of 67.9%. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses, for example,

- 96.4% of patients said that the GP they saw was good at listening to them compared to the CCG average of 89.7% and national average of 87.2%.
- 95.8% of patients said that the GP they saw or spoke to was good at giving them enough time compared to the CCG average of 88.1% and national average of 85.3%.
- 97.7% of patients said they had confidence and trust in the last GP they saw and spoke to compared to the CCG average of 93.9% and national average of 92.25%.
- 90.8%of patients said had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 86.5% and national average 85.5%.

Patients completed comment cards to tell us what they thought about the practice. We received 24 completed cards and all of them were positive. Patients commented on the good services and high quality care provided by staff, they felt involved in their care and they were treated with dignity and respect. We spoke with seven patients who told us they were happy with the care provided by GPs and nurses and that staff listened to them and involved them in their care.

A GP had rearranged his consulting room with armchairs next to a fireplace. They told us that this helped patients to feel comfortable and more relaxed during their consultations.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Doors were closed during consultations but some conversations could be heard in the corridor. There was a door between the corridor and the waiting room and consultations could not be heard by patients who were waiting for appointments.

A confidentiality policy was available and all staff signed a confidentiality agreement. We saw that staff respected patients' confidentiality and that there was a sign in the waiting room asking patients to respect other patients' privacy. A system had been introduced to allow only one patient at a time to approach the reception desk. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained. A room next to reception was used if a patient wanted to have a private conversation. 82.9% of patients said that they found the receptionists helpful compared to CCG average of 89.6% and the national average of 86.9%.

There was a procedure for dealing with patients that had become violent or aggressive and staff told us they would refer the patient to the practice manager or to the deputy manager. The deputy practice manager had completed training in conflict resolution and said that if a patient became aggressive they would ask them to leave until they had calmed down. Staff told us that a zero tolerance policy would be operated if a patient did not stop being abusive or violent. A staff member told us they had dealt with a patient who was angry and they had listened to the patient and asked a GP to assess the patient. The patient apologised and thanked the staff member for listening.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example,

- 93.7% of patients said that the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 84.1% and the national average of 82%

Good

Are services caring?

- 84.5% of patients said that the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 77.4% and the national average 74.6%
- 80.2% of patients said that the last nurse they saw or spoke to was good at explaining tests and treatments compared to CCG average of 77.6% and national average of 76.7%
- 70.2% of patients said that the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 66.1% and the national average of 66.2%.

Patients we spoke with on the day of our inspection told us that they felt involved in decision making about the care and treatment they received. They told us that they felt listened to and supported by staff and had sufficient time during consultations to make choices about the treatment they wished to receive. Patient feedback on the comments cards we received was also positive and aligned with these views.

A staff member told us they had a small number of patients who did not speak English as a first language but they had never needed to use a translation service as a relative would usually help the patient to understand. Language line translation services were available.

Older patients and patients that were vulnerable were involved in their care plans and completed care plans were signed by patients. Patients were supported to make end of life decisions and information about do not resuscitate was shared with emergency and out of hours services.

Children and young people were treated in an age appropriate way and a GP said that asthma consultations were always directed at the child as they needed to be able to use inhalers and needed to be involved in their treatment.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 97% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 85.9% and the national average of 82.7%.
- 81.5% of patients said that the last nurse they saw or spoke to was good at treating them with care and concern, compared to the CCG average 79.2% and the national average of 78%.

The patients we spoke with on the day of our inspection and the comments cards we received were also consistent with this survey information, for example, patients told us that they were treated compassionately and a patient told us that the GP had visited them at home when they were ill even though they had not asked for a home visit.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The information had been ordered in a way that made it accessible to patients, for example, information regarding services that support parents with young children was arranged on a board near the children's toys. There was a separate board that contained information about services that were available to people who were carers. The information board asked patients to inform reception staff if they were a carer and patients that were carers were highlighted on the practice computer system. Young carers were recorded on a list of vulnerable patients as well as a carers list.

Information was available to patients about end of life care. The practice had a form that was completed when a patient was bereaved and was passed to the GP, who contacted the bereaved relative by telephone and saw them at home or at the surgery. Vulnerable patients and patients with mental health needs were seen immediately by the duty GP and receptionists were aware of those patients who benefitted from this arrangement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice had the systems in place to maintain the level of service provided in most key areas. The needs of the patient population were understood and systems were in place to address identified needs in the way that services were delivered. For example, the practice provided treatment to a local rehabilitation unit and a GP was the lead for liaising with this service. However QOF data from 2014/ 2015 indicated that outcomes for patients with mental health needs had not been met.

The practice provided care to 52 patients who lived in a supported living complex for people with mental health problems, including depression, substance misuse and schizophrenia. Multi-disciplinary team meetings were held every 5 weeks.

Patients who were over the age of 75 years and all patients who had not been seen by a GP in the last 3 years were invited for a health check.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in planning its services. For example, patients who are at risk of forgetting appointments such as those with dementia were reminded by telephone on the day of their appointment and GPs visited patients at home to carry out checks on people with long-term conditions such as diabetes.

The majority of the practice population were English speaking patients but access to telephone translation services was available. A staff member told us that they have a small number of patients who do not speak English as a first language but they had never needed to use a translation service as a relative would usually help the patient to understand.

The practice information leaflet identified that foreign visitors may not be entitled to NHS treatment and would therefore be treated as a private patient. They were advised to contact reception for a current scale of fees.

The premises were suitable to meet the needs of people with disabilities. The majority of consultation and treatment rooms at the practice were downstairs. There was 1 consultation room and a physiotherapy room upstairs. There was a ramp to the practice and corridors and walkways were wide to allow access for wheelchair users and pushchairs. There was a bell on the outside of the building for people to request assistance. However the doors within the practice did not open automatically and we observed some patients with pushchairs who had difficulty in opening the doors. There were signs in the waiting area indicating that patients could request assistance at reception. One area of the reception desk was lower so that it was accessible to people in a wheelchair. A hearing loop was available.

The practice had a stair lift but this was not risk assessed. There was a sign that indicated that patients used the lift at their own risk, however, there was also a sign to indicate that reception staff could provide assistance. Some staff had completed manual handling training but others had not.

There were two toilets downstairs. One was labelled as a men's toilet and the other was labelled as a ladies' toilet and wheelchair accessible toilet. This toilet had a baby change facility. This was confusing to men who may need to use a wheelchair accessible toilet or for male carers who may need to use the baby change facilities.

There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female GP. Staff had not received training in equality and diversity. We were told that the practice had a lot of older patients but that they were mindful not be ageist. They discussed ensuring equality of access to care and discussed the case of a very elderly patient who had been referred to the orthopaedic department for a hip replacement.

Access to the service

The surgery was open from 7.30am and 6.30pm Monday to Friday. Appointments between 7.30am and 8am were pre-bookable routine appointments, to meet the needs of those patients who could not attend the surgery during routine hours due to work or other commitments. The practice provided contraception services, including intrauterine contraceptive device (IUCD) and contraceptive implant fitting with designated doctors by pre-bookable appointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the practice website. There were arrangements in place to ensure that patients received medical assistance when the practice was closed. These arrangements were displayed on the practice website.

The patient survey information we reviewed showed that patients rated the practice in line with the Clinical commissioning Group and higher than national averages in these areas. For example:

- 76.5% of patients were satisfied with the surgery's opening hours compared to the CCG average of 77.8% and the national average of 75.7%
- 76.3% of patients described their experience of making an appointment as good compared with the CCG average of 81.9% and the national average of 73.8%
- 72.6% of patients usually wait 15 minutes or less after their appointment time to be seen compared with the CCG average of 67.8% and the national average of 65.3%
- 76.3% of patients said they find it easy to get through to this practice by phone compared with the CCG average of 81.7% and 71.8%.

Patients we spoke with were generally satisfied with the appointment system and we were told that it was sometimes difficult to get an appointment with a named GP but they confirmed that they could see a doctor on the same day if they felt their need was urgent. Routine appointments were available within two weeks and routine appointments could be booked up to six weeks in advance.

GPs had a number of telephone appointments available each day and a duty GP carried out telephone consultations every afternoon. Children were seen without pre-booked appointments on the same day and reception staff could confirm this.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice manager was the designated responsible person who handled complaints.

Information was available to help patients understand the complaints system and who to complain to within the practice; however some of this information regarding external organisations was inaccurate because it was out of date and referred to organisations that were no longer in operation. There was a leaflet in reception entitled how to make comments, suggestions and complaints, which also advised patients to complain to former organisations.

We looked at seven complaints and identified that they had been responded to appropriately and complaints were acknowledged within three working days, in accordance with the practice policy. This procedure had improved after a delay in acknowledging a complaint from a bereaved spouse. The practice acknowledged that the complaint process should have been more robust and had acted to make the improvement accordingly.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice did not have a documented vision and strategy but staff told us that the practice vision was to keep the family doctor ethos but ensure that they kept up to date with modern clinical practice. GPs had an understanding of the partnership model and how it delivered objectives in terms of meeting patients' needs and managing partner workload. They had recruited a new GP partner and said that this would improve the availability of care to patients and reduce the workload on current practice partners. GPs discussed the importance of a family doctor ethos.

Governance arrangements

A patients' charter was available and this was promulgated in the practice information booklet. This charter stated that it had been produced so that patients knew what level of service they could expect. The arrangements for governance did not always operate effectively. There were some policies and procedures in place but the majority of policies and procedures required to be updated and did not relate to current guidance. For example, there were no written procedures that could be followed by staff who were acting as chaperones. The procedure used did not protect GPs or patients.

There was a clear leadership structure with named members of staff in lead roles. For example, each GP partner was the lead for a specialist area such as accident and emergency admissions, elderly care, diabetes, endocrinology, asthma, dermatology, family planning, women's health, cerebrovascular disease, coronary heart disease and minor surgery. Nurses also had lead roles and provided specialist clinics in asthma and chronic obstructive pulmonary disease and there was a lead nurse for infection control. However nurses undertaking vaccinations were doing so without the necessary patient group directives in place. The lead nurse for infection control had not received any additional training in this area and the staff training matrix did not record all training in Health and Safety received by staff. The staff we spoke with were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

A GP partner and practice manager had a lead role in overseeing that the systems in place to monitor the quality of the service were being used and were effective. However we found that some systems such as those for monitoring infection prevention control were not documented or available during the inspection. There were systems in place to monitor performance against the Quality and Outcomes Framework (QOF). The practice had made significant improvements in QOF during the last 12 months. This showed that the practice QOF performance was largely in line with national standards.

The practice had completed some clinical audits used to monitor quality. The practice audited minor surgery and reviewed the number of samples sent to histology, whether the results were returned and complication rates. Evidence from other data from sources including incidents and complaints was used to identify where improvements could be made. The practice had not completed its own independent a patient satisfaction survey but data from the national GP survey and the friends and family test was available. The practice submitted governance and performance data to the Clinical Commissioning Group and the lead partner attended CCG meetings.

The practice did not have systems in place to identify record and manage risks to patients and staff. There were no risk assessments in place and there was no record of actions that had been put in place to manage risks to patients. The Practice Manager stated that she met with GPs weekly to discuss practice business and there are also evening partnership meetings held every two to three months but meetings were sometimes cancelled due to staff shortages. Nurses did not attend clinical meetings routinely due to the fact that they worked part-time hours. Information about significant events was discussed at GP meetings and significant event meetings were not minuted but a record of actions was recorded on the significant event record The practice had a stair lift but use of the stair lift had not been risk assessed and staff had not received training to assist people accordingly

There was a documented plan to deal with business continuity but systems to manage emergencies with the practice were not clear. Fire evacuation procedures were on consulting room walls but no trained fire wardens were in place and no fire evacuation drill had been undertaken. The practice had successfully managed a recent medical

Are services well-led?

Requires improvement

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

emergency but we found an item of emergency medication that had expired and some medicines identified on the emergency medicines protocol did not match those available in the practice.

The practice manager was responsible for human resource policies and procedures. We spoke with a GP who had started at the practice recently. They told us they had an e-mail from the practice prior to starting had a through induction process. We were shown the staff handbook that contained policies and procedures to support staff but the handbook had not been updated since 2008.

Leadership, openness and transparency

The GP partners were visible in the practice and staff told us they were approachable and always took time to listen to members of staff. Nurses told us that they approached GPs to discuss patient care on an individual basis and patients told us that the nurse would book them in with the doctor if further advice was needed.

The leadership structure was democratic and staff had lead roles and individual areas of responsibility. Staff indicated that there was an open door policy and that they felt confident to raise concerns. Staff said that they felt respected, valued and supported within the practice. Staff told us that they thought that people were very team focused and worked together.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had received feedback from patients, through the Patient Participation Group (PPG), survey and complaints received, although a practice survey had not been conducted in the last 12 months. The practice had a PPG that had declined in recent months but were actively looking to recruit new members.

The practice data from the national GP survey indicated that the practice had performed highly and that patients were satisfied with the care that they received at the practice.

A staff survey had not been conducted but staff told us that the practice manager had an open door policy and they could talk to GPs and the practice manager if they had any concerns. A member of staff told us that they had been consulted regarding the refurbishment of their treatment room. They advised as to the layout of the room and what equipment they needed to work with. A member of staff told us that they felt part of the team, they were asked for their opinion and they could challenge information. They told us that they had suggested that an extra 15 minutes should be allocated at the end of immunisations clinics for staff to catch up and ensure that they do not over run and this was actioned.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their professional development. Protected time was available for nurses training. We saw a list of educational sessions that had been completed by GPs in 2014. Learning had taken place on a monthly basis. These including multi-disciplinary team meetings and, significant event reviews, diabetes course feedback and a prescribing update. We received a copy of a learning log template that GPs used to record learning from attendance at education sessions. The learning was recorded and disseminated to peers. This showed that they had undertaken 'Hot Topics' training (an update course focussing on new developments, papers and guidelines relevant to a GPs daily work), and completed learning in relevant topics and family planning and virtual ward meetings.

Staff told us they had received induction training and attended practice meetings every two months. They had appraisals annually and that they could request any additional training required.

The practice was a GP training practice. A GP registrar had worked at the practice since February. They had a two week induction process. Appointment times had been extended so that they had sufficient time to see patients; they had attended clinical meetings and had been involved in discussions about the day to day running of the practice. They received supervision and if the GP trainer was not available, they would have a nominated person to provide support. They felt well supported and specific time was set aside each day for discussions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The practice did not follow current national guidance in relation to the assessing the risks to the health and safety of service users of receiving the care or treatment and were not doing all that was reasonable practicable to mitigate any such risks. The practice did not ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. The practice did not follow current national guidance in relation to the use of Patient Group Directions and guidance in relation to the safe use and storage of medicines. The provider did not follow current national guidance on and assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. How the regulation was not being met: There were no systems in place to document risks and record controls in place to mitigate risk. Some equipment was in use that had not had the appropriate checks completed and had not been declared fit for use. Patient Group Directions were not in place for the provision of vaccination by nurses, expired medicines were available for use and the medicines available for use did not match those on the emergency medicines checklist. Policies and procedures to prevent, detect and control infections had not been fully implemented. There was an infection control audit checklist but this had not been completed and actions had not been identified. Some treatment couches were cracked and had not been covered with a non-permeable cover so infection control could be compromised. This was a breach of Regulation 12 (2)(a)(b)(e)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The practice did not have system in place to monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; How the regulation was not being met The practice did not have appropriate systems and processes designed to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff had received such appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties of a chaperone. How the regulation was not being met. There were no policies and procedures in place for staff to follow regarding the chaperoning of patients. Staff who chaperoned stood outside of the curtain and could not observe the GP treating the patient. They had not been appropriately trained for this role. This was in breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing