

Hawthornden Surgery

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Our previous comprehensive inspection at Hawthornden Surgery on 5 December 2016 found breaches of regulations relating to the safe and well-led delivery of services. The overall rating for the practice was requires improvement. Specifically, we found the practice inadequate for the provision of safe services and require improvement for provision of well led service. It was good for providing effective, caring and responsive services. Consequently we rated all population groups as requires improvement. The full comprehensive report on the previous inspections can be found by selecting the 'all reports' link for Hawthornden Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 9 August 2017 to check that the practice was meeting the regulations and to consider whether sufficient improvements had been made.

We found the practice had made improvements since our last inspection. At this inspection we found the practice was meeting the regulations that had previously been breached. We have amended the rating for this practice to reflect these changes. The practice is now rated good

for the provision of safe, effective, caring, responsive and well led services. Overall the practice is now rated as good. Consequently we have rated all population groups as good.

Our key findings were as follows:

- Risks to patients were assessed and well managed.
- During the previous inspection in December 2016 we found high risk issues relevant to the suitability of the premises and health and safety procedures at the branch practice. However, the practice had taken urgent steps and stopped offering appointments at the branch practice from the day after that inspection.
- The practice had carried out patients' consultation and submitted a formal application in March 2017 to close the branch practice (Flackwell Surgery). NHS England had approved the application and the branch practice was formally closed on 20 June 2017.
- All the areas of concerns identified during the previous inspection relating to the branch practice had been resolved due to the permanent closure of the branch practice.
- Improvements had been made to maintain a safe system for medicines management including the safe storage of medicines requiring refrigeration.

Summary of findings

- Vaccines were safely stored and the fridge temperatures were monitored daily and records maintained.
- The practice had carried out a fixed electrical installation check to ensure safety of the wiring system.

- The practice demonstrated improvement in governance arrangements.

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?

The practice had taken appropriate action to become good for the provision of safe services.

Records and processes we reviewed confirmed this.

- When we inspected the practice in December 2016 we found concerns relevant to health and safety procedures at the branch practice and the monitoring of fridge temperature checks at the main practice.
- At the inspection in August 2017, we noted the practice had taken urgent steps and stopped offering the appointments at the branch practice from the day after the December 2016 inspection.
- The practice had carried out a patients' consultation from January 2017 to March 2017. The practice then submitted a formal application on 28 March 2017 to NHS England requesting to close the branch practice (Flackwell Surgery). NHS England had approved the application and the branch practice was formally closed on 20 June 2017.
- All the areas of concerns identified during the previous inspection relating to the branch practice had been resolved due to the permanent closure of the branch practice.
- The practice had ensured all vaccines were safely stored. We found the fridge minimum and maximum temperatures were monitored daily and all the readings we checked showed the fridge to be operating within the required temperature ranges.
- A fixed electrical installation check was carried out in January 2017 to ensure safety of the wiring system.

Good



Are services well-led?

The practice had taken appropriate action to become good for the provision of well-led services.

- When we inspected the practice in December 2016, we found governance monitoring of specific areas required improvement. For example, the suitability of the branch premises including disability access and monitoring of health and safety procedures to ensure risks were managed appropriately. Improvements were required to the systems in place to effectively monitor fridge temperatures checks at the main practice.

Good



Summary of findings

- At the inspection in August 2017, we observed that there was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- For example, we saw the practice had implemented an effective monitoring system to ensure fridge temperatures were recorded on regular basis.
- We found all the areas of concerns identified during the previous inspection relating to the branch practice had been resolved due to the permanent closure of the branch practice.

Summary of findings

The six population groups and what we found

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

Older people

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



People with long term conditions

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



Families, children and young people

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



Working age people (including those recently retired and students)

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



People whose circumstances may make them vulnerable

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



People experiencing poor mental health (including people with dementia)

The provider had resolved the concerns for safe and well-led services identified at our inspection on 5 December 2016 which applied to everyone using this practice, including this population group. The population group ratings have been changed to reflect this.

Good



Hawthornden Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

Background to Hawthornden Surgery

Hawthornden Surgery is situated in Bourne End, Buckinghamshire within a converted premises. All patient services are offered on the ground and first floors. Hawthornden Surgery comprises of five consulting rooms, two treatment rooms, two patient waiting areas, a reception area, administrative and management office.

Hawthornden Surgery has core opening hours from 8am to 6.30pm Monday to Friday. The practice offers a range of scheduled appointments to patients every weekday from 8.30am to 5.50pm including open access appointments with a duty GP throughout the day. The practice offers extended hours appointments fortnightly every Wednesday from 7am to 8am, fortnightly every Thursday from 6.30pm to 8.30pm, one Tuesday a month from 6am to 8am and one Saturday a month from 8.30am to 2pm.

The practice has a patient population of approximately 7,040 registered patients. The practice population of patients aged between 0 to 39 years old is lower than the national average and there are a higher number of patients aged above 50 years old compared to national average.

Ethnicity based on demographics collected in the 2011 census shows the patient population is predominantly White British and 5% of the population is composed of

patients with an Asian, Black or mixed background. The practice is located in parts of Bourne End and Flackwell Heath with the lowest levels of income deprivation in the area.

There are six GP partners at the practice. Three GPs are female and three male. The practice employs two practice nurses and a health care assistant. The practice manager is supported by an IT manager, an administration manager, a team of administrative and reception staff. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

Services are provided from following location. We visited the practice during this inspection.

Hawthornden Surgery

Wharf Lane

Bourne End

Buckinghamshire

SL8 5RX

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice, in the practice information leaflet and on the patient website. Out of hours services are provided during protected learning time by Care UK Primary Care service or after 6:30pm, weekends and bank holidays by calling NHS 111.

Why we carried out this inspection

We carried out the previous comprehensive inspection of this service under Section 60 of the Health and Social Care

Detailed findings

Act 2008 as part of our regulatory functions. This inspection took place on 5 December 2016 and we published a report setting out our judgements. These judgements identified two breaches of regulations. 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 carried out a follow up focussed inspection on 9 August 2017 to follow up and assess whether the necessary changes had been made, following our inspection in December 2016. We focused on the aspects of the service where we found the provider had breached regulations during our previous inspection. We followed up to make sure the necessary changes had been made. We found the practice was meeting all the conditions of regulations that had previously been breached.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, review the breaches identified and update the ratings provided under the Care Act 2014.

This report should be read in conjunction with the full inspection report of CQC visit on 5 December 2016. The full comprehensive report on the previous inspections can be found by selecting the 'all reports' link for Hawthornden Surgery on our website at www.cqc.org.uk.

How we carried out this inspection

Before visiting on 9 August 2017 the practice confirmed they had taken the actions detailed in their action plan.

Prior to the inspection we contacted the Chiltern Clinical Commissioning Group, NHS England area team and the local Healthwatch to seek their feedback about the service provided by Hawthornden Surgery. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced focused visit on 9 August 2017.

During our visit we undertook observations of the environment and spoke with a practice manager.

Are services safe?

Our findings

When we inspected the practice in December 2016 we found risks to patients and staff were assessed and managed in some areas, with the exception of those relating to health and safety arrangements at the branch practice more commonly known as Flackwell Surgery. For example, we found risks relating to infection control procedures, fire safety arrangements, lone working, and management of legionella at the branch practice and monitoring of fridge temperature checks at the main practice which had not been monitored regularly. The practice did not have sufficient arrangements in place to deal with emergency situation at the branch practice. The practice had not carried out the fixed electrical installation checks at both practices. We rated the practice inadequate for the provision of safe services in December 2016.

At this inspection in August 2017 we found significant improvement had been made and we rated the practice good for the provision of safe services.

Overview of safety systems and processes

During this visit we found the practice had clearly defined and embedded systems, processes and practices in place to keep patients safe. The practice had made the following improvement:

- A day after the previous inspection in December 2016 the practice had contacted Care Quality Commission and informed us in writing that they had taken urgent steps and stopped offering the appointments at the branch practice until all the high risk health and safety issues had been rectified.
- Ten days after the previous inspection in December 2016 the practice informed us they had decided to close the branch practice temporarily and was in discussion with NHS England about the future use of the branch location.
- The practice had carried out patients' consultation from January 2017 to March 2017. The practice had submitted formal application on 28 March 2017 and requested to NHS England to close the branch practice (Flackwell Surgery) because the premises were not fit for purpose and it was not financially viable to bring the building up to the high standards required for modern GP practices.

- NHS England had approved the application and the branch practice was formally closed on 20 June 2017.
- We found all the areas of concerns identified during the previous inspection relating to the branch practice had been resolved due to the permanent closure of the branch practice.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We checked the records of three fridges during this inspection. We found all vaccines were safely stored and the fridge minimum and maximum temperatures were monitored daily and all the readings we checked showed the fridge to be operating within the required temperature ranges.
- The practice had developed a rota and management system to ensure the effective monitoring of fridge temperature checks.
- There was a policy for ensuring that medicines were kept at the required temperatures, which also described the action to take in the event of a potential failure.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- We noted that the fixed electrical installation check was carried out on 13 January 2017.
- All the other areas of concerns identified during the previous inspection relevant to this sub-section had been resolved due to the permanent closure of the branch practice. For example, the practice did not have satisfactory fire safety procedures in place for monitoring and managing risks to patient and staff safety at the branch practice.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- All the areas of concerns identified during the previous inspection relevant to this sub-section had been resolved due to the permanent closure of the branch practice. For example, medicines and equipment required to support a patient in a medical emergency were present at the main practice. These had not been available at the branch premises.

Are services well-led?

Good 

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

Our findings

When we inspected the practice in December 2016 we found governance monitoring of specific areas required improvement. For example, monitoring of health and safety at the branch premises. The practice had not carried out a formal written risk assessment to ensure the suitability of the branch premises including disability access and monitoring risks to patients. For example, we noted there was no disabled toilet. A GP was lone working in the branch premises and no other staff was available who would help in emergency or act as a chaperone when required. The practice had not had an effective system to monitor and ensure fridge temperatures were recorded on regular basis.

At this inspection in August 2017 we found improvements had been made.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. For example:

- The practice had implemented an effective monitoring system to ensure fridge temperatures were recorded on regular basis.
- We found all the areas of concerns identified during the previous inspection relating to the branch practice had been resolved due to the permanent closure of the branch practice.