

The Waterfield Practice

Inspection report

Ralph's Ride
Harmans Water
Bracknell
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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 location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Overall summary

We carried out an announced comprehensive inspection at The Waterfield Practice on 6 February 2019 as part of our inspection programme.

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as requires improvement overall. We found the practice requires improvement for safe and well led and good for effective, caring and responsive. All the population groups were rated as good.

During this inspection we found:

- Systems and processes around safeguarding were well managed.
- Some risks had not been identified, such as control of substances hazardous to health or assessing emergency medicine provision and storage.
- Identifying and learning from significant events was inconsistent and the practice had recently reviewed their systems and processes but these were not yet embedded.
- The practice monitored patient care effectively and had achieved positive outcomes for their patients.
- Uptake of health checks for patients with learning disabilities was low.
- The majority of patients were positive about the care they received.

- The practice website had been developed with patient access in mind. It was utilised well and had reduced appointment requests and telephone calls to the practice.
- Governance arrangements required review as these were inconsistently applied. Risks and areas of concern were not always identified or effectively managed.
- Staff felt supported by management and enjoyed working at the practice.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Review the arrangements for recall of female patients for the cervical screening programme to improve uptake.
- Review the processes for engaging with patients with a learning disability to improve uptake of annual health checks.
- Continue to consider the need for and review the effectiveness of, an effective patient participation group.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC inspector accompanied by a GP Specialist Advisor and a second CQC inspector.

Background to The Waterfield Practice

The Waterfield Practice provides GP services to approximately 13,300 patients across two practice sites in the Bracknell area of East Berkshire. It is one of 16 practices in the Bracknell and Ascot area and is commissioned by East Berkshire Clinical Commissioning Group.

The provider, The Waterfield Practice, is registered with the CQC to provide the following regulated activities:

- Diagnostic and screening procedures
- Family Planning
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

All the regulated activities are provided from both practice sites at:

The Waterfield Practice (main site)

Ralphs Ride

Harmanswater

Bracknell

RG12 9LH

The Waterfield Practice (branch site)

1 County Lane

Whitegrove

Bracknell

RG42 3JP


We visited both sites during this inspection.

The practice has six GP partners (two male, four female) and two salaried GPs (both female). Between the GPs they offer a whole time equivalent (WTE) of six full time GPs. The nursing team consists of three female nurses (WTE 1.93) a health care assistant and phlebotomist. There is also a Paramedic Practitioner (female) who works full time at the practice.


The day-to-day organisation and running of the practice is provided by a practice manager and assistant practice manager. They are supported by a number of administration, secretarial and reception staff.

According to statistics there is a low level of deprivation and high numbers of employed patients. There is a large white British population, with 10% of patients coming from black or other minority ethnic groups.

The provider is part of the Bracknell and Ascot federation of GPs who have combined to offer an extended hours service to all patients who are registered with Bracknell



and Ascot GPs. The extended hours operate from a specific practice site in Bracknell and offers GP, nurse and HCA appointments Monday to Friday between 6.30pm and 8pm and Saturday and Sunday mornings.



Out of hours GP cover is provided by an external stakeholder who provides out of hours services to the whole of East Berkshire. Patients can access this service when the practice is closed by contacting NHS 111.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is 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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met...</p> <p>There was a lack of systems and processes established and operated effectively to ensure compliance with requirements to demonstrate good governance.</p> <p>In particular we found:</p> <ul style="list-style-type: none">• Governance arrangements required regular review to identify risks and ensure consistency of safe processes.• Recruitment processes had not been monitored or reviewed in line with schedule 3 and there were gaps in background checks that had been inconsistently followed up.• Documentation relating to chaperones and chaperone training was inconsistently managed.• Staff training records were inconsistently maintained and monitored. Not all staff training was documented or recorded.
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met...</p> <p>Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out.</p> <p>In particular:</p> <ul style="list-style-type: none">• Risk assessments had not been undertaken in a number of areas including, COSHH, Emergency medicines (and the storage arrangements of these) and emergency procedures at the branch practice.

This section is primarily information for the provider

Requirement notices

- Significant event arrangements required establishing and embedding. Learning from significant events was inconsistent and did not always lead to effective changes in systems and processes.
- Risk assessments relating to DBS checks were not effective.
- Actions arising from infection control audits had not been risk assessed or acted upon.