Kinson Road Medical Centre

Quality Report

440 Kinson Road
Kinson
Bournemouth
Dorset
BA10 5EY
Tel: 01202 574604
www.kinsonroadmedicalcentre.co.uk

Date of inspection visit: 3 June 2014
Date of publication: 27/08/2014

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

Summary of findings

Contents

Summary of findings

Overall summary

The practice provides primary medical services to approximately 8,400 patients from two sites. The main site is a leased, two storey building in the Kinson area of Bournemouth in Dorset. The branch surgery, which we did not inspect, is in West Howe. The practice provides a range of primary medical services including; family planning, minor surgery and chronic disease management.

This was an announced inspection, which focused on how systems and practice were: safe, caring, effective, responsive and well led. We spoke with 16 patients and four representatives of the patient reference group (PRG). We reviewed written patient feedback from a number of sources and made observations of staff interactions with patients. The majority of patient feedback about care, treatment and staff was positive.

The practice demonstrated it understood the local patient population well and provided flexible and responsive services to meet patients' needs. Staff worked collaboratively with other professionals and services to minimise risks for people and safeguard vulnerable adults and children from abuse. Patients told us they felt respected and were involved in making decisions about their care. The practice used high numbers of locums to cover unplanned GP absences. Patients said the use of locum GPs affected the consistency and experience of care and treatment. Senior staff said they were actively working to resolve this situation. Effective governance and risk management measures were in place. There was an open culture, which promoted learning and development. Staff we spoke with reported the GP partner and practice manager were visible, supportive and approachable.

Information from the local clinical commissioning group (CCG) and Public Health England showed higher levels of deprivation and unemployment amongst patients registered at Kinson Road Medical Centre. This was in comparison to other primary medical services in Dorset, and across England.

Site visited for inspection:

440 Kinson Road

Kinson

Bournemouth

Dorset

BA10 5EY

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 was safe. Policies and procedures such as infection control, minimised risks for patients and staff, and were written in line with national guidance. Staff demonstrated they understood and followed procedures to protect children and vulnerable adults from abuse. Clinical staff worked in partnership with other services and professionals to develop and share strategies to reduce risks to patients. The practice demonstrated learning from incidents which was shared with appropriate staff to ensure services continued to be safe. There were robust plans in place to manage emergencies, such as a power failure which could disrupt the smooth running of the practice.

Are services effective?

The practice was effective. Staff received appropriate training and were supported with professional development. Systems were in place to work collaboratively with other health professionals and services for the benefit of patients. Patients had good access to a range of health promotion advice and support. The practice had developed initiatives to improve the monitoring, management and outcomes for patients at the surgery and within the local clinical commissioning group (CCG) area.

Are services caring?

The practice was caring. The majority of patient feedback about care received was positive. Patients felt respected and involved with their care. We observed staff treating patients kindly, appropriately and with dignity. Patients preferred not to see locum GPs who did not know them well and felt this affected the continuity of their care. The practice provided a range of services to support patients. These included a chaperone service, carers' information packs and use of signing and interpreting services. Some staff were not able to demonstrate a clear understanding of the Mental Capacity Act (2005) and how this related to their role with vulnerable patients.

Are services responsive to people's needs?

The practice was very responsive to patients' needs. The practice demonstrated an understanding of the local patient population and planned its services in response acted responsively to different needs. There was a culture of care which put patients' needs first. The practice demonstrated it was responsive to patient feedback, including concerns and complaints, and took remedial actions. The

Summary of findings

surgery offered staggered appointment times which enabled good access for patients who had work or other commitments. Access to the building was difficult for small children, frail patients, and those using walking aids, wheelchairs or patients bringing pushchairs.

Are services well-led?

The practice was well led. The practice had an organisational structure in place and roles and responsibilities of staff were clear. Members of staff said senior managers were approachable and had an open door policy. The practice demonstrated learning from significant events and patient feedback. There was a culture of learning and development at all levels. The practice had good links to the local clinical commissioning group and other primary healthcare providers. Of concern, was the lack of a plan outlining arrangements for responding to any long-term absence of the senior partner or practice manager.

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 proportion of patients registered with the practice who were aged 75 years and over was similar to that of other practices in the area. GPs worked closely with four local care homes to provide primary medical services. The practice was identifying a named GP for patients aged over 75 years to ensure care was consistent and coordinated. The practice was responsive to the needs of elder patients and had adapted access and care to be able to better monitor and maintain health and reduce risks.

People with long-term conditions
The practice demonstrated an understanding of how long term conditions such as diabetes and asthma affected patients in the locality. Patients said staff were caring and supportive and a range of resources was available. The practice demonstrated systems and plans they had actioned to provide effective, safe care and management of long term conditions. Analysis of prescribing and monitoring for patients with heart disease had resulted in a reduction of emergency admissions to hospital.

Mothers, babies, children and young people
The practice had robust and effective systems in place to recognise and safeguard children from abuse. The practice worked with other community health services to provide a range services for children and women. This included child developments and ante and postnatal services.

The working-age population and those recently retired
Working age people had access to services at Kinson Road Medical Centre. The practice provided staggered clinic times covering early, late and lunch periods and a GP telephone contact system. The surgery provided well person checks to monitor health and provide lifestyle advice.

People in vulnerable circumstances who may have poor access to primary care
The practice was responsive to the needs of vulnerable patients. The practice accessed signing and interpreting services and provided a formal chaperone service. Staff at the practice provided specific resource and information packs to people in care roles.

Summary of findings

People experiencing poor mental health

The practice worked collaboratively with community services and other health professionals to support patients with mental health problems. This was to co-ordinate care between different professionals and agencies and review risk management strategies. Some staff were not able to demonstrate a clear understanding of the Mental Capacity Act 2005 and how this related to their role with vulnerable patients.

Summary of findings

What people who use the service say

We spoke with 16 patients and four representatives of the practice reference group (PRG) during the inspection. The PRG consists of volunteer patients who provide feedback on their experiences and views of the practice. This information was used to assist with service improvements by the practice. We reviewed three comment cards and three letters from patients who shared their views and experiences of using the practice.

Many of the patients we spoke with told us staff were caring, respectful and considerate and they felt well looked after. Some patients we spoke with told us they had had to wait too long for referrals to specialists. We spoke with the practice manager who investigated and found the correct processes had not been followed for approximately two months. This occurred during a temporary change in staff. The practice manager said this had now been rectified.

The practice surveyed patients during November 2013, and 187 patients responded. Patients were asked if they felt they received a good service from their GP. 93% rated their experiences between 'good' and 'excellent'.

We reviewed other information about Kinson Road Medical Practice. The most recent GP patient survey completed by NHS England during 2013, showed 81.1% of patients would recommend the practice. The most recent comments on the NHS Choices website recorded one negative comment regarding appointment times. The practice had reviewed this comment and responded with an explanation and apology. Two other comments on the site were very complimentary about the services received and the attitudes of staff

Areas for improvement

Action the service COULD take to improve

- The practice could ensure that all staff receive training and are able to demonstrate understanding of processes related to the Mental Capacity Act 2005.
- The practice could ensure maintenance is up to date and repairs carried out to the broken windows.
- The practice could review access to ensure that frail patients, those using walking aids or wheelchairs, and parents with small children are able to enter the practice easily.

Good practice

- The practice took proactive actions to monitor and promote health for vulnerable housebound patients.
- The practice provided a prompt specialist joint service, which was available and used by patients from other primary and secondary care services.
- The practice offered staggered appointment times, covering early, late and lunch time periods which suited patients' needs.

Kinson Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector with a GP specialist advisor. The team included a specialist manager advisor and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatments from similar services.

Background to Kinson Road Medical Centre

The practice provides primary medical services to approximately 8,400 patients from two sites.

Kinson Road Medical Centre

440 Kinson Road

Kinson, Bournemouth,

Dorset, BA10 5EY

West Howe Clinic

Cunningham Crescent

West Howe

BH11 8DN

The main site is a leased, two storey building in the Kinson area of Bournemouth in Dorset. The branch surgery, which we did not inspect, is in West Howe.

The practice provides a range of primary medical services including; family planning, minor surgery and chronic disease management. Patients are supported by GPs, nurses, a health care assistant, practice management team and administration staff.

Information from the local clinical commissioning group (CCG) and Public Health England showed higher levels of deprivation and unemployment amongst patients registered at Kinson Road Medical Centre. This was in comparison to other primary medical services in Dorset, and across England.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

- Vulnerable older people (over 75s)

Detailed findings

- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem

Prior to the inspection, we spent time reviewing information we hold about Kinson Road Medical Centre. We contacted the local CCG, NHS England area team and Healthwatch to seek their feedback about the practice.

We completed an announced inspection visit to the surgery on 03 June 2014. We spoke with 16 patients and four representatives of the practice reference group. We also reviewed three comment cards and three letters from patients who shared their views and experiences using the practice. We interviewed 14 practice staff including; GPs, a nurse, the practice manager and administration staff. Throughout the day we observed how staff interacted and cared for patients. We also looked at a range of management records, policies and procedures.

Are services safe?

Summary of findings

The practice was safe. Policies and procedures such as infection control, minimised risks for patients and staff, and were written in line with national guidance. Staff demonstrated they understood and followed procedures to protect children and vulnerable adults from abuse. Clinical staff worked in partnership with other services and professionals to develop and share strategies to reduce risks to patients. The practice demonstrated learning from incidents which was shared with appropriate staff to ensure services continued to be safe. There were robust plans in place to manage emergencies, such as a power failure which could disrupt the smooth running of the practice.

Our findings

Safe patient care.

Patients received safe care and treatment. The practice proactively engaged with other health and social care providers to coordinate care and meet patient needs. For example, the practice worked collaboratively with the community nursing team to safely support patients who required additional care or treatment or during times of crisis.

The health of patients were appropriately investigated and reviewed to ensure treatments were safe and appropriate. For example, patient investigations and test results were checked by GPs. Patients were contacted if results required additional investigations or referrals to specialists. New patients registering at the practice were asked to complete a health questionnaire. This information was reviewed and checked during the first appointment. This was done to ensure health was safely managed, treated and maintained.

A duty GP was available during all morning and afternoon clinics to respond to requests for urgent appointments. Patients requiring an urgent home visit were triaged by a GP. Home visits were made during or after clinic times depending on patients' needs.

Learning from Incidents

The practice learned from incidents and significant events. The practice manager was responsible for recording and disseminating actions resulting from significant events, incidents and near misses. We looked at records. These provided summaries of situations, who was involved and what subsequent actions and learning had occurred as a consequence. Learning was shared with all relevant staff. For example, we saw a clinical procedure, which required heated instruments which had reacted to the hair products of a patient. Consequently, alternative personal protective equipment (PPE) was ordered. Staff said the alternative PPE was effective and had minimised the risk of similar incidents occurring and reduced risks for patients and staff. We saw analysis and evaluation documented from a recent test fire evacuation procedure. Learning points had been emailed directly to all staff at the practice. The practice manager further reviewed all types of incidents when completing an annual review for the Quality and Outcomes Framework (QOF). The QOF includes a number of performance indicators and forms part of primary care

Are services safe?

contracts. The QOF has indicators relating to the management of common chronic conditions, how well the practice is organised, patient experience and the number of additional services offered above the routine. For example maternity services.

Safeguarding

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. We spoke with the GP safeguarding lead. They described how they took their safeguarding responsibilities seriously, preserving the need to attend training updates and meetings. This GP told us they had recognised some patients directly involved with vulnerable families were registered with other primary care services. This GP took actions to minimise risks and improve coordination of care. Systems were therefore created which linked vulnerable patients registered at Kinson Medical Practice to step parents registered elsewhere. This information was shared with other relevant services and agencies.

All staff received appropriate safeguarding children and vulnerable adults training. Records indicated most staff had received training or were booked to attend in line with practice policy. Staff at all levels demonstrated they understood potential signs and symptoms of abuse and knew what to do with concerns. The practice had information leaflets for patients about safeguarding children and vulnerable adults from abuse. This included who to contact if they had any concerns.

Monitoring safety and responding to risk.

The practice facilitated a primary health risk meeting approximately six times per year. Attendees included health visitors, district nurses, social workers and mental health clinicians. Each practitioner discussed patients they were most concerned about. One GP told us the meeting aimed to co-ordinate care between different professionals and agencies. This included risk management discussions to maximise strategies to protect people from potential abuse and avoidable harm.

Medicines Management

Medicines were managed appropriately. A nurse was responsible for the management of medicines at the practice. Medicines were kept securely with appropriate staff access. The surgery did not keep controlled medicines on site. The lead nurse showed us records documenting that regular medicine audits had been completed. Any remedial actions required had been actioned. This included stock and expiry date checks. We observed medicines were organised and accessible to appropriate staff. Each GP maintained responsibility for medicines carried in their bags for home visits.

Cleanliness & Infection Control

Effective systems were in place to reduce the risk and spread of infection. A nurse was the infection control lead for the practice. Documentation we looked at showed staff had completed infection control training, or were booked to attend. Infection control audits and risk assessments were completed annually and corrective action documented. Infection control policies and procedures were in place which encompassed statutory guidance including. This meant the practice had ensured they met the requirements outlined in the Department of Health's publication, 'The Code of Practice for health and adult social care on the prevention and control of infections and related guidance. 2009

Patients were cared for in a clean and hygienic environment. Staff told us the practice had an internal refurbishment approximately one year ago. This included the replacement of flooring, examination couches and elbow taps above sinks. In addition, one of the clinic rooms had been prepared for minor surgeries with new easy to clean cupboards and surfaces. Hand washing guidance was displayed above sinks and antiseptic hand gels were available for patients and staff use.

The environment was clean and clinical rooms were tidy. Personal protective equipment (PPE) such as gloves and aprons were readily available. Staff were offered Hepatitis B immunisations to prevent the spread of infection.

The practice employed cleaners who worked to a list of identified tasks. Staff checked standards of cleaning and a communication book was used to notify the cleaner of any concerns. A contract-cleaning supervisor formally reviewed the standard of cleaning every month. Clinical waste was stored securely and removed weekly by a private contractor supplied by the local Clinical Commissioning Group (CCG).

Staffing & Recruitment

There were effective recruitment and selection processes in place. Staff personnel records showed appropriate pre-employment checks were undertaken. These included criminal records checks via the Disclosure and Barring

Are services safe?

service (DBS). Applicants provided two references and details of any essential professional registrations required for posts. The practice manager reviewed and checked this information.

Dealing with Emergencies

Reception staff had clear visibility of the patient waiting areas. Reception staff explained if a patient appeared particularly unwell they observed and checked the person while they waited. Staff said a doctor saw patients immediately if conditions were noted to be deteriorating.

All staff had training in basic life support. Staff had access to medicines, a mobile defibrillator, a nebuliser and oxygen. We saw information which recorded emergency equipment had been regularly checked and serviced as required.

Equipment

Equipment was checked and serviced appropriately. This included diagnostic equipment, emergency lights, electrics, security and fire alarms. The practice manager was responsible for ensuring equipment used with patients and on the premises were safe. Information was recorded which identified which practice staff were authorised to use what specific piece of equipment. The practice manager said this ensured equipment was only used by those who knew how to use it correctly. Records were kept listing the dates checks and services completed, when they were next due and the contact details of contractors.

Monitoring Safety and Responding to Risk

The practice had emergency action plans in place to deal with circumstances which would interrupt the smooth running of the practice. The plan informed staff what exact actions to take and whom to contact. For example, mobile phones were available in the event of telephone system failures. In addition, a contract was in place to fix emergency problems with telephone systems and lines. Staff had access to panic buttons in clinical rooms, which linked directly to a police station.

During our inspection, we saw ten large paper sacks, marked as containing confidential paper waste. These were stored in an unused shower in a toilet room on the first floor of the building. The practice had one consulting room on the first floor next to the toilet room, which we were told was used rarely. This storage presented possible safety risks to patient confidentiality in accordance with the practice's confidentiality policies and the Data Protection Act (1998).

A comprehensive risk assessment of the practice was completed annually. This included staff training, use of equipment and the practice environment. Current actions to minimise risks were recorded with further actions and timescales identified. We observed the premises needed some repairs and modernising. For example, some external glass was cracked and the entrance to the surgery was not easily accessible to patients using walking aids, wheelchairs or pushchairs or for small children. The practice manager told us the building was leased and improvements were being negotiated with the landlord.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Staff received appropriate training and were supported with professional development. Systems were in place to work collaboratively with other health professionals and services for the benefit of patients. Patients had good access to a range of health promotion advice and support. The practice had developed initiatives to improve the monitoring, management and outcomes for patients at the surgery and within the local clinical commissioning group area.

Our findings

Promoting best practice

The practice participated in recognised national benchmarking programmes such as the Quality and Outcomes Framework (QOF) and local and direct enhanced services (LES and DES). Recent QOF results demonstrated Kinson Road Medical Practice scored a high overall achievement of 98.9%. The QOF system allows practices to exclude (exception report) patients from data. All primary medical services aim for low QOF exception reporting. Kinson Road Medical Practice had higher clinical exception-reporting rates compared to other practices within the local CCG. Senior staff suggested this was linked to the number of patients with multiple conditions, limiting the efficacy of treatments. In addition, whilst practice staff demonstrated they were responsive to patients, there was awareness many patients' lifestyles did not enable treatment plans to be effectively followed.

Management, monitoring and improving outcomes for people.

The practice had developed initiatives to improve the monitoring, management and outcomes for patients at the surgery and within the local CCG area. For example, information from Public Health England showed Kinson Road Medical Practice had higher levels of patients who had chronic back or joint problems compared to national figures. In response, one GP provided specific treatments for joint problems and pain management at the practice. This GP said in order to increase responsiveness to patient needs they were in the process of teaching the clinical procedures to other GPs at the practice. The practice had extended this service for the benefit of the wider community by accepting referrals from other primary and secondary health care services, such as pain clinics. The practice had also positively responded to advice from dermatology specialists and was providing a service to remove moles and lesions at the practice.

The practice surveyed patients during November 2013, and 187 patients responded. Patients were asked if they felt they received a good service from their GP. 93% of patients rated their experiences between 'good' and 'excellent'.

Staffing

Staff followed a comprehensive induction and completed ongoing training in order to provide effective care for patients. The induction plan for new staff listed clear

Are services effective?

(for example, treatment is effective)

objectives and learning points. This included incident reporting, health and safety information and review of the practice's policies. New employees were expected to shadow and observe experienced staff and then had their own practice observed. The practice manager said staff performance was kept under regular review and evaluation until the person was deemed proficient to work independently.

The practice had a rolling programme of mandatory training, which included fire safety and manual handling. Staff were positively supported with training updates and professional development. One member of staff told us senior managers had been very supportive with applications for non-essential professional development training. Staff throughout the practice said they attended any training necessary for their roles.

Working with other services

The practice facilitated regular multi-disciplinary clinical meetings with other health practitioners to review and coordinate care for patients and prevent hospital admissions. These meetings included health visitors, district and community nurses and the local community matron. The practice provided regular primary care to elder patients living in four local care homes which specialised in caring for people dementia and those who required support with mental health.

Health Promotion & Prevention

New patients were requested to complete a health questionnaire and any identified issues were reviewed by clinical staff. Patients had access to health advice and various health promotion resources such as specialised appointments with a practice nurse, written information and videos via the practice website. Two patients told us they stopped smoking directly because of advice they had received at the surgery. This included being given individual self-management plans for support. One GP told us about actions planned and taken for housebound patients who had difficulty getting to the surgery. These ensured these patients had their health conditions reviewed and flu vaccines provided.

The practice displayed health promotion leaflets in the waiting room and sign posted patients to other local services and support groups. Patients could meet with the nursing team for individual health promotion advice and support. The surgery website contained advice and information about long-term conditions. These were written and video formats of symptom management and health promotion advice. Each health condition had additional links to national bodies such as the National Institute for Health and Care Excellence (NICE), the Macmillan Cancer Support and the Mental Health Foundation.

Are services caring?

Summary of findings

The practice was caring. The majority of patient feedback about care received was positive. Patients felt respected and involved with their care. We observed staff treating patients kindly, appropriately and with dignity. Patients preferred not to see locum GPs who did not know them well and felt this affected the continuity of their care. The practice provided a range of services to support patients. These included a chaperone service, carers' information packs and use of signing and interpreting services. Some staff were not able to demonstrate a clear understanding of the Mental Capacity Act (2005) and how this related to their role with vulnerable patients.

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 16 patients during the inspection. We met with four members of the patient reference group (PRG) who represented views of patients through surveys and meetings with the practice. We reviewed three comment cards and three letters from patients who shared their views and experiences of using the practice. We also reviewed comments and patient feedback about the practice from other sources of information.

The practice surveyed patients during November 2013, and 187 patients responded. Patients were asked whether they received a good service from their GP and 93% rated their experiences between 'good' and 'excellent'. The most recent GP Patient Survey completed by NHS England during 2013 showed 81.1% of patients would recommend Kinson Road Medical Practice to others.

Recent comments on the NHS Choices website recorded one negative comment about staff attitudes. The practice had appropriately responded by giving a possible explanation and an apology. Two other comments on the site were very complimentary about services received by patients and the attitudes of staff.

The majority of patients reported staff were caring, respectful and considerate and that they felt well looked after. Some patients had provided positive and negative experiences with reception staff. These ranged from reception staff being exceedingly kind and helpful to reception staff being abrupt. Patients said doctors and nurses explained things well and they were able to ask questions. The practice had been using high numbers of locum (temporary) GPs to cover the extended absence of one GP. The practice informed us another GP had recently left at short notice and cover was being arranged with additional locum GPs. Patients reported they preferred not to see locum GPs, as relationships were not established and they felt this affected the continuity of their care. The practice told us they were actively pursuing alternative and permanent solutions including recruitment options for the recent vacancy.

We observed reception and clinical staff spoke kindly and appropriately when dealing with patients in person or on the telephone. One member of staff kept a list of patients

Are services caring?

and their relatives who had caring responsibilities. This person ensured the notice board was updated and people were given carers' packs which signposted them to services, support and information.

Clinicians supported patients who wished to be accompanied during consultations, examinations or procedures by allowing them to be accompanied by friends or relatives of their choice. The practice provided a formal chaperone service. Four clinical staff plus seven reception staff, who had received specific training, were available to chaperone patients.

The practice manager said families of patients were contacted when a person died and offered a bereavement home visit. The home visit was provided by the GP who had been the most involved with the deceased patients care.

Involvement in Decisions and Consent

The majority of patients told us staff listened to them and care and treatment met their needs. We observed staff took care to protect patients' privacy. The practice manager said all staff signed a patient confidentiality agreement as part of employment terms and conditions.

Patients were supported to be involved in their care. Patients they were notified of test results, medicines were discussed with them, and they were given adequate information about their conditions. The practice had access to signing and interpreting services to help with communication with patients who had learning disabilities, those who had hearing difficulties, or for patients for whom English was not their first language.

The practice had a consent policy and protocol. These outlined the ways and means consent could be obtained with patients. The policy included arrangements for obtaining consent to treat children, and was linked to national and legal guidance. We asked how care and treatment was established for patients who might be unable to provide valid consent, such as people who had learning disabilities or dementia. Staff told us they worked with carers where possible to maximise communication and understanding. Some staff we spoke with did not demonstrate a clear understanding of the Mental Capacity Act 2005 (MCA 2005) and how this related to their roles with vulnerable patients. Staff did not reference the key principles related to assessing capacity. For example, other than speaking with a carer, staff did not demonstrate what other actions had been taken to maximise a patients capacity. Staff records showed training in the MCA 2005 was not mandatory.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. The practice demonstrated an understanding of the local patient population and planned its services in response acted responsively to different needs. There was a culture of care which put patients' needs first. The practice demonstrated it was responsive to patient feedback, including concerns and complaints, and took remedial actions. The surgery offered staggered appointment times which enabled good access for patients who had work or other commitments. Access to the building was difficult for small children, frail patients, and those using walking aids, wheelchairs or patients bringing pushchairs.

Our findings

Responding to and meeting people's needs

There was a culture of patient centred care and the practice worked flexibly to meet patient needs. Staff said many patients did not like to book advance appointments preferring instead to book appointments when required. Training records showed the nurses and health care assistant (HCA) were trained in the management of multiple chronic diseases. For example, diabetes and asthma. Reception staff were aware of what treatments the nurses and HCA were able to provide and when they were available. This enabled patients to get appointments when they required at short notice. Results from the GP Patient Survey 2013 showed 75% of patients reported they had a good experience making appointments.

The practice had responded positively to feedback from the patient reference group (PRG) and individuals. For example, patients reported they did not like the music piped through reception which was linked to the telephone system. In response, the practice purchased a new sound system which was due to be installed the day after our inspection. One patient requested a secure bike rack which was provided. Other patients expressed concern at the speed of some cars in the car park. In response the practice installed brightly painted speed bumps.

The practice was flexible in order to meet the needs of different types of people. For example, staff told us patients with learning disabilities did not respond to letters from the surgery. In response staff communicated with this patient group via telephone. This resulted in an increased take up of health surveillance appointments.

Access to the Service.

Patients had a choice of appointment booking systems. Appointments could be made in person at the surgery, by telephone, or by accessing a patient computer online system (EMIS) via the internet. This included an option to download a free app for mobile phones, which sent reminders of appointments to patients.

The practice provided staggered clinic times covering early, late and lunch periods. The practice reception and clinics were available from 8.30am to 6.30pm five days per week. Answerphones were used for one half hour period during each day. Early morning appointments were provided twice per week from 7.30am to 8am. A late clinic was available for

Are services responsive to people's needs?

(for example, to feedback?)

patients once per week between 6.30pm and 8pm. The branch surgery at West Howe provided a clinic form 9am to 11.30am five days per week. This provided patients choices of appointments times and venues that suited them.

An on call GP was available for emergency appointments throughout the day at Kinson Road Medical Practice. Patients had the option of booking a telephone consultation with a GP.

The surgery was not easily accessible to patients using walking aids, wheelchairs, pushchairs or small children. The entrance to the practice was through two doors which had to be opened manually. The practice manager told us the building was leased and building improvements were currently being negotiated with the landlord. The practice was accessible to all patients once inside the building. Consultation rooms and toilets were on the ground floor and fully accessible for people using walking aids and wheelchairs.

Concerns & Complaints

Systems were in place to receive, monitor and respond to complaints. The practice had a complaints policy and procedure. Information about how to make a complaint was available to patients in the practice and on the practice's website. The patients we spoke with told us if they had concerns about their care they would not hesitate to raise them with staff. The practice manager told us there was a 'no blame' culture and complaints and comments were used to improve services and outcomes for patients. Other staff said senior management were approachable and they would not hesitate in discussing any concerns.

The practice manager was responsible for managing the practice complaints process. We looked at how the practice responded to patient complaints. We saw evidence that the practice had appropriately investigated concerns and responded to them in accordance with their policy. The complaints log recorded subsequent actions taken and learning points. The complaints log also noted when information, outcomes and learning were fed back to relevant staff.

Are services well-led?

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

Summary of findings

The practice was well led. The practice had an organisational structure in place and roles and responsibilities of staff were clear. Members of staff said senior managers were approachable and had an open door policy. The practice demonstrated learning from significant events and patient feedback. There was a culture of learning and development at all levels. The practice had good links to the local clinical governance group (CCG) and other primary healthcare providers. Of concern, was the lack of a plan outlining arrangements for responding to any long-term absence of the senior partner or practice manager.

Our findings

Leadership and Culture

The practice had a clear organisational structure in place and roles and responsibilities of staff were clear. All the staff we spoke with demonstrated consistent values and vision for the practice. This was evidenced in the guidance followed by staff, minutes of meetings, and action plans. Senior staff met regularly to coordinate and share leadership responsibilities. Minutes of these meetings recorded actions to be taken by staff in order to promote high quality care and good outcomes for people. For example, there was a meeting during which ways to identify patients who were at increased risk of emergency admissions were discussed.

Learning and Improvement.

There was a strong culture of learning and development. For example, one GP said the nursing team including health care assistant were being developing additional skills to be able to provide specific monitoring of some chronic health conditions. Permanent GPs had protected study time. One GP said they belonged to an external educational forum which supported continued learning and development. Staff said they followed best practice guidance. For example, National Institute for Health and Care Excellence (NICE) guidance for treating, monitoring and managing various conditions such as diabetes.

The practice manager told us guest speakers were invited to team meetings when general learning needs were identified. The last guest speaker had been a mental health professional. Staff said senior managers positively supported applications for non-statutory professional development.

There was good communication between all staff at the practice. For example, various meeting minutes identified which information was to be cascaded down to individuals, specific professional groups or the whole practice team. The practice had 'locum packs' for temporary GPs which included essential governance information such as incident reporting.

The practice learned from significant events, near misses and incidents. Records showed who was involved and what subsequent actions and learning had taken place. The

Are services well-led?

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

practice demonstrated it was responsive to patient feedback and complaints and took remedial actions. Learning shared with the appropriate staff which minimised the risks of similar incidents reoccurring.

Governance Arrangements

Robust arrangements were in place to regularly review the quality and performance of the practice. Staff leads had been identified for infection control and safeguarding. These roles included additional responsibilities for audit, staff training and liaising with other agencies. Regular meetings took place to discuss risk management, performance management and staff training, supervision and appraisals. We saw written and electronic records that evidenced this which ensured the practice continued to develop the skills of staff for the benefit of patients.

Systems to Monitor and Improve Quality & Improvement

Staff were able to demonstrate how data, audits and benchmarking information had been used to minimise risks and make improvements to standards of care. For example, every month the practice manager produced and reviewed the referrals rate for all conditions made by each GP. The practice manager said this identified any outliers (significant differences) such as under or over referring. The GPs used this information to redress any imbalances which ensured patients received the same level of service regardless of which GP they saw.

The practice manager told us they attended meetings with the commissioning group (CCG) in order to share information, identify risks, and coordinate local primary medical services. The practice manager attended Bournemouth and Poole practice managers meetings every two months. Minutes of these meetings showed governance information such as the Quality and Outcomes framework (QOF) results, direct enhanced services (DES) and NHS health checks were discussed. Speakers who had recently attended the practice managers' meetings included representatives from Public Health Dorset. The practice manager said all information was used to improve standards at Kinson Road Medical Centre for the benefit of patients.

Patient Experience and Involvement

The practice had responded positively to feedback from the patient reference group (PRG) and individuals. The practice had a complaints policy and procedure. Information about how to make a complaint was available to patients in the practice and on the practice's website. The patients we spoke with told us if they had concerns about their care they would not hesitate to raise them with staff.

Systems were in place to receive, monitor and respond to complaints. We saw evidence that the practice had appropriately investigated concerns and responded to them in accordance with their policy. The complaints log recorded subsequent actions taken and learning points. The complaints log also noted when information, outcomes and learning were fed back to relevant staff.

Staff engagement & Involvement

Staff told us they felt valued, supported and loyal to the practice. This was evident in the way staff worked flexibly in order to effectively manage the practice's shortage of GPs. Some staff said they would like the frequency of team meetings to be increased. The practice manager said they checked for concerns with all staff groups where possible every day and had an 'open door' policy. Staff said the practice manager and partner GP were very approachable.

Identification & Management of Risk

The senior partner and practice manager were pivotal to the leadership and governance of the practice. The senior GP partner and practice manager undertook the majority of governance, risk management and safeguarding lead roles. There were systems in place to identify and manage risks to patients. Staff were able to demonstrate how data, audits and benchmarking information had been used to minimise risks and make improvements to standards of care. There were no management risk assessments or plans which would ensure the smooth running of the practice in the event of any long-term absence of the senior partner or practice manager.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The proportion of patients registered with the practice who were aged 75 years and over was similar to that of other practices in the area. GPs worked closely with four local care homes to provide primary medical services. The practice was identifying a named GP for patients aged over 75 years to ensure care was consistent and coordinated. The practice was responsive to the needs of elder patients and had adapted access and care to be able to better monitor and maintain health and reduce risks.

Our findings

Effective

The practice provided primary medical services to four care homes for elder people in the locality. One GP said they visited frequently to review patients and monitor health. Senior practice staff meeting records showed patients aged over 75 years were to be given a named GP. This was to provide reassurance for patients that care would be consistent and coordinated. The practice manager was taking responsibility for identifying which GPs patients most frequently saw. Patients were going to be notified who their named GP was by letter.

Responsive

We reviewed information from Public Heath England, 2012. This showed high deprivation levels for older patients registered at the practice. The national average in England of older people in deprived circumstances was recorded as 18.1%. The percentage of older patients in deprived circumstances registered at Kinson Road Medical Centre was 26%. Older people in deprived circumstances in other primary medical services in the local clinical commissioning group (CCG) was 14.6%. The surgery had acted responsively to older patients' needs. For example, one GP told us they had identified older and vulnerable patients who would have difficulty getting to the practice for routine appointments. A GP and nurse visited these patients to review and evaluate their conditions and offer flu vaccinations. In another example, one GP explained how some older patients had limited care packages and how this had impacted on the effectiveness of treatments. This GP said they had acted on behalf of older people to increase the levels of care they received which enabled improved health outcomes.

Staff told us some elder patients were not able to easily get to the practice or access the online resources. These patients had the option of telephoning the practice to order repeat prescription medicines.

Clinical staff told us they had good relationships with community nurses and enabled care for elder patients to

Older people

be coordinated and responsive to needs. Staff said they worked with the community nurses and community matron to provide end of life care needs and minimise hospital admissions.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice demonstrated an understanding of how long term conditions such as diabetes and asthma affected patients in the locality. Patients said staff were caring and supportive and a range of resources was available. The practice demonstrated systems and plans they had actioned to provide effective, safe care and management of long term conditions. Analysis of prescribing and monitoring for patients with heart disease had resulted in a reduction of emergency admissions to hospital.

Our findings

Responsive

Patients with long-term conditions were supported to manage their health, care and treatment. Individual self-management plans were devised with patients, taking account of personal circumstances in order to maximise outcomes. The nursing team and health care assistant (HCA) were being 'skilled up' to be able to provide additional resources to monitor some long-term conditions, including diabetes and COPD.

Staff said patients did not often attend appointments made in advance for health monitoring. One nurse told us in response to this, the nurses and health care assistant (HCA) did not specialise in specific disease management. Alternatively, the nursing team had been trained to review, treat and provide advice on some chronic long-term conditions and common treatments. Records of what treatments the nurses and HCA were qualified to provide were kept with reception staff. Staff said this meant patients were able to access a prompt health appointment when requested.

Effective

The practice displayed health promotion leaflets in the waiting room and sign posted patients to other local services and support groups. Patients could meet with the nursing team for individual health promotion advice and support. The surgery website contained advice and information about long-term conditions. These included written information and videos of symptom management and health promotion advice. Each health condition had additional links to national bodies such as the National Institute for Health and Care Excellence (NICE), the Macmillan Cancer Support and the Mental Health Foundation. Two patients told us they had stopped smoking as a direct result of the care, support and advice of practice staff.

People with long term conditions

Well led

The practice was aware they had high numbers of patients with chronic obstructive pulmonary disease (COPD) compared with other primary care services in the local CCG. This was reflected in the Quality and Outcomes Framework (QOF) data. One GP had proposed to other local surgeries the benefits of employing an additional qualified nurse and healthcare assistant. This would be to monitor and maintain the health of patients with COPD and other long-term conditions.

One GP had analysed the medicines prescribed and emergency admission rates to hospital for patients with heart disease. These evaluations lead to a review of processes, monitoring and prescribing which resulted in a reduction of emergency admissions. This information was shared with other local practices in order to improve management of long-term conditions for a greater numbers of patients.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice had robust and effective systems in place to recognise and safeguard children from abuse. The practice worked with other community health services to provide a range services for children and women. This included child development and ante and postnatal services.

Our findings

Safe

Children were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. One GP said they had recognised some patients directly involved with vulnerable families were registered with other primary care services. This GP took actions to improve the coordination of care and minimise risks. Systems were created linking vulnerable children to step parents registered elsewhere. This information was shared with other relevant services and agencies.

All staff received appropriate safeguarding training to protect vulnerable adults and children from the risks of abuse. Records indicated most staff had received training or were booked to attend in line with practice policy. Staff at all levels demonstrated they understood potential signs and symptoms of abuse and knew what to do with concerns. The practice provided information leaflets for patients about safeguarding which included whom they should contact in the event of identifying any concerns.

The surgery provided child development and child immunisation clinics.

Responsive.

The surgery provided weekly antenatal and postnatal care in conjunction with the local midwifery service. The health visiting service was introduced during antenatal time, which ensured care was coordinated and consistent.

The surgery was not easily accessible for pushchairs or small children. The entrance to the practice was through two doors, which had to be opened manually. The practice manager told us the building was leased and improvements were being negotiated with the landlord.

Mothers, babies, children and young people

Effective

The practice provided effective services to meet the needs of patients who were mothers. These included a range of family planning and contraceptive services and NHS screening programmes.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Working age people had access to services at Kinson Road Medical Centre. The practice provided staggered clinic times covering early, late and lunch periods and a GP telephone contact system. The surgery provided well person checks to monitor health and provide lifestyle advice

Our findings

Responsive

Working age people had access to services. The practice provided staggered clinic times covering early, late and lunch periods. The practice reception and clinics were available from 8.30am to 6.30pm five days per week. Early morning appointments were provided twice per week from 7.30am to 8.00am. A late clinic was available for patients once per week between 6.30pm and 8.00pm. The branch surgery at West Howe provided a clinic form 9.00am to 11.30am five days per week.

An on call GP was available for emergency appointments throughout the day at Kinson Road Medical Practice. Patients had the option of telephone consultations with a GP which were booked in advance.

The surgery provided well person checks to monitor health and provide lifestyle advice.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice was responsive to the needs of vulnerable patients. The practice accessed signing and interpreting services and provided a formal chaperone service. Staff at the practice provided specific resource and information packs to people in care roles.

Our findings

Responsive

The practice was responsive to the needs of vulnerable patients. The practice participated in recognised national benchmarking programmes such as the Quality and Outcomes Framework (QOF) and local and direct enhanced services (LES and DES). Staff said the QOF and LES had supported primary medical care for vulnerable patients. For example, adults with learning disabilities were invited for an annual health check. The practice recognised these patients did not respond well to letters and set up systems to telephone patients. This resulted in a higher uptake of health screening by people with learning disabilities.

The practice accessed signing and interpreting services for those patients requesting them. Clinicians supported patients who wished to be accompanied to consultations, examinations or procedures by friends or relatives of their choice. The practice provided a formal chaperone service. The practice identified people in care roles and provided resource, information and advice packs to support them. This included signposting to other services available locally.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice worked collaboratively with community services and other health professionals to support patients with mental health problems. This was to co-ordinate care between different professionals and agencies and review risk management strategies. Some staff were not able to demonstrate a clear understanding of the Mental Capacity Act 2005 and how this related to their role with vulnerable patients.

Our findings

Effective

The practice worked collaboratively with community services and other health professionals. Staff said some patients living in local care homes had high dependency needs due to mental health issues or dementia type illnesses. One GP said they visited care homes frequently to review patients and monitor health.

Safe

The practice facilitated regular primary health risk meetings. Attendees included social workers and mental health clinicians. Each practitioner discussed patients they were most concerned about. One GP told us the meeting aimed to co-ordinate care between different professionals and agencies and review management strategies.

The practice had a policy and guidance regarding consent and patients who may lack capacity. Staff told us they worked with carers where possible to maximise communication and understanding. Some staff we spoke with did not demonstrate a clear understanding of the Mental Capacity Act and how this related to their role with vulnerable patients. Staff did not reference the key principles related to assessing capacity. For example, other than speaking with a carer, staff did not demonstrate what other actions had been taken to maximise a patients capacity. Staff records showed training in the MCA 2005 was not mandatory.