Beaufort Road 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.

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Overall summary

The Beaufort Road Surgery provides medical care to over 10,900 patients living in Southbourne and the surrounding areas of Bournemouth. The surgery consists of six GPs, three nurses, two healthcare assistants and a team of administration staff. The opening hours are 7.25am to 6.30pm and the surgery does not provide emergency cover outside normal opening times.

During our visit we spoke with 12 patients who were using the service. We also spoke with five GPs, two nurses, and the administrative staff.

The practice was caring. Patients described the staff as helpful and friendly and were involved in decisions about their treatment. The practice recognised the diversity of their patients and responded well to their individual needs.

Systems were in place to recognise and support patients who were at risk of abuse. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and any learning was shared with staff to mitigate future risks.

There was effective infection prevention and control, and staff were aware of their roles and responsibilities.

Not all patients and staff would be safe in the event of a fire at the surgery, as staff lacked confidence in the first floor fire escape route.

Patient care was delivered in line with best practice. Robust monitoring systems were in place, and ways for improving the service for patients were explored, but systems for recruiting new staff needed improvements.

GPs worked with other healthcare providers to ensure that patients received effective care. Patients were offered advice, treatment and support for their health. The practice was responsive to people's needs. Patients were able to access the care they needed promptly and efficiently. The practice had systems to ensure patient views were listened to and acted on. The building was accessible for patients with mobility difficulties or those with young children.

The practice was well led. There was a clear leadership structure and processes in place to keep staff informed. Staff felt valued and well supported. Patients gave positive feedback on the care provided to them. The practice had taken account of patients' views on how it should be run.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Systems were in place to recognise and support patients who were at risk of abuse. Staff were suitable to work with vulnerable adults and children. There was appropriate equipment, medicines and procedures for managing patient emergencies. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints, and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and learning was shared with staff.

Staff were aware of their roles and responsibilities regarding infection prevention and control and protocols were in place. However, the GPs' examination rooms were not always kept clean.

Not all patients and staff would be safe in the event of a fire at the surgery, as staff lacked training and confidence in the first floor fire escape route.

Are services effective?

Patient care was delivered in line with best practice. Systems were in place to ensure the service was monitored and ways for improving the service for patients were explored, but systems for recruiting new staff were not always completed.

The GPs worked with other healthcare providers to ensure patients received effective care. Patients were offered advice, treatment and support for their health.

Are services caring?

The service was caring. Patients described the staff as helpful and friendly. The receptionists had a warm and friendly approach to patients and visitors. They knew and understood the needs of patients who attend the practice regularly and their approach was kind but not patronising. Patients told us they were involved in decisions about their treatment. The practice could improve arrangements to ensure privacy in order to prevent confidential conversations being overheard

Are services responsive to people's needs?

The practice was responsive to patients' needs. The services provided enabled patients to access the care they needed promptly and efficiently. The practice had systems to ensure patients' views were listened to and acted on. Arrangements were in place to ensure the practice could meet the demand and needs of patients with minimal delay. Staff told us they had access to appropriate

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equipment to attend to patient needs. Staff were aware of arrangements for responding to medical emergencies. The practice was accessible to patients with mobility difficulties or those with young children.	
Are services well-led? The practice was well led. There was a clear leadership structure and processes were in place to keep staff informed of any changes. The GPs and practice manager met weekly to review complaints and significant events, to maintain and improve patient care. Staff felt valued and well supported. They were able to give their views on any improvements. The practice had responded to patients' views and patients gave positive feedback about the care provided.	

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 practice supported older people by having systems in place to assist people with memory loss. Nursing staff were trained in the treatment of physical conditions that affected older people.

People with long-term conditions
The practice supported patients with long-term conditions such as respiratory disease and diabetes by offering screening, treatment and information. Regular monthly clinics were held for patients with long-term conditions.

Mothers, babies, children and young people
The practice supported mothers, babies, children and young people by working with other healthcare providers to provide maternity services and young children clinics.

The working-age population and those recently retired
The practice supported people of working age and those recently retired with early opening hours. The practice opened each weekday morning at 7:25am. This early start time allowed patients to see the GP or have tests from the nurses prior to them going to work. Regular blood pressure monitoring and health screening was available to help early diagnosis of conditions and give opportunity to promote health and wellbeing.

People in vulnerable circumstances who may have poor access to primary care
The practice had procedures in place to assist patients to contact the practice and provide treatment to vulnerable patients using their practice.

People experiencing poor mental health
The practice supported people with mental health problems by ensuring that staff were aware of the Mental Capacity Act 2005. The practice also had a leaflet called 'steps to wellbeing', which gave information about free local talking therapies that were available to patients with mental health problems.

Summary of findings

What people who use the service say

We spoke with 12 patients using this service during our visit. We also reviewed the comment cards that were given out to people who used the service before we arrived, so that people could share with us their views and experiences.

All seven comment cards we received were positive, describing the staff as being helpful and supportive.

Patients told us they were usually able to arrange appointments to see their named GP. If they needed an urgent appointment and their named GP was not available, patients said they could see another doctor. Patients told us they were treated with dignity and respect. They said the GP explained their treatment to them in a way they could understand.

Patients felt the GPs knew them well. They greeted them at the door with a handshake and were very approachable. This set the tone and made patients feel welcome, reassured and valued.

Areas for improvement

Action the service MUST take to improve

A robust recruitment policy is required to ensure staff checks were completed. The practice must have a risk assessment for roles that they consider to not require a criminal record check via the Disclosure and Barring Service (DBS).

The fire procedures must include instruction on how to safely exit the building in the event of a fire especially from the first floor.

Consideration must be given to the privacy and dignity of patients during consultations with the practice nurses and the GP's.

Good practice

Our inspection team highlighted the following areas of good practice:

The lead for carer support had formed links with organisations that supported carers in the local community. They regularly gave training and advice to leaders of these groups

The GPs had formed joint working links with midwives and health visitors.

Beaufort Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a second CQC inspector, a GP specialist advisor and an Expert by Experience (a person with experience as a patient or carer).

Background to Beaufort Road Surgery

Beaufort Road Surgery is located at 21 Beaufort Road, Southbourne, Bournemouth. BH6 5AJ. The practice provides health advice and treatment, as well as referrals to other care agencies, reflecting patient choice wherever practicable. The practice is open from 7:25am until 6:30pm Monday to Friday. At weekends and when the surgery is closed, patients are directed to the out-of-hours service.

The practice has six GPs and a team of three qualified nurses and two healthcare assistants who are supported by a team of administrative staff. There are more than 10,900 patients. The doctors have the responsibility for personal lists, where possible, although sometimes patients presenting with acute problems are seen by the duty doctor.

Why we carried out this inspection

We inspected this service 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)
- 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.

Before visiting to inspect the practice, we reviewed a range of information we hold about the service and asked other organisations, such as the local Clinical Commissioning Group, Healthwatch and NHS England, to share what they knew about the practice. We carried out an announced visit on 30 May 2014. During our visit we spoke with five GPs, the practice manager, deputy practice manager, a registered nurse, and reception staff. We also spoke with 12 patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

Are services safe?

Summary of findings

Systems were in place to recognise and support patients who were at risk of abuse. Staff were suitably trained to work with vulnerable adults and children. There was appropriate equipment, medicines and procedures for managing patient emergencies. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints, and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and learning was shared with staff.

Staff were aware of their roles and responsibilities regarding infection prevention and control and protocols were in place. However, the GPs' examination rooms were not always kept clean.

Not all patients and staff would be safe in the event of a fire at the surgery, as staff lacked training and confidence in the first floor fire escape route.

Our findings

Safe patient care

Systems were in place to ensure that all clinical and medical staff were aware of risks within the practice. Senior members of staff were responsible for reviewing complaints. An accident and incident book was available and staff were aware of how to report incidents. The GPs met every day to discuss any issues as they arose. Any decisions or new arrangements were either discussed at staff meetings or emailed to all staff, depending on urgency.

A staff noticeboard gave clear details about the local safeguarding processes, including a website and telephone number for reporting concerns.

The nurses' treatment rooms were clean and infection prevention control procedures were in place.

Learning from incidents

All the GPs, practice nurses and the practice manager attended a weekly meeting between 1pm and 3pm on Mondays. Any incidents or risks that had been identified were discussed at this meeting with further significant event review meetings held six-monthly.

We saw the log of significant event reviews. The practice manager told us he had reported two significant events in 2014. One included an instance where a blood sample had been mislabelled with the wrong patient's name. Following the discovery of this mistake, it had been impressed on staff to use patients' date of birth and NHS number. Staff were also required to place a warning message on the computer system to alert other staff when any patient had a similar name to other people on the system.

The second was when the out-of-hours service made a report when a patient called them to report that the practice was open at 7:30am but the phone lines were not working. The practice manager explained that the practice had been asked to provide five and a half additional clinical hours per week, and were now offering early morning services; however, they were unable to answer phones until 8am under their current contract. Following this incident the practice updated their answerphone message to make this clear to people.

Are services safe?

Safeguarding

We saw the policy on safeguarding children and vulnerable adults. This gave staff clear guidance, including a flow-chart to help when making decisions about action to take, and contact details for the local safeguarding team for making alerts about possible abuse. Staff were suitably trained to work with vulnerable adults and children.

Staff told us they had found the GPs to be very responsive with regards to safeguarding concerns. Two GPs were mentioned as being particularly approachable in this area. Staff told us they felt well supported by the lead GP for safeguarding.

A designated staff member was responsible for monitoring the safeguarding process. Alerts were put on patients' records to identify any particular issue(s) with vulnerable adults and children. The lead GP for safeguarding told us they had used the safeguarding process. In one case they queried an injury, and in another a health visitor reported concerns on behalf of a baby before it was born. On this occasion the GP safeguarding lead contacted the social worker to help ensure safety for the unborn child.

Monitoring safety and responding to risk

Arrangements were in place to deal with emergencies. Emergency medication was available, along with oxygen and an automated defibrillator (AED) with ventilation (breathing) equipment for adults and children. We saw evidence that the staff had been trained in emergency support to ensure that they could provide assistance with resuscitation until further help arrived. There were robust procedures to check emergency medical equipment and the expiry dates of emergency medication monthly.

Staff told us they felt confident that they could seek assistance in the event of an emergency. Staff told us there was a panic button in reception that was connected directly to the police but it had not been used in ten years. Staff showed us other safety systems they could use if there was an emergency of any kind that would summon other staff to assist.

Fire alarms and equipment was tested and serviced on an annual basis. Some designated fire doors had been wedged open and the closure devices on several doors did not allow the door to close properly. This increased the risk that fire could spread. The practice manager told us that where this occurred the mechanism had been adjusted to allow for patients with mobility problems to be able to open the door.

We looked at the fire risk assessment. It was not dated, but the practice manager told us that it had been reviewed at the same time the fire extinguishers had been checked (October 2013). The need for staff training on fire prevention had been recorded but staff confirmed that no training had been provided. Staff told us that they had not received any instruction how to use fire fighting equipment, such as fire extinguishers. The practice manager told us that in the event of a fire staff were instructed to leave the building. Lack of fire training for staff puts patients and staff at risk in the event of fire.

The fire risk assessment stated that there was a way for people to get out of the building other than the stairs, which involved climbing from a first floor window onto a corrugated flat roof. We were not clear how to get to the ground from there. When we suggested trying this, staff were not confident about using this route. At the time of our inspection, patients attended a pre-natal clinic on the first floor, although the practice manager told us they were working towards moving this service downstairs. Staff and patients on the first floor may be at risk in the event of fire and the inspector referred this to the Fire service.

Medicines management

Systems were in place to ensure that patients' medicines were safe. Any identified problems with medication were emailed to individual GPs and the prescription clerk by the pharmacist and a pop-up alert was added to the electronic patient record of any patients taking that medication.

The practice employed a prescription clerk to oversee all aspects of prescribing for patients obtaining repeat medication. Patients could order their prescriptions in person at the practice or online once they had registered for this service. The practice did not accept requests for repeat prescriptions over the telephone. This was to avoid errors being made.

There was a system in place to monitor the storage of vaccines. The nurses monitored and recorded refrigerator temperatures before and after surgery. They told us that

Are services safe?

they would report any abnormal readings to the practice manager for appropriate action to be taken. This demonstrated that staff recognised the importance of storing vaccines at the correct temperature.

We saw that the emergency drugs in the GPs bags were in date and kept updated and practice nurses checked expiry dates. We looked at the controlled drugs (CD) book and saw that correct procedures were in place for storage and administration.

Cleanliness and infection control

The practice nurse was the lead for the prevention of infection control. There were policies and procedures in place and regular infection control audits. On our visit to the practice we toured the building and looked at areas where care and treatment were delivered.

The two treatment rooms used by the nurses had recently been refurbished. They had new washable flooring and there were sinks for handwashing with a supply of handwash and paper towels. There was a supply of disposable gloves and aprons with foot operated waste bins. All surfaces could be thoroughly cleaned and we were told that this procedure was carried out after each patient was seen. Each of the examination beds had disposable paper covers that were changed after each use. Disposable curtains were used for privacy and we saw that these were clean and last changed less than three months ago. There was a third smaller treatment room that was used by the phlebotomist. This room was equipped with a sink for handwashing with a supply of soap and paper towels and a pedal operated bin for waste products.

Dedicated sharps boxes were available in all the treatment rooms and were used appropriately. A contract was in place for the collection and safe disposal of clinical waste. There were systems in place to manage clinical waste.

Staffing and recruitment

We found that the practice had written guidance to support staff with the recruitment and selection process. Suitable candidates were asked to provide documentation to verify their identity and qualifications. More than one staff members file recorded contact details for two referees but there was no evidence references were followed up. We did not see that a criminal record check via the Disclosure and Barring Service (DBS) had been carried out for all staff. Staff told us they had not considered completing a risk assessment around employing a person in a position of trust without a criminal records check. The recruitment policy had also not been applied consistently.

Dealing with Emergencies

The practice manager told us the practice had continuity plans for certain situations, such as severe weather and loss of power. We were told that when it had snowed, staff who lived in walking distance all came in and cleared the drive. This showed that the practice had a culture of goodwill to ensure that the practice remained open.

If the practice lost electricity, the telephones and emergency lighting would continue to operate for three hours. The reception staff printed out a list of pre-booked appointments at the beginning of each day, so in the event of a power failure GPs and nurses would work to this and be able to carry out home visits.

Equipment

First aid kits and emergency equipment were in order and stored appropriately where they could be reached easily in an emergency.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patient care was delivered in line with best practice. Systems were in place to ensure the service was monitored and ways for improving the service for patients were explored, but systems for recruiting new staff were not always completed. The GPs worked with other healthcare providers to ensure patients received effective care. Patients were offered advice, treatment and support for their health.

Our findings

Promoting best practice

Patient care and treatment was delivered in line with current best practice. Staff told us they applied national guidelines in the treatment and support of patients, such as guidance developed by the National Institute for Health and Care Excellence (NICE) and the Mental Capacity Act 2005 (MCA). The MCA is a framework that supports people who need help to make decisions about their care. Staff were confident in their knowledge of consent and the importance of the assessment of capacity, and the application of the law. They gave examples of how this applied to children and adults with impaired mental capacity. The practice had a system in place called 'Steps to Wellbeing', which enabled staff to refer patients with mental health issues to a specialist.

Management, monitoring and improving outcomes for people

All the GPs worked on a Monday and attended a practice meeting on Monday afternoon. This meeting was also open to the practice manager, practice nurses and the district nurses, health visitors and midwives attached to the practice. Any concerns and complaints from patients were discussed at this meeting, as well as any clinical and organisational matters that needed to be discussed. For example, chaperones (where a patient chooses to have a person of their choice accompany them for their consultation) were available but staff told us patients rarely took up this service and possible reasons for this were discussed at a meeting.

The GPs also met every day at 11am when they had finished their morning surgery. This was to provide peer support, discuss issues with regards to patients, and share workload. Staff were aware that the GPs were available to answer any questions during this time. This demonstrated an open and inclusive culture within the practice.

The GPs discussed palliative care patients on a regular basis, and met with the district nurses and the Macmillan nurse on a three-monthly basis to ensure they were coordinating the best possible care.

Are services effective?

(for example, treatment is effective)

Staffing

There was a commitment to professional practice and staff development. Staff told us they had received appraisals in the past year. A new format had been introduced and we saw that it covered areas such as performance training needs and where the staff had done well.

The nursing staff received their clinical appraisal from a GP at the practice. The nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council.

Continuous professional development was also evident with the GPs, who were all members of the Wessex GP Education Trust. GPs told us they had attended local courses as well as educational events at the practice.

Working with other services

The GPs worked with other healthcare providers to ensure that patients received effective care. We were given examples of when multidisciplinary meetings had been held, such as the involvement of the mental health team when assessing capacity to give consent.

GPs discussed palliative care patients on a regular basis, and met with the district nurses and the Macmillan nurse on a three-monthly basis to discuss patients' needs.

The GPs told us they received good clinical support from the community psychiatric nurse team as well as the psychogeriatric team, who held memory clinics for their patients.

There were also links with the local safeguarding teams for adults and children, this promoted good understanding of roles and good communication.

Health, promotion and prevention

Information about health promotion and prevention was readily available to patients in the form of pamphlets, large print notices and printed sheets in the reception area, around the waiting room and corridors, and on the practice website. These included information on how to recognise signs of or prevent illness.

The practice offered clinics for patients with diabetes, respiratory problems and other conditions where health promotion discussions were part of the treatment plan. Screening clinics were held for conditions such as the early detection of diabetes and high blood pressure.

Staff told us they had recently given out questionnaires that included a question asking whether patients had concerns over memory loss. They were in the process of inviting each respondent for an appointment, to give them a memory test.

Are services caring?

Summary of findings

The service was caring. Patients described the staff as helpful and friendly. The receptionists had a warm and friendly approach to patients and visitors. They knew and understood the needs of patients who attend the practice regularly and their approach was kind but not patronising. Patients told us they were involved in decisions about their treatment. The practice could improve arrangements to ensure privacy in order to prevent confidential conversations being overheard.

Our findings

Respect, dignity, compassion and empathy

We spoke with 12 patients on the day of our visit who gave complimentary comments about the practice. Patients told us the reception staff were always nice and helpful and made them feel valued. We observed that the receptionists had a warm and friendly approach to patients and visitors, and clearly understood the needs of their regular patients. The receptionists worked hard to find the earliest appointment to suit the patient.

We saw reception staff being courteous to patients arriving for treatment. The waiting room was set back from the reception desk, which meant people would not overhear what was said. The staff receiving calls from patients requesting appointments were in a separate area away from the reception. This meant their conversations could not be overheard. Patients had the opportunity to check in using a computerised system if they preferred.

Some aspects of the building did not promote dignity and privacy for patients. For example, The practice had loosened the automatic closure system on doors into consulting rooms to ease access for people with mobility problems. Due to the way this had been done the doors did not close properly, which meant that private conversations during consultations could be clearly and easily heard leading to a compromise of patients privacy and dignity. In addition, we found that we were able to overhear private conversations taking place in treatment rooms which compromised patients' privacy and dignity. During the inspection we overheard confidential conversations in the treatment rooms.

Patients accessed the practice using either steps or a ramp. The reception desk was too high to allow people in wheelchairs to see the receptionist. Staff told us that they would go round into the reception area to speak with the patient if this was required.

The practice had a lead for carer support. They told us they had formed links with other organisations that supported carers in the local community, and gave regular training and advice to leaders of these groups. The carer support lead also told us they were building on previous links and aiming to ensure that carer support was developed holistically in conjunction with GPs, other agencies and the

community. This was to ensure the practice could provide the best possible support and care for this group. There was a noticeboard in the waiting area signposting the services in place to support carers.

Chaperones were available to patients who needed them. There was signage in the reception area informing people that they could request a chaperone when being treated or seen by their GP. One patient told us that they were aware of this service but had not felt the need to use it as if they needed to see a female doctor then it was arranged by the reception staff when the appointment was made.

Patients were advised of delays. On one occasion during the inspection, patients waiting to see a GP were informed of a 45-minute delay. One patient was unable to wait any longer due to a prior commitment. The receptionist was able to explain the reason for the delay; the patient was offered a choice of alternative appointments and was clearly satisfied by the outcome.

There was a confidentiality policy, which staff told us had been discussed during their induction. Staff told us they were always aware when a person phoned on behalf of a patient, because the computer highlighted which patients had given their consent for staff to discuss their care with another person; for example, it might show: please contact my daughter. Copies of the practice's confidentiality policy and a confidentiality agreement were in individual personnel files. They had been given to staff when they were recruited, and staff had signed and dated the policy to show they had read and understood it.

Involvement in decisions and consent

Patients told us they were involved in the decisions about their treatment. Patients we spoke with told us the GPs explained the treatment and fully involved them in the process. They told us that they were always asked for their consent before treatment was given. We saw that there were diagrams on consulting room walls, as well models of limbs, that doctors could use to visually demonstrate what the problem was, to help people make informed decisions.

We saw leaflets giving information on a range of medical conditions in the waiting area. The practice website contained information and guidance about how patients could treat themselves at home for conditions such as back pain, sprains and sunburn.

We asked staff how they managed when patients arrived needing care or treatment who did not understand English. Staff told us that such patients usually came from the local language school so they generally stayed with local families and always brought somebody with them for support.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. The services provided enabled patients to access the care they needed promptly and efficiently. The practice had systems to ensure patients' views were listened to and acted on. Arrangements were in place to ensure the practice could meet the demand and needs of patients with minimal delay. Staff told us they had access to appropriate equipment to attend to patient needs. Staff were aware of arrangements for responding to medical emergencies. The practice was accessible to patients with mobility difficulties or those with young children.

Our findings

Responding to and meeting people's needs

Patients we spoke with were satisfied and happy with the practice. There were systems in place to ensure patients' views were listened to and acted on. The annual patient survey conducted by the patient representative group indicated that patients were satisfied with the services provided by the practice.

The practice recognised the diversity of their patients and responded well to their individual needs.

We asked staff how they managed when patients arrived needing care or treatment who did not understand English. Staff told us that such patients usually came from the local language school so they generally stayed with local families and always brought somebody with them for support. People staying with families locally were mostly European. Staff told us about a patient who used a fax machine to make their appointments. Another patient who was deaf used an online audio service with an operator to book appointments, where the operator spoke to staff and relayed the information to the person. Staff said this patient was able to lip-read so they advised the GP that the person would need to be collected from the waiting room as they could not hear when the tannoy called them for their appointment.

Information was readily available and could be found in the reception, waiting room and around the corridors in the form of pamphlets, large print notices and printed sheets.

Access to the service

The practice operated a system where patients could make an appointment by telephoning or calling into the practice. A smartphone app had very recently been added as an additional booking route.

If patients wished to see a specific GP they were generally given an appointment within seven days. If the problem was more pressing but non-urgent, an appointment could be made within three working days with the next available GP.

Routine appointments could be made up to one month in advance. This enabled the practice to offer an appointment at a time more suitable for those patients that needed them.

Are services responsive to people's needs?

(for example, to feedback?)

Emergency appointments were available for patients who needed them.

GPs were responsible for their personal lists and knew most of their patients well. They sometimes spoke to patients on the phone to determine whether a visit to the practice was really necessary. Home visits were distributed between the GPs when they had their morning meeting.

Concerns and complaints

The complaints policy was displayed in the reception area and there were leaflets in the entrance giving patients information about how to make a complaint. We looked at the recent complaints that had been received by the practice and found the practice had responded in a timely way.

The practice manager explained the practice's complaints procedure to us and gave examples of actions they had taken in response to complaints. They told us they would telephone the patient making the complaint on the same day. They described an occasion following a complaint, where a new patient information leaflet had been drafted and sent to the complainant for their consultation before being widely circulated.

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. There was a clear leadership structure and processes were in place to keep staff informed of any changes. The GPs and practice manager met weekly to review complaints and significant events, to maintain and improve patient care. Staff felt valued and well supported. They were able to give their views on any improvements. The practice had responded to patients' views and patients gave positive feedback about the care provided

Our findings

Leadership and culture

The practice had a clear leadership structure. There was a documented charter, which aimed to achieve a professional, caring and friendly service. There were daily meetings for the GPs and other staff were able to access them during this time. A meeting for all staff took place three monthly to raise awareness of practice issues. All staff we spoke with were very satisfied with the working environment, team working and management at the practice.

Governance arrangements

Staff were designated as leads for various aspects of the service. We spoke with the prescriptions clerk who had overall responsibility for ensuring that repeat prescription requests were managed in a safe and timely way. The lead for carer support had formed links with organisations that supported carers in the local community. They regularly gave training and advice to leaders of these groups. All of the GPs took responsibility for safeguarding and complaints, and these issues were discussed daily.

Each staff department had a lead to develop their service and manage their staff.

Systems to monitor and improve quality and improvement

The senior partner was responsible for the Quality and Outcomes Framework (QOF). QOF is a means of measuring, collecting and monitoring information to meet nationally recognised standards for improving patient care and maintaining quality. The senior partner met with the practice manager on a regular basis to review progress against these targets and, when necessary, individual patients were identified and passed on to the appropriate GP.

GPs were auditing the number of emergency admissions to hospital and aimed to reduce these where possible. They were taking part in a pilot of a 'virtual ward' system, where 20 patients benefited from geriatric and community matron input while remaining in their own homes. This showed clear initiatives were being taken to help people maintain their independence and remain at home.

Are services well-led?

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

Patient experience and involvement

The practice used a variety of strategies to collect patient views on the service. The practice and the Patient Representative Group (PRG) conducted an annual patient survey. The patient survey allowed patients to provide feedback on appropriate use of GP and nurse appointments, their understanding of when to access the local Accident and Emergency Department and out of hours services, and using other resources available to reduce the need to see a GP or nurse.

During our inspection we met with a representative of the PRG. The group consisted of patient representatives, GPs, the practice manager and other health professionals. They informed us that the group met two to three times a year but if the need arose, additional meetings could be arranged. This showed a flexibility and willingness to meet demand.

The representative felt that as a group their opinions were valued and they had a real role to play in moving the practice forward. We were informed that prior to meetings, the practice manager contacted members to ask if they had any items they wished to be added to the agenda.

Feedback was via written or face-to-face contact. A summary was posted on the practice website, which had recently replaced the printed newsletter. There was ongoing discussion that patients without computer access may find it difficult to access information this way.

The representative we spoke with the ability to see a GP on the same day if necessary was one of the practice's strengths. GPs knew their patients well and would always greet them at the door with a handshake. This set the tone and made patients feel welcome, reassured and valued.

The PRG was exploring ways of encouraging young persons and members of ethnic minorities to become involved with the PRG.

Staff engagement and involvement

Staff told us they felt engaged with practice issues. They felt they could suggest ideas for improvement or concerns at their staff meetings. Important information would be reported back promptly either verbally by email. All of the staff we spoke with were satisfied with their involvement at the practice.

Learning and improvement

The deputy practice manager was responsible training the administrative staff at the practice. He told us they were devising training that could be delivered to a group or individually, and that some training was shared with the neighbouring practice.

We saw records confirming that administrative staff had an individual appraisal carried out by the deputy practice manager. One staff member said they had found this helpful and that they had been encouraged to contribute their own ideas of anything that could be changed for the better. For example, they changed to a timetable of administrative tasks on rotation, rather than staff having their own preferred tasks. This helped job sharers work effectively, as all staff needed to be able to do everything, and be able to cover for absence.

Identification and management of risk

The practice had a risk assessment in place for fire safety, this was not dated. Areas of concern that had been identified during assessment had not been completed, for example fire training.

We looked at two staff personnel files and saw that criminal record checks had not been carried out by the practice. There was no risk assessment to support this.

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 practice supported older people by having systems in place to assist people with memory loss. Nursing staff were trained in the treatment of physical conditions that affected older people.

Our findings

The practice supported this population group by having systems in place to assist people, for example, with memory loss. The nursing staff were trained in the treatment of physical conditions that affected older people.

A stroke clinic, and in conjunction with the community nurses, a leg ulcer clinic were offered by the practice.

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 supported patients with long-term conditions such as respiratory disease and diabetes by offering screening, treatment and information. Regular monthly clinics were held for patients with long-term conditions.

Our findings

The practice offered screening, treatment and information to support those with long-term conditions such as respiratory disease and diabetes. Regular monthly clinics were held for patients with long-term conditions. The nurses also held monthly clinics to provide support to patients in the management of their condition, they included regular monitoring and testing and to give advice on diet and healthy lifestyles. These clinics assisted the GPs with the treatment plans.

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 supported mothers, babies, children and young people by working with other healthcare providers to provide maternity services and young children clinics.

Our findings

The practice provides services for mothers, babies and young children.

Community Midwives attended the surgery on two days of the week. They worked with the GPs to provide pre- and post-natal care for mothers, and for babies in the first 28 days of life.

A health visitor was available for babies and young children. They monitored child development, promoted family and public health, offered advice on immunisation and ran a weekly child health clinic.

The practice also provided inoculation against disease to babies and children under the age of five years.

The patient representation group (PRG) was exploring ways of encouraging young persons and members of ethnic minorities to become involved with the PRG.

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

The practice supported people of working age and those recently retired with early opening hours. The practice opened each weekday morning at 7:25am. This early start time allowed patients to see the GP or have tests from the nurses prior to them going to work. Regular blood pressure monitoring and health screening was available to help early diagnosis of conditions and give opportunity to promote health and wellbeing.

Our findings

The practice supported the working age population and those recently retired by providing screening for common conditions. They offered a flexible appointment system and access to information and services, such as being able to order repeat prescriptions via the internet. The practice opens each weekday morning at 7:25am. This early start time allows patients to see the GP or have tests from the nurses prior to them going to work. Regular blood pressure monitoring and health screening was available to promote early detection of illness or disease.

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 had procedures in place to assist patients to contact the practice and provide treatment to vulnerable patients using their practice.

Our findings

The practice had procedures in place to assist patients to contact the practice and provide treatment to vulnerable patients using their practice.

We asked whether the practice would be able to arrange an appointment for a patient who had no home address. Staff said they would ask the duty doctor to see them, and would complete the temporary resident (TR) form. They could not recall a homeless person needing this assistance but frequently people on holiday or staying with relatives fell ill or suffered a fall and they were able to help them.

The practice manager told us they were proactive with services to patients with a learning disability. They had carried out health checks on half of these patients last year. He said they had good relationships with care homes but were finding it harder to reach people with a learning disability when they were still living with their parents. He said they identified their vulnerable patients and ensured computer codes were correct, which meant the patients would be included in appropriate services.

Patients with sensory impairment were able to contact the practice to order prescriptions or make appointments by the method of sending a fax. For each appointment the reception staff would alert the GP to any particular needs of the patient by putting an alert on the computer.

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 supported people with mental health problems by ensuring that staff were aware of the Mental Capacity Act 2005. The practice also had a leaflet called 'steps to wellbeing', which gave information about free local talking therapies that were available to patients with mental health problems.

Our findings

The practice supported people with mental health problems by ensuring that staff were aware of the Mental Capacity Act 2005. The practice also had 'steps to well-being', which gave information about local free talking therapies for patients with mental health problems.

During our visit we spoke with a younger patient who had complex issues that required them to have quality time with their GP. They told us they were not rushed and could have more time if they needed. They said they were always treated with respect.

Staff said that if they saw a patient was distressed and may be in a mental health crisis they would call for a GP to attend and may take them to a quiet room. If they observed deterioration in the mental abilities of an older person they would bring this to the attention of the patient's named GP. If they had concerns about their wellbeing they would tell the GP who took the lead for safeguarding.

Staff gave an example of assistance given at this practice when a family with an autistic child arrived for an appointment. Staff had suggested they waited in their car rather than come into the waiting room if it was busy, to avoid stress. The staff then called the family when it was their time for their appointment, which saved the child from being distressed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 15: Safety and suitability of premises** The registered person must ensure that service users and others having access to the premises where a regulated activity is carried out are protected against the risks associated with unsafe or unsuitable premises by means of- (c) adequate maintenance and, where applicable, the proper – (i) operation of the premises **How the regulation was not being met:** The practice did not have adequate arrangements in place with regards to fire safety. This meant patients and staff were not protected against risk of harm in the event of a fire.

Regulated activity	Regulation
Diagnostic and screening procedures	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 15: Safety and suitability of premises** The registered person must ensure that service users and others having access to the premises where a regulated activity is carried out are protected against the risks associated with unsafe or unsuitable premises by means of- (c) adequate maintenance and, where applicable, the proper – (i) operation of the premises **How the regulation was not being met:**

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Surgical procedures	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 15: Safety and suitability of premises** The registered person must ensure that service users and others having access to the premises where a regulated activity is carried out are protected against the risks associated with unsafe or unsuitable premises by means of- (c) adequate maintenance and, where applicable, the proper – (i) operation of the premises **How the regulation was not being met:**

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Regulated activity	Regulation
Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 21: Requirements relating to workers.** The registered person must – (1) (a) Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person- is of good character (b) ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate **How the regulation was not being met:** The practice did not undertake adequate checks to ensure information from Schedule 3 was available for all staff. This meant the recruitment process was not robust to effectively protect patients from being cared for or supported by unsuitable staff. Risk assessments were not in place for roles that were considered by the practice to not require a criminal record check.

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Diagnostic and screening procedures	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 17: Respecting and involving service users.** (1)The registered person must, so far as reasonably practicable, make suitable arrangements to ensure- (a) the dignity, privacy and independence of service users. (2)(a) treat service users with consideration and respect. **How the regulation was not being met:** The practice had loosened the automatic closure system on doors into consulting rooms to ease access for people with mobility problems. Due to the way this had been done the doors did not close properly, which meant that private conversations during consultations could be

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