Northbourne 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.

Summary of findings

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Summary of findings

Overall summary

Northbourne Surgery is located at 1368 Wimbourne Road, Dorset BH10 7AR, a residential area of north Bournemouth. The practice is registered to provide the following regulated activities:

- Diagnostic and screening procedures;
- Family planning;
- Maternity and Midwifery services;
- Surgical procedures;
- Treatment of disease, disorder or injury.

During our inspection we spoke with 11 patients and in some cases their carer or family members. We also reviewed the comment cards that three patients had completed before our visit.

The patients we spoke with and two of the three comment cards we received commented positively on the service they received from this medical practice. The most recent patient survey conducted by the practice in December 2013 also showed high levels of satisfaction with the care and treatment patients received.

The practice was aware of the needs of their practice population and had taken steps to improve or make more accessible the services for their patients. The practice worked closely with a local nursing home to support the health needs of the people who lived there. Young children were prioritised for urgent appointments and an evening surgery took place each week for patients who were unable to attend during the daytime due to work commitments.

There was evidence that the practice worked with other health and social care professionals to safeguard their patients and improve their health and treatment outcomes.

We had some concerns about the records of staff recruitment and the practice could not be sure that the people they employed were suitable or fit for their role.

The practice manager was very supportive and staff felt able to approach them for help, guidance and support.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that there were areas for improvement for safety. This was about the recruitment documents relating to staff and resuscitation equipment being available in working order. There was a robust process for identifying and reporting safeguarding issues. We saw evidence the practice had systems in place to deal with emergencies that may arise.

Are services effective?

The practice was effective. There were systems in place to ensure there were sufficient staff to meet patients' needs. Staff received regular training and ongoing support through an effective appraisal system.

The service worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment.

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained.

Are services caring?

Overall the practice was caring. The patients we spoke with were very complimentary about the caring compassionate attitude of staff. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients. Patients we spoke with felt well informed about their care and treatment.

Are services responsive to people's needs?

The practice was responsive to patients' needs. Patients told us they could always get an emergency appointment and waiting time for routine appointments was good. The practice sought feedback from patients about the service such as the on line booking system and the introduction of a self-monitoring system for patients to check and record their blood pressure and weight. The practice understood the needs of their patients and had made changes to the practice building and systems to meet some of those needs.

Summary of findings

Are services well-led?

The practice was well led by practice management staff with clinical leadership from the GP partners. Staff were supported by practice management and a culture of openness and honesty was encouraged. Risks to the safe and effective delivery of service were assessed and there were suitable business continuity plans in place.

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

A number of the patients we spoke with during our inspection were from this population group. They told us that they were treated with dignity and respect. We saw that the practice met the needs of patients in this population who had mobility difficulties. GPs situated on the first floor came downstairs to use a spare consulting room so that patients were still able to see the GP of their choice even if their normal consulting room was upstairs.

The practice had developed good links with a local nursing home and treated patients who lived there. They had met with nursing home staff to discuss and advise on the care and support needs of the residents.

People with long-term conditions

Patients with long term conditions were supported by the practice to manage their conditions. Nursing staff had specific training to help them understand the needs of these patients. A specialist nurse from a local hospital worked with one of the practice nurses to provide a specialist clinic to assess and monitor patients with long term conditions such as diabetes. They also advised patients on the management of their long term condition and signposted them to relevant support organisations.

Mothers, babies, children and young people

We spoke with parents who attended the surgery on the day of our inspection with their new born baby. They told us that all ante natal care had been provided by midwives who ran a weekly clinic at the practice. They told us that their GP was well informed of their progress by the midwives. They had good direction and health education throughout the pregnancy especially in relation to healthy eating.

The working-age population and those recently retired

The practice had an evening surgery one night a week to increase the accessibility of their service to patients who were unable to attend during the day due to work commitments.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care The practice had considered specific needs of vulnerable patients. One of the GPs had identified that there was a risk to the health and wellbeing of a family they had seen. An appropriate safeguarding referral had been made to the local authority to protect all members of the family.	
People experiencing poor mental health The practice supported patients with mental health problems. A counsellor from a local support group worked at the surgery. The counsellor, who was also a psychiatrist, was able to see referrals from the GPs and patients were able to self-refer to use their service. The practice had built strong relationships with the community mental health team (CHMT). A representative from CHMT was invited to the practice's multi-disciplinary meetings when appropriate to do so.	

Summary of findings

What people who use the service say

We spoke with 11 patients and in some cases their carers or family members as well. We reviewed three comment cards which had been completed by patients in the two weeks leading up to our inspection. Two of the three comment cards were very complementary about the practice mentioning patient, understanding and friendly staff. We received negative feedback from one person who had concerns about waiting times.

The patients we spoke with all spoke positively about the practice. We were able to speak with patients from a number of the population groups we look at. These included mothers and children, people of working age, people with long term conditions and people aged over 75 years of age.

Patients told us that staff had a caring attitude and they felt safe with the care they received. In all but one case people were satisfied with the appointment system and their ability to get appointments to suit their needs. We were told by three people that when they had received care from other health care professionals they were pleased that information was shared appropriately and in a timely way. For example transfer to or from hospital or private medical care had been a smooth process.

We saw the results of the practices latest patient satisfaction survey. There had been 100 responses from the survey in December 2013, which had been given to patients at the reception desk or sent to patients. 90% of the patients surveyed said they would recommend the practice to others.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that they have a robust recruitment procedure in place which specifies that appropriate checks must be carried out on all staff employed by the service. The practice must ensure that all information is recorded appropriately.

Action the service COULD take to improve

Policies and procedures relating to infection prevention and control (IPC) should be reviewed against best practice guidelines. IPC procedures should be audited and findings acted on to improve infection control practices.

The practice should make sure that patients are aware of how they could feedback to the service or be supported should they wish to make a complaint or raise a concern.

The practice should record all concerns/comments and complaints so that trends and themes can be identified.

The practice should ensure that evidence of clinical audits, other than those required for The Quality and Outcomes Framework, is available to demonstrate the effectiveness of treatments provided.

Good practice

Our inspection team highlighted the following areas of good practice:

An effective relationship had been established with a local nursing home. There had been meetings with the home to identify the best way to meet the medical needs of the patients who lived there and to provide help and advice to the home staff.

Northbourne Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP the team also included a specialist advisor in governance, risk and patient safety management and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Northbourne Surgery

Northbourne Surgery is located at 1368 Wimbourne Road, Dorset BH10 7AR, a residential area of north Bournemouth. The practice operates from a building which is owned by the practice's GP partners. A physiotherapist and a local counselling service also use the building.

The practice provides a range of primary medical services to approximately 5800 patients. Patients are supported by a number of GPs, practice nursing staff, a practice manager and administrative staff. The practice is a member of the Dorset Clinical Commissioning Group (CCG). One of the GPs at this practice is a member of the CCG board.

Northbourne Surgery has a higher percentage of their population group over the age of 65 than the average for England.

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, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service. Organisations included local Healthwatch, NHS England and the Clinical Commissioning Group.

Detailed findings

We carried out an announced visit on 4 June 2014 between 8.30am and 5pm

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager and reception and administrative staff. We spoke with patients who used the service and their carers or family members. We observed how patients were being cared for and reviewed some of the practice's policies and procedures. We also reviewed a small number of comment cards on which patients had shared their views and experiences of the service.

Are services safe?

Summary of findings

We found that there were areas for improvement for safety. This was about the recruitment documents relating to staff and resuscitation equipment being available in working order. There was a robust process for identifying and reporting safeguarding issues. We saw evidence the practice had systems in place to deal with emergencies that may arise.

Our findings

Safe patient care

The practice received patient safety alerts from organisations alerting them to safety issues around medication and equipment. The practice manager and GPs told us how these were dealt with in the practice to ensure the information was received and acknowledged by clinical staff. The practice nurse told us that as well as receiving information cascaded from the practice manager or GP they also received online alerts from an organisation they subscribed to. The information was used to ensure that staff were aware of any issues which could be a risk to patient safety.

GPs at the practice offered patients the services of a chaperone during examinations. We saw that details of this service were displayed around the practice building. Non clinical staff sometimes acted as chaperones, those we spoke to told us they had not had any specific training for the role. We saw that not all staff used as chaperones had received criminal record checks through the disclosure and barring service (DBS). We saw a risk assessment that recorded the reason why the service felt it unnecessary to make DBS checks for non-clinical staff. However the risk assessment did not take into account that some of these staff carried out duties as a chaperone. This meant the provider could not assure themselves that staff undertaking these duties were suitable for the role and this could put patients at risk for their safety.

Learning from incidents

There were arrangements in place for reporting significant events. We saw that the reports of these events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at weekly practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where systems within the practice had been changed to minimise further risks. A more robust system of checking patients' identities had been put in place to ensure correct and appropriate referrals were made.

Safeguarding

Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in specific

Are services safe?

high level training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Contact telephone numbers for reporting any safeguarding concerns were displayed in a number of places throughout the practice making the information easily accessible to staff.

The GPs we spoke with told us that they had made contact with social services when they identified concerns about patients in their care. Representatives from social services were invited to multi-disciplinary meetings when it was felt appropriate by the practice.

Monitoring safety and responding to risk

The practice had appropriate equipment, emergency drugs and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and drugs in date so that they would be safe to use should an emergency arise. The practice had an automated external defibrillator (AED) which is used in the emergency treatment of a person having a cardiac arrest. We saw that at a recent check it was noted that the battery was low. On the day of our inspection the AED was no longer working. We were told that a new battery had been ordered and they were awaiting delivery. There was nothing to alert staff that the AED was out of operation and in the case of an emergency staff may have relied on equipment which would be ineffective.

All staff had taken part in emergency life support training. Reception staff were able to describe their training and felt confident that they could respond appropriately to an emergency in the waiting room. All computer terminals had the ability to raise an alarm if the operator felt at risk or if there was an emergency so that other staff would be able to go to their assistance quickly.

On the day of our visit two of the GP partners, one of which was the registered manager, chose not to be at the practice due to other commitments. The use of a locum GP had been organised to ensure that patient care was not disrupted. Staff told us their mornings were always the busiest part of the day and there were more reception staff on duty at that time to manage the increased workload.

Medicines management

One of the GP partners is the lead clinician for the management of medicines. Medicines at the practice were kept securely and no controlled drugs were kept on the premises. (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.) There were systems in place to report any medicines issues to the appropriate external organisations. Any medicines related issues were also recorded as a significant event and were the subject of discussion at practice meetings to avoid a recurrence and to identify if any lessons learnt or changes to process were necessary.

Medicines fridges were located in the nurses' treatment room. These were lockable to ensure their contents were safe. Fridge temperatures were logged daily to ensure they were at optimum temperature for temperature sensitive medicines and vaccines. Staff were clear on the actions to take should an error in the operation of the fridges occurred.

We were told that alerts relating to medicines were cascaded to clinical staff by the GP lead and copies of the alert were given to the clinicians who signed to confirm they had noted the contents. The service identified and acted on potential risks to patient safety.

Cleanliness and infection control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Although the practice nurse we spoke with confirmed the policies and procedures still reflected current practice the documents we saw had not been reviewed by their due date. There was no evidence that any audits of the practice's infection control procedures had been carried out or an annual infection control statement.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a supply of liquid soap and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste and clinical waste was disposed of appropriately, after being removed from the practice it was kept in locked waste bins to await collection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared clean and well maintained. Work surfaces were easily cleanable and were clutter free. There were checklists in place for cleaning staff and clinical staff to sign and record their individual

duties. One of the nurses we spoke with clearly described the procedures in place to maintain a clean and safe working environment. The infection control policy clearly laid out the national colour coding guidance for cleaning equipment. Colour coding of cleaning equipment means that the risk of cross contamination is reduced. For example, equipment used for high risk areas such as toilets was not used in clinical areas.

Staffing and recruitment

The staff we spoke with told us that the majority of the staff had worked at the practice for a number of years. The practice manager and GPs we spoke with told us that they felt the stable work force provided a safe environment for their patients. We looked at the recruitment and personnel records for three staff, two of whom, had been employed within the last year. We saw that references were not available for two staff and there was no documentary evidence of the qualifications of a recently employed nurse. The practice manager was able to confirm that they had seen documentary evidence of qualifications however a copy was not retained on file. We did not see any employment history in one of the staff files. The practice manager told us that verbal references had been taken and provided the handwritten notes. However there was no formal record available of the details from the referee, therefore the practice could not be assured that staff they employed were qualified and competent to carry out their role.

The practice did not routinely record the registration and immune status, of the doctors and nurses so they could not be assured that people they employed were registered with their relevant professional body and were protected from risks related to work.

Dealing with Emergencies

The practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service. Arrangements had been made with a neighbouring practice to use their facilities and premises in an emergency. Arrangements had also been made with other practices for working together should there be a pandemic. (A pandemic is an infectious disease that has spread through the population across a large area.)

There were occasions when a locum GP was necessary to cover for unexpected sickness. Although the practice's aim was to use a known locum GP it was recognised that this was not always possible. The provider had put together a locum pack with relevant information about the practice to back up their local induction process. However the locum pack lacked information about referring vulnerable adults or children to local authority safeguarding teams.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. We saw that medical equipment such as blood pressure machines and medicines fridges had been recently tested for safety and performance. However we did note that some electrical items did not show that they had been portable appliance tested (PAT tested). This could be a risk to staff using this equipment as there were no assurances that the equipment was in efficient working order and in good repair. The practice did not have any records of visual checks on this equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. There were systems in place to ensure there were sufficient staff to meet patients' needs. Staff received regular training and on-going support through an effective appraisal system.

The service worked with other health and social care professionals and organisations to ensure that their patients received the most effective support and treatment.

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained.

Our findings

Promoting best practice

The practice had regular meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. This enabled the practice staff to discuss best practice and to learn from any incidents or concerns to improve the service to patients.

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs. Each patient who relied on long term medication was regularly assessed and their medication needs reviewed.

All staff we spoke with were aware of the need to gain informed consent from patients. Although we saw there were some gaps in staff training in the Mental capacity Act (MCA) 2005 staff were aware of the principles of the Act and the need to ensure best interests decisions were made appropriately for people who lacked the capacity to consent.

Management, monitoring and improving outcomes for people

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Northbourne Surgery completed the clinical audits that were required to fulfil the requirements of their quality outcome framework (QOF). We did not see evidence that any further audits of clinical practice took place to test the effectiveness of treatment.

The practice regularly reviewed their achievements against QOF. The practice manager was a regular attender at locality practice meetings where representatives from neighbouring practices met to discuss ways of improving outcomes for their patients.

The practice used the Quality Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that it generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local Clinical Commissioning Group (CCG) data demonstrated that the surgery performed well in comparison to other surgeries and practices within the CCG.

Are services effective?

(for example, treatment is effective)

Staffing

All the staff we spoke with in both clinical and administrative roles told us they were well supported by the provider especially by the practice manager. We saw there was a good system of induction in place for recently recruited staff. We spoke with a member of staff who had recently started to work at the practice. They explained the buddy system that was in operation and how that had given them the opportunity to shadow and learn from more experienced staff.

There was an annual appraisal system in place for staff which had been developed by the local medical committee. Staff we spoke with confirmed they had been part of the appraisal process and could approach the practice manager for support at any time. GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC).

During our inspection we spoke with 11 patients and in some cases their carer or family member, we also reviewed three comment cards. They all, apart from one, commented positively on the timeliness of their appointments, how quickly their telephone calls were answered and waiting times once they were at the surgery.

Working with other services

The practice had a range of health promotion literature in both their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations. To encourage patients to monitor certain aspects of their own health, a health pod had been introduced to the practice. This was an area where patients could take their own blood pressure and weight. The information was then fed into their patient record to be checked by the GP. We saw people using this facility during the day.

New patients were offered health checks with the practice nurse. These were left for the new patient to organise.

Health, promotion and prevention

The practice had a range of health promotion literature in both their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations. A health pod had been introduced to the practice. This was an area where patients could take their own blood pressure and weight. The information was then fed into their patient record to be checked by the GP. We saw people using this facility during the day. This meant that patients were encouraged to monitor certain aspects of their own health.

New patients were offered health checks with the practice nurse. These were left for the new patient to organise. This meant that the service missed an opportunity to meet with patients, assess their health care needs, risk factors and to promote healthy living.

Are services caring?

Summary of findings

The practice was caring. The patients we spoke with were very complimentary about the caring compassionate attitude of staff. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients. Patients we spoke with felt well informed about their care and treatment.

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with 11 patients and in some case their carers or family members. Everybody was very complementary about the care they received from all the practice staff. We spoke to a range of patients of different ages and ethnic origin. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

Staff told us how they respected patients' confidentiality and privacy. The majority of telephone calls were answered by staff who were not sitting at the reception desk. This ensured that confidential information could not be overheard. There was a sign at reception offering patients a private room if they needed to discuss anything with reception staff. Unfortunately on the day of our inspection this notice had been obscured by other items on the reception desk and therefore could not be seen by patients.

Bereaved families were given contact details for local services which could support them. GPs told us that they involved families and carers in end of life care. They ensured that the out of hours service was aware of any information regarding their patients' end of life needs.

Involvement in decisions and consent

All the people we spoke with told us the GP explained their treatment and one person commented that there always seemed enough time to discuss their needs. We spoke with a patient's carer who told us that they were very involved in their family member's care. They had been consulted and involved in decisions that had been made in the patient's best interest. The practice took account of the Mental Capacity Act (MCA) 2005 and the laws surrounding decisions made for people who lacked the capacity to consent.

There were systems in place to gain written consent for certain procedures. Clinical staff explained how they gave patients the information they required about their treatment to ensure they were able to make informed choices. Patients were given the choice of GP and that

Are services caring?

choice was respected. We saw that a carer had asked that their family member was not seen by a certain doctor This request had been noted and reception staff would be alerted through the electronic booking system.

Most of the patients at this practice did not have any difficulties with language. However staff could access language support for a number of nationalities. The health pod and touch screen booking system had instructions in other languages such as Polish. Staff told us that they had a small population of Chinese patients who visited the practice. They told us they had been able to communicate verbally or through family members, however no consideration had been given to producing any information for this group of patients and this could prevent them from having all their needs met.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. Patients told us they could always get an emergency appointment and waiting time for routine appointments was good. The practice sought feedback from patients about the service such as the on line booking system and the introduction of a self-monitoring system for patients to check and record their blood pressure and weight. The practice understood the needs of their patients and had made changes to the practice building and systems to meet some of those needs.

Our findings

Responding to and meeting people's needs

The practice and all the staff were aware of the practice population in respect of age, ethnic origin and number of patients with long term conditions. The practice had responded to the needs of their practice population in a number of ways. Extended hours had been introduced with a late surgery one night a week. The practice ran an evening surgery to increase accessibility for people who could not attend during the day due to work commitments. An induction loop was available at the reception area to enable people with a hearing impairment to communicate with reception staff. Changes to the practice had been made to meet the needs of people with a disability. A toilet accessible for patients with a disability with automatic doors had been installed. However the reception area remained at a high level which could be a barrier to anybody who used a wheelchair.

Although two of the consulting rooms were on the first floor we saw that patients with mobility issues were asked if they wanted to be seen on the ground floor. On at least one occasion during the day of our inspection their GP came downstairs to see their patient in another consulting room.

Access to the service

Patients we spoke with told us that they did not have any problems making appointments when they needed them. They told us that they were able to get emergency appointments on the day they needed them and had to wait longer for a routine appointment or to see the GP of their choice. Each patient had a named GP and were also able to make a request to see other GPs.

Reception staff explained the appointment booking system. Patients could telephone the surgery or book appointments on line. Telephone consultations were also available to enable patients to speak with their own GP. Any patient calling the practice could have been able to access a routine appointment the following day. However, it may have taken up to five working days to access a specific GP.

One of the GPs we spoke with explained that however busy the practice was children under the age of five were seen the same day and the receptionists referred children under the age of 10 to a GP to the decide if the child should be offered a same day appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

We looked at the record of complaints that had been received by the practice. All the complaints had been responded to in a timely courteous way by the practice manager. Reception staff told us that if a patient approached them with a concern or complaint they would direct the patient to speak with the practice manager or to put their complaint in writing. Practice staff told us that whenever possible the practice manager tried to address concerns to satisfy the patient as soon as possible. The practice manager told us that they were often able to resolve issues before they escalated into more serious concerns. The practice did not keep a record of verbal concerns or complaints and did not recognise these as formal complaints or concerns and were not able to identify any common factors or trends in relation to patient dissatisfaction.

There was no information displayed for patients about how they could raise their concerns or feedback to the practice. A suggestions box was available on the reception desk but this did not have any forms or paper available to encourage patient feedback.

The practice sought the views of their patients in an annual satisfaction survey. We saw the results of the latest survey for 2013-2014. The practice had a small virtual patient reference group and had consulted with them to devise the questions for the survey. The results of the latest survey showed that 90% of the people who responded would recommend people to the service. The practice had not taken any action to find out what could be done to increase this figure. The survey had also been used to gain people's views on whether they would use the health pod and requested feedback about the online booking service

Are services well-led?

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

Summary of findings

Overall the practice was well led by practice management staff with clinical leadership from the GP partners. Staff were supported by practice management and a culture of openness and honesty was encouraged. Risks to the safe and effective delivery of service were assessed and there were suitable business continuity plans in place.

Our findings

Leadership and culture

The leadership was established at the practice and staff told us they felt supported by the practice manager. There was an open culture at the practice and the staff we spoke with felt able to go to the practice manager with any problems or concerns. All staff were clear about their roles and responsibilities, and that they were provided with opportunities for development and training. Appraisals were carried out annually and training was supported by the GP partners and practice management. Northbourne Surgery is a training practice and at our inspection we spoke with a GP trainee. They had been supported in their development by the GP who was their mentor and trainer. We saw that serious events were reported and discussed at weekly practice meetings for learning and not to apportion blame.

Governance arrangements

Quality and performance were monitored by the practice. The quality outcome framework (QOF) was used to monitor the effectiveness of the practice. Partner GPs had areas of responsibility, such as women's health, prescribing or safeguarding it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice. It appeared that the GPs relied on the management skills of, and delegated tasks to, the practice manager who was responsible for the day to day running of the service and assessing, monitoring and developing non clinical staff.

The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

Systems to monitor and improve quality and improvement

We saw that incidents were reported promptly and analysed. Although we were aware of an incident which had not, at the time of inspection, been reviewed. There were no guidelines in place to ensure that these serious events were reviewed in a timely way. We saw examples of learning from incidents and audits, and noted that where

Are services well-led?

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

applicable practices and protocols had been amended accordingly. There were no guidelines available for staff to help them decide what should be documented as a significant event.

Patient experience and involvement

There is a virtual Patient Participation Group (PPG) that is newly established. The practice had been actively trying to recruit members to the group in order to gain greater feedback from patients. The practice used an annual satisfaction survey to monitor the quality of the service and to be assured that patients remained satisfied with the care and treatment they received. All the patients we spoke with were complimentary of the staff at the practice and the service that people had received. Patients told us that they felt involved in the decisions about their care and treatment. They were confident that they could discuss any areas of concern with the practice staff.

Staff engagement and involvement

Staff we spoke with told us they enjoyed working at the practice, most had been in their role for a number of years. The GPs we spoke with and the practice manager thought that the consistency of staff improved the service for their patients. Staff we spoke with all told us that they felt supported by their colleagues and the practice manager. Regular staff meetings were held which gave the opportunity to provide feedback about the practice or to raise any concerns.

We saw minutes of a recent staff meeting; these showed that everybody was given the opportunity to make comments or suggestions. There was evidence that relevant staff were involved in reviewing incidents in order to learn from them and minimise future risks.

Identification and management of risk

There was evidence that the practice continually learnt from incidents and feedback. We saw examples of changes that had been made to procedures as a result of lessons learnt. GPs were given protected time for study or to complete training. There were robust risk management plans in place. The practice had a business continuity plan and had worked with local practices to ensure care to patients would continue to be provided if there was an event affecting the operation of the service. Risks related to any future pandemic had been assessed and a plan was in place to manage that risk in collaboration with other local practices. (A pandemic is an infectious disease that has spread through the population across a large area.)

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

A number of the patients we spoke with during our inspection were from this population group. They told us that they were treated with dignity and respect. We saw that the practice met the needs of patients in this population who had mobility difficulties. GPs situated on the first floor came downstairs to use a spare consulting room so that patients were still able to see the GP of their choice even if their normal consulting room was upstairs.

The practice had developed good links with a local nursing home and treated patients who lived there. They had met with nursing home staff to discuss and advise on the care and support needs of the residents.

Our findings

Safe

Staff had received training in safeguarding vulnerable adults. The practice had a lead GP responsible for coordinating safeguarding issues; they had taken part in high level training in this subject. We saw evidence that appropriate referrals to local safeguarding teams had been made when abuse had been suspected

Caring

We spoke with patients from this population group who told us that staff treated them with dignity. They did not feel rushed. We were given examples where best interest decisions had been made for a patient who lacked the capacity to consent. We reviewed a comment card that praised the practice for the care of a patient with dementia.

Effective

An effective relationship had been established with a local nursing home. There had been meetings with the home to identify the best way to meet the medical needs of the patients who lived there and to provide help and advice to the home staff .

Responsive

Although two of the consulting rooms were on the first floor we saw that patients with mobility issues were asked if they wanted to be seen on the ground floor. On at least one occasion during the day of our inspection the GP came downstairs to see their patient in another consulting room.

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

Patients with long term conditions were supported by the practice to manage their conditions. Nursing staff had specific training to help them understand the needs of these patients. A specialist nurse from a local hospital worked with one of the practice nurses to provide a specialist clinic to assess and monitor patients with long term conditions such as diabetes. They also advised patients on the management of their long term condition and signposted them to relevant support organisations.

Our findings

Safe

Patients who had long term conditions had their medicines reviewed and monitored. All repeat prescriptions were checked by the patients GP and regular reviews of medication took place.

Caring

Patients with long term conditions were encouraged to manage their own care as far as possible. Practice nurses provided support and met with specific patients to provide help and advice.

Effective

The clinical staff at the practice had taken part in training to ensure they had the right skills to appropriately treat and support people with certain long term conditions. The practice nurse worked closely with a specialist nurse from the local hospital to provide advice and support to specific patients with long term conditions.

Responsive

The practice planned specialist services to meet the needs of patients with long term conditions.

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

We spoke with parents who attended the surgery on the day of our inspection with their new born baby. They told us that all ante natal care had been provided by midwives who ran a weekly clinic at the practice. They told us that their GP was well informed of their progress by the midwives. They had good direction and health education throughout the pregnancy especially in relation to healthy eating.

Our findings

Safe

The practice had a child immunisation programme. All vaccines were held in a medicines fridge which was checked daily to ensure it remained at a safe temperature. Incorrect temperatures could mean that the vaccine would not be effective.

Practice staff had taken part in safeguarding children training and had established links with the local authority safeguarding team and were clear that they would raise an alert if they felt a child was at risk of abuse.

Caring

Patients were able to request a chaperone for consultations or examinations. Patients we spoke with felt that the GPs explained their treatment with them in a way they could understand.

Effective

A GP partner had the lead role of women's health. The practice offered women attending their first cervical screening a further self-test for chlamydia.

Responsive

One of the GPs we spoke with explained that however busy the practice was children under five were seen the same day and the receptionists referred children under 10 years of age to the them to decide if they should be offered a same day appointment.

Well-led

The practice had a lead for women's health. A female GP partner provided support and direction for other staff for this population group. They ensured up to date information and research was cascaded to other staff at the practice.

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 had an evening surgery one night a week to increase the accessibility of their service to patients who were unable to attend during the day due to work commitments.

Our findings

Safe

Patients we spoke with commented positively on the standard of cleanliness at the practice. There were occasions when a locum GP was necessary to cover for unexpected sickness so that the practice could continue without disruption to patient care which would otherwise have resulted in cancelled appointments which may have been particularly inconvenient to patients with work commitments.

Caring

As with all the population groups we report on, all the patients we spoke with were complimentary about the care they received at the practice. Patients told us they were treated politely and compassionately. All consultations were conducted with surgery or treatment rooms doors closed to maintain patients' privacy.

Effective

The practice had a range of health promotion literature in both their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations. A health pod had been introduced to the practice. This was an area where patients could take their own blood pressure and weight. The information was then fed into their patient record to be checked by the GP. We saw people using this facility during the day. This meant that patients were encouraged to monitor certain aspects of their own health.

Responsive

The practice had an evening surgery one night a week which had increased the accessibility of their service to patients who were unable to attend during the day due to work commitments.

Well-led

Risks related to any future pandemic (a pandemic is an infectious disease that has spread through the population

Working age people (and those recently retired)

across a large area) had been assessed and a plan was in place to manage that risk in collaboration with other local practices. Risks to patient health and the continued service to patients had been assessed and planned for.

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 considered specific needs of vulnerable patients. One of the GPs had identified that there was a risk to the health and wellbeing of a family they had seen. An appropriate safeguarding referral had been made to the local authority to protect all members of the family.

Our findings

Safe
Appropriate referrals to the local authority safeguarding team had been made to protect families and children.

Caring
We spoke with a patient's carer who told us that they were very involved in their family member's care. They had been consulted and involved in decisions that had been made in the patient's best interest. The practice took account of the Mental Capacity Act (MCA) 2005 and the laws surrounding decisions made for people who lacked the capacity to consent.

Effective
Children from all vulnerable groups were encouraged to take up child immunisations.

Responsive
We spoke with a carer for a patient with learning difficulties. They told us that when their family member was discharged from hospital, there was a smooth change over back to the GP They had been consulted and involved in the on-going care which meant they were able to support their family member appropriately.

Well-led
The practice had not actively sought the views of this minority group, or their carers, in satisfaction surveys so they could not be sure that they were meeting the needs of this population group.

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 patients with mental health problems. A counsellor from a local support group worked at the surgery. The counsellor, who was also a psychiatrist, was able to see referrals from the GPs and patients were able to self-refer to use their service. The practice had built strong relationships with the community mental health team (CHMT). A representative from CHMT was invited to the practice's multi-disciplinary meetings when appropriate to do so.

Our findings

Safe

The practice referred patients experiencing poor mental health to the community mental health team (CMHT) if appropriate. A representative from CMHT was invited to the practice multi-disciplinary meetings. A counsellor from a local support group worked at the surgery. The counsellor who was a psychiatrist was able to see referrals from the GPs and patients were able to self-refer to use their service.

Responsive

One of the GPs we spoke with told us that patients experiencing poor mental health were often those who failed to attend their appointments. These missed appointments would sometimes be followed up by a telephone consultation with the patient.

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
Diagnostic and screening procedures	The provider had not operated effective recruitment procedures in order to ensure that persons employed were of good character, have the qualifications, skills and experience which were necessary for the work to be performed and were physically and mentally fit for that work. The provider had not ensured that information specified in Schedule 3 was available in respect of people employed by the service and that people were registered with the appropriate professional body. Regulation 21 (a) (i) (ii) (iii) (b) (c)(i)(ii)

Regulated activity	Regulation
Family planning services	The provider had not operated effective recruitment procedures in order to ensure that persons employed were of good character, have the qualifications, skills and experience which were necessary for the work to be performed and were physically and mentally fit for that work. The provider had not ensured that information specified in Schedule 3 was available in respect of people employed by the service and that people were registered with the appropriate professional body. Regulation 21 (a) (i) (ii) (iii) (b) (c)(i)(ii)

Regulated activity	Regulation
Maternity and midwifery services	The provider had not operated effective recruitment procedures in order to ensure that persons employed were of good character, have the qualifications, skills and experience which were necessary for the work to be performed and were physically and mentally fit for that work.

This section is primarily information for the provider

Compliance actions

The provider had not ensured that information specified in Schedule 3 was available in respect of people employed by the service and that people were registered with the appropriate professional body. Regulation 21 (a) (i) (ii) (iii) (b) (c)(i)(ii)

Regulated activity	Regulation
Surgical procedures	The provider had not operated effective recruitment procedures in order to ensure that persons employed were of good character, have the qualifications, skills and experience which were necessary for the work to be performed and were physically and mentally fit for that work. The provider had not ensured that information specified in Schedule 3 was available in respect of people employed by the service and that people were registered with the appropriate professional body. Regulation 21 (a) (i) (ii) (iii) (b) (c)(i)(ii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had not operated effective recruitment procedures in order to ensure that persons employed were of good character, have the qualifications, skills and experience which were necessary for the work to be performed and were physically and mentally fit for that work. The provider had not ensured that information specified in Schedule 3 was available in respect of people employed by the service and that people were registered with the appropriate professional body. Regulation 21 (a) (i) (ii) (iii) (b) (c)(i)(ii)