

Phoenix Surgery

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Summary of findings

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Summary of this inspection

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Phoenix Surgery on 23 June 2016. The overall rating for the practice was good; the practice was rated as requires improvement for providing services that are safe. The full comprehensive report of the inspection undertaken in June 2016 can be found by selecting the 'all reports' link for Phoenix Surgery on our website at www.cqc.org.uk.

At the inspection in June 2016 we found a breach of Regulation 12 (safe care and treatment). We found there were inconsistent arrangements in how risks were assessed and managed; not all staff that were undertaking chaperone duties had received a Disclosure and Barring Scheme (DBS) check.

This inspection was an announced focused inspection carried out on 21 February 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations

that we identified at our previous inspection on 23 June 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as good, the practice is rated as good for providing safe services.

Our key findings were as follows:

- The practice had ensured that all staff undertaking chaperone duties had a Disclosure and Barring Scheme (DBS) check in place to ensure patient safety is fully considered.
- The practice had reviewed systems that identified, recorded and supported patients who were also carers; the practice had increased the number of patients that it had identified as carers from 88 (1.5% of the patient list) in June 2016 to 106 (1.8% of the patient list) in February 2017. The practice had introduced a new system to identify carers when they registered as a new patient at the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

At our comprehensive inspection undertaken in June 2016 we found that the practice had not undertaken appropriate Disclosure and Barring Scheme (DBS) checks for all staff members who were undertaking chaperone duties. Due to improvements made, following this focused Inspection we have rated the practice as good for providing safe services.

During this focused inspection undertaken 21 February 2017 we found that the practice had completed Disclosure and Barring Scheme (DBS) checks for all staff who had undertaken chaperone duties.

Other actions undertaken by the provider included;

- The practice had introduced a system that clearly identified the current list of chaperones available, the date they had completed chaperone training and when their Disclosure and Barring Scheme (DBS) check had been received.
- The practice displayed a list of staff who were able to undertake chaperone duties in the reception area.

Good



Phoenix Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The follow up focused inspection was undertaken by a CQC Lead Inspector and an Assistant Inspector.

Background to Phoenix Surgery

Phoenix Surgery is situated in the town of Camborne in Cornwall. The practice provides a general medical service to 5,820 patients covering an area from Hayle, to Trevingay and Illogan to Praze-an-Beeble.

The practice's population is in the second decile for deprivation. The lower the decile the more deprived an area is compared to the national average. The practice population ethnic profile is predominantly White British. There is a practice age distribution of male and female patients' broadly equivalent to national average figures. The average male life expectancy for the practice area is 77 years which is lower than the national average of 79 years; female life expectancy is 81 years which is also lower than the national average of 83 years. The practice has a higher percentage of patients with long standing health conditions.

There is a team of six GP partners, four female and two male. The GPs all work part time. The whole time equivalent was that of four staff. Partners hold managerial and financial responsibility for running the business. The team are supported by a practice manager, two practice nurses, two healthcare assistants, a phlebotomist (a person trained to take blood) and additional administration staff and support staff. The practice is a training practice and has two GP registrars.

Patients using the practice also have access to community nurses, mental health teams and health visitors and other health care professionals who visit the practice on a regular basis.

The practice is open between 8am - 6pm Monday to Friday. Appointments are offered between 8.30am to 1pm and 3pm to 6pm. Extended hours are offered from 6.30pm to 8pm one evening a week. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

When the practice is closed at lunchtimes, evenings and weekends, patients are directed to contact the out of hour's service by using the NHS 111 number.

The practice had a General Medical Services (GMS) contract with NHS England.

The Phoenix Surgery provides regulated activities from the site at Camborne Health Office, Rectory Road, Camborne, Cornwall TR14 7DL.

Why we carried out this inspection

We undertook a comprehensive inspection of Phoenix Surgery on 23 June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall but the practice was rated as requires improvement for providing safe services. The full comprehensive report following the inspection on 23 June 2016 can be found by selecting the 'all reports' link for Phoenix Surgery on our website at www.cqc.org.uk.

Detailed findings

We undertook a follow up focused inspection of Phoenix Surgery on 21 February 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out a focused inspection of Phoenix Surgery on 21 February 2017.

During our visit we:

- Spoke to a GP partner.
- Reviewed the information contained within the practice chaperone file; including training and DBS certificates for staff who had undertaken chaperone duties.
- Reviewed the carers list.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

At our previous inspection on 23 June 2016, we rated the practice as requires improvement for providing safe services for the following reason;

- The practice had not completed Disclosure and Barring Scheme (DBS) checks for all staff who were undertaking chaperone duties (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

When we completed this follow up focused inspection on 21 February 2017 we found that appropriate action had been taken by the practice to make services safe.

- During this focused inspection we found that the practice had completed Disclosure and Barring Scheme (DBS) checks for all staff who had undertaken chaperone duties; we reviewed DBS certificates for each relevant staff member.
- Our review of the chaperone file demonstrated to us that the practice had introduced a system that clearly identified the current list of chaperones available, the date they had completed chaperone training and when their Disclosure and Barring Scheme (DBS) certificate had been received.

The practice displayed a list of staff who were able to undertake chaperone duties in the reception area in order that patients would be aware of this.

Overview of safety systems and process