Dr Latchem & Partners

Quality Report

The Medical Centre Old Leake
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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
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 1 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

The overall rating for this service is good. We found the practice to be good in the effective, caring and well-led domains and good in the safe and responsive domains. We found the practice provided good care to older people, people with long term conditions and people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- The practice recognised from the recent practice survey carried out by the Patient Participation Group that patients were concerned that they could not hear in the waiting room if a prescription was ready for collection from reception. As a result a loudspeaker system was installed.
- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make required improvements.
- Evidence we reviewed demonstrated that the majority of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.

However, there were also areas of practice where the provider should make improvements.

The provider should:

- Improve the low performance for the treatment of low blood pressure in hypertension and diabetes.
- Improve the documentation of alcohol consumption in patients with severe mental illness.

Summary of findings

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE (National Institute for Health and Care Excellence) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

The practice carried out a review of Accident and Emergency (A&E) admissions in which they found that a large proportion of children from a local school were among the admissions. A protocol was

Summary of findings

established with the school. The school would ring the practice on the staff line for advice before sending pupils to A&E, these included pupils from any GP practice. Following this an audit was carried out of A&E admissions in the following 12 months and an overall reduction of over 3% was recorded.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for patients whose circumstances may make them vulnerable. We found that the practice enabled all patients to access their GP services. Staff told us that they supported those who were in temporary residence or travellers to register with the practice. All patients within the practice boundary were permitted to register. They had received appropriate training to meet the needs of vulnerable adults and patients with learning difficulties. All staff had received Equality and Diversity training. The practice had installed a hearing loop, a visual and auditory patient call system and a visual and auditory fire alarm. Pictorial invitations for annual health checks were sent to persons with learning disabilities. Visually impaired patients received a phone call invitation for monitoring rather than a letter.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for patients experiencing poor mental health. The practice maintained a register of patients who experienced mental health problems. We saw that staff had the knowledge, skills and competencies to assess and respond to their needs. Patients experiencing poor mental health or dementia received an annual health review to ensure appropriate treatment and support was in place. All GPs within the practice have had Mental Health Act training and regular updates were provided. The practice worked with the local primary care mental health team to provide appointments at the practice for patients experiencing poor mental health. This enabled patients to receive counselling and treatment in surroundings that were familiar to them and maintained their discretion.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received 13 completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly, helpful and respectful. They said staff treated them with dignity and respect and never patronised them. We also spoke with five patients on the day of our inspection. All of the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Areas for improvement

Action the service SHOULD take to improve

- The practice should improve the low performance for the treatment of low blood pressure in hypertension and diabetes.
- The practice should improve the documentation of alcohol consumption in patients with severe mental illness.

Dr Latchem & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The lead inspector was accompanied by a GP specialist advisor and a CQC Inspector.

Background to Dr Latchem & Partners

Dr Latchem & Partners practice provides primary medical services to patients living in and around Old Leake, Lincolnshire. The practice is a single storey purpose built surgery. There are seven consulting rooms and one treatment room. The surgery has its own patient car park with easy access for patients with disabilities. The practice houses attached staff including district nurses, health visitors and a midwife all of whom provide clinics within the surgery. The practice is a dispensing practice and as such dispenses medicines to 99% of its registered patients.

A team of three GP partners, two salaried GPs, four GP Registrars, three nurses, a health care assistant, a practice manager, deputy practice manager, dispensary manager and a number of receptionists and administrative staff provide care and treatment for approximately 6,700 patients. There are four male GPs and one female GP at the practice to provide patients with a choice of who to see. The practice provides an anticoagulation clinic for patients who are on warfarin and need to have their blood monitored on a regular basis. The practice has been a training practice for doctors to gain experience and higher qualifications in General Practice and family medicine for over 25 years. They do not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

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.

How we carried out this inspection

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

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

Detailed findings

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before carrying out our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We spoke with the deputy chair of the Patient Participation Group. We carried out an announced inspection on 1 October 2014. During our inspection we spoke with three GPs, one GP Registrar, two nurses, two receptionists, the practice manager, the dispensing manager and 5 patients. We observed how patients were cared for. We reviewed 13 patient comment cards sharing their views and experiences of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda and a dedicated meeting was held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system she used to manage and monitor incidents. We saw that records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by way of the weekly practice meetings to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All staff within the practice had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

The surgery was a dispensing practice and there was a full dispensing team lead by a dispensary manager

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a safe and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice offered a medicines delivery service for patients for routine repeat prescriptions. The service was open to a number of patient groups. Including housebound patients, patients aged 65 and over and the spouse of any patient aged 65 and over (Patients in this group must ensure their delivery date was aligned with their husband/wife's who was already signed up to the service).

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit in September 2014 and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury,

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

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environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, the fridge thermometer and nebulisers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named doctor or nurse. Home visits were made to the adjacent care home by a named GP to those patients who needed one.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Population group evidence

Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks to patients. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. They were aware of the most appropriate person to report their concerns to. We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records

Good

Are services safe?

confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (Anaphylaxis is a severe, potentially life-threatening allergic reaction) and hypoglycaemia (Hypoglycaemia is a condition characterised by an abnormally low level of blood sugar (glucose). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electrician to contact in the event of any failure of electrical equipment.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes were required to be included on the practice risk log. We saw an example of this regarding the incapacity of GPs and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of for instance the use of managing urgent referrals for suspected Cancer (Two-week waits) within Choose and Book (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic). We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits

The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a robust system in place to frequently review QOF data and recall patients when needed. The practice participated in a benchmarking process with other practices within the East Lincolnshire Commissioning Group (CCG). This allowed practices to compare their performance against other practices in the CCG in areas such as referrals to A&E. We saw minutes demonstrating that the GP who attended these meetings shared the information with the other staff at the practice.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. An audit of febrile children (febrile seizures are convulsions brought on by a fever in infants or small children.) was carried out which resulted in a paediatric pulse oximeter (used to monitor oxygen levels and pulse rate in small children) being sourced.

The GP trainer partner discussed with us data from the local CCG regarding the practice's performance for the treatment of low blood pressure in hypertension and diabetes. We also discussed the need to improve the documentation of alcohol consumption in patients with severe mental illness. He stated that the practice will investigate, audit and take any action required. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

The practice showed good use of Information Technology (IT) to support clinical governance. This enabled them to

monitor fridge temperatures, contents and expiry dates in medicine bags, staff rotas and controlled drugs. The practice had facilities and equipment throughout with a rolling schedule regarding upgrades and maintenance.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice manager and a lead GP were responsible for staff training. The practice was a training practice for GP registrars (trainee doctors) to gain experience and higher qualifications in general practice and family medicine. There were four GP registrars at the practice when we inspected. There was a comprehensive two week induction programme in place to support new doctors into the practice. A GP registrar we spoke with told us that they were at the practice for a year's attachment. They told us they had excellent advice and support from the GP trainer, other GPs and the practice manager. GPs we spoke with told us they were supported in their revalidation through an appraisal system. Revalidation is the process by which licensed doctors are required to demonstrate that they are up to date with current best practice and fit to practise.

A management task planner was in place which identified when staff appraisals and training were due. We looked in the records of three recently recruited members of staff and saw that they had all received an induction to the practice, completed an appraisal within the last year and identified their training needs. Staff we spoke with all confirmed they received an annual appraisal. Staff told us they had been supported to access additional training specific to their role or for their professional development. The practice manager showed us training logs that identified what training staff had completed, when they had completed it and when it needed to be repeated. Continual clinical development and supervision was supported through practice based learning sessions within the practice. We saw evidence that these sessions included such areas as reviewing significant events and audit or guest speakers.

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the community nursing team, the local authority, local nursing and residential services, hospital consultants and a range of local and voluntary groups.

The practice held multi-disciplinary meetings to discuss patients with complex and palliative care needs. The practice operated a prescription delivery service for those who were housebound. They operated a VIP list for palliative care patients and this was flagged on the SystmOne clinical computer system at the practice, this enabled those patients to receive priority treatment along with continuity of care. Palliative care meetings were held fortnightly where the deputy practice manager acted as note taker and from those notes updated the Gold Standard Framework (GSF) care plans accordingly. (GSF is about giving the right person the right care, in the right place at the right time, every time). They carried out regular patient care reviews these involving both patients and carers.

Information Sharing

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with. Blood and X-ray results were received electronically. These were reviewed and appropriate action taken. The practice used special notes to ensure that the out of hours service were also aware of the needs of patients receiving end of life care when the practice was closed. The practice was in the process on putting patient care plans on to SystmOne so that the out of hours service were aware of patients' needs.

Hospital discharge, A&E, outpatients and discharge letters were received in electronic format. Once the practice received the letters they were allocated to the most appropriate doctor and followed up the same day.

Consent to care and treatment

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We saw a minor surgery audit for 2013–2014 had been carried out at the practice which included consent to treatment. The audit demonstrated that 100% of minor surgery procedures carried out on patients had written consent in place.

We saw signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a

Good

Are services effective?

(for example, treatment is effective)

parent was unavailable. There were leaflets available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. (A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options). The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Staff we spoke with had received training in the Mental Capacity Act 2005 and could demonstrate knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. We saw examples of how young people, patients with a learning difficulty, mental health difficulty or dementia were supported to make decisions. For example, there were easy read leaflets and health action plans to enable patients with learning difficulties to understand their planned treatment and care. When patients did not have capacity the staff we spoke with gave us examples of how the patient's best interest was taken into account.

Health Promotion & Prevention

We saw that people had access to a range of information leaflets and posters in the waiting room about the practice and promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare. Health promotion is important because it supports patients to take responsibility for their own health and can help prevent illness in the future.

The practice offered all new patients registering with the practice and patients aged 40-75 years old a health check with the practice nurse. Well women and well men checks were available for patients on request. The practice nurse carried out weekly vaccination sessions for children in line with the Healthy Child Programme. We saw that the percentage of children who had received the appropriate vaccination at the appropriate time ranged from 90-100% which was in line with the Clinical Commissioning Group (CCG) regional average. A travel vaccination programme was also carried out at the practice.

Family planning services were provided by the practice for women of working age. All three of the practice nurses were trained in performing cervical smears.

The practice nurses offered healthy living advice and support to patients. This included referrals to weight watchers and physical activity exercise classes for patients who needed a weight management programme. All patients with a learning disability were offered an annual physical health check and provided with healthy living advice leaflets in an easy read format.

Flu vaccination was offered to all patients over the age of 65, those in at risk groups and pregnant women. The shingles vaccination was offered according to national guidance for older people.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 257 patients who took part in the GP patient survey. The GP patient survey is an independent survey run by Ipsos MORI on behalf of NHS England. The evidence from this source demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 91% of patients said the last GP they saw or spoke to was good at treating them with care and concern their overall experience of this practice as good or very good. This was 12% above the Clinical Commissioning Group (CCG) regional average. 84% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 89% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments. All these scores were above the CCG regional average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 13 completed cards and all were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were friendly, helpful and respectful. They said staff treated them with dignity and respect and never patronised them. We also spoke with five patients on the day of our inspection. All of the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Patients we spoke with on the day of our inspection confirmed that they had never overheard anything confidential at the reception desk. The practice switchboard was located at the reception desk. The receptionists closed the windows to the waiting area when they answered the phone thus ensuring patient confidentiality at all times.

We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles in achieving this. An example of this was how the practice has dealt with housebound patients. Patients were informed by letter (or phone call if on the blind/partially sighted register) at least one week in advance that the health care support worker would be coming out to them and the reason why. If the date was not convenient for the patient they were advised that they could ring and change the date to a more suitable time. If the test was a fasting blood test then fasting instructions were also sent out to the patient. Views of external stakeholders were very positive and aligned with our findings.

The practice had 22 patients registered at a local care home and there were care plans for each patient including frailty care plans if appropriate.

The practice carried out home visits and follow up visits as required. Influenza, pneumonia and shingles vaccinations were offered to older patients according to national guidance for older people. Letters were sent out to eligible patients. In the case of housebound patients' flu and shingles vaccinations were carried out at the person's place of residence.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG regional average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Good

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Every patient over 75 years of age had a named GP to ensure continuity of care and to develop relationships between the GP patients and carers. The practice operated a priority list for palliative care patients and this was flagged on the SystmOne clinical computer system at the practice, this enabled those patients to receive priority treatment along with continuity of care. Palliative care meetings were held fortnightly where the deputy practice manager acted as note taker and from those notes updated the Gold Standard Framework (GSF) care plans accordingly. GSF is about giving the right person the right care, in the right place at the right time, every time. They carried out regular patient care reviews these involved both patients and carers. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice web site was also available in a variety of languages.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it good or very good in this area. For example, 91% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern with a score of 87% for nurses. These results were above the CCG regional average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients described the care they received as excellent and of a higher standard than other practices they had previously been registered with.

Notices in the patients waiting room and on the practice website signposted patients to a number of support groups and organisations. The practice website provided a direct link with Carers Connect as part of the Lincolnshire Carers Partnership to offer carers more support. This enabled carers to be referred for an individual needs assessment and could include, emotional support, benefits advice, access to education, employment, learning and leisure activities for example driving lessons, gym membership, social activities, an emergency response scheme and support groups.

Staff told us families who had suffered bereavement were called by their usual GP and offered a GP consultation if required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. The needs of the practice population were understood and systems were in place to address identified needs.

We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations. For example the practice carried out a review of Accident and Emergency (A&E) admissions in which they found that a large proportion of children from a local school were among the admissions. As a result they contacted the school and have agreed a protocol whereby the school would ring the practice on the staff line for advice before sending pupils to A&E, this included pupils from any GP practice. Following this protocol a review was carried out of A&E admissions in the following 12 months and a reduction of over 3% was recorded.

All patients needing to be seen urgently were offered same-day appointments.

The practice had an active patient participation group (PPG) and a virtual patient participation group (VPPG) to help it to engage with a cross-section of the practice population and obtain patient views. We spoke with the deputy chair of the PPG who explained their role and how they worked with the practice. They told us there was a regular membership of 12 patients. PPG meetings were held every two months and the minutes were available on the practice's website.

The practice had achieved and implemented the gold standard framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families' care and support needs.

For families, children and young people appointments were available outside of school hours and the premises were suitable for children and young people and included baby changing facilities.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice informed us they had a policy to accept homeless patients and any patient who lived within their practice boundary irrespective of race, culture, religion or sexual preference. They told us all patients received the same quality of service from all staff to ensure their needs were met.

Patients with learning difficulties were provided with an annual health review and health advice leaflets in an easy read format. The primary care mental health team offered appointments at the practice. This enabled patients with mental health difficulties to receive counselling and treatment in surroundings that were familiar to them and maintained their discretion

All patients over 75 years were provided with a named doctor for continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. We saw that the premises and services met the needs of patients with disabilities such as hearing and mobility difficulties. We saw there were baby changing facilities and that breast feeding mothers were offered a private room in which to feed their babies.

The practice was situated on ground level. There were arrangements to ensure that care and treatment was provided to patients with regard to their disability. There was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a wheelchair available for patients with mobility problems, a disabled toilet and disabled parking spaces. Consulting rooms were situated on the ground floor of the practice making rooms easily accessible

Good

Are services responsive to people's needs?

(for example, to feedback?)

for patients. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Access to the service

The practice opened 8.30am until 6.30pm Monday to Friday. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hours service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also told us that they could see another doctor if there was a wait to see the doctor of their choice, however they said appointment times sometimes over-ran. A number of comments we received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice

The practice's opening hours until 6.30pm Monday to Friday were particularly useful to patients with work commitments. The online booking system was available and easy to use, there was a text message reminder for appointments and test results, online or telephone consultations were used where appropriate and support was given to enable people to return to work.

The practice had a population of over 99% English speaking patients though it could cater for other different languages through translation services and the practice website could also be read in a variety of languages.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Accessible information was provided to help patients understand the complaints system. This was available on the practice web site and displayed on posters in the waiting room. The website also showed links to other organisations to which the patient could complain if appropriate. These included Independent Practitioner Complaints at NHS England, Patient Advice and Liaison Service (PALS), The Parliamentary and Health Service Ombudsman and POhWER, an organisation that provides advocacy support.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed the practice responded quickly to issues raised. We saw that in the period from April 2013 to March 2014 the total number of formal complaints received was seven. Six of these were dealt with in three days. Of the total completed complaints investigation the number that were assessed by the practice as being well-founded (upheld) were seven. No complaints had been referred to the Parliamentary and Health Service Ombudsman.

All informal complaints were dealt with as soon as they came in by the Complaints Manager, either by phone, letter or generally face to face. If necessary complaints were discussed as a significant event or brought up in training sessions.

All formal complaints were discussed at weekly practice meetings.

We looked at 12 closed complaint files and found these were handled correctly the nature of the complaint being recorded, how it was received , what the learning points were and who was to action it.

The practice also analysed complaints on an annual basis to ensure they could detect themes or trends and improve the service patients received as a result of feedback.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. There had been several staff changes at the practice over the previous year but the management team were in the process of considering their three to five year business plan. The practice values were clearly displayed in the waiting areas, in the staff room, on their website, in their patient charter and patient practice guide. It stated, 'At our surgery we aim to provide our patients with the best quality care available.'

We spoke with eight members of staff and they all understood and demonstrated the vision and values and knew what their responsibilities were in relation to these. The practice's strategy to achieve their vision placed a high emphasis on supporting staff through education, training and embracing new and innovative ideas.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice and from their home address if needed. We looked at ten of these policies and procedures. We saw evidence that and all staff had read the policies. All ten policies and procedures we looked at had been reviewed annually and were up to date.

The practice used clinical audit to monitor quality and systems to identify where action needed to be taken. The practice had completed a number of clinical audits, for example the prescribing of Strontium Ralenate, a medicine used in the treatment of osteoporosis. Following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) relating to Strontium Ralenate and cardiovascular safety the practice reviewed all patients prescribed this medicine to consider whether or not to continue treatment. The first audit cycle identified that nine patients were receiving this medication. All patients were called in for a review of their medication. A second audit cycle identified that all the patients had received a medication review and their prescription had been stopped where clinically indicated and replaced by an alternative.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as fire risks, manual handling and building structures. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example as part of the fire risk assessment in a room of the practice they identified that there were a number of hazards that could have harmed both patients and staff. Having identified the risk the practice installed a smoke detector, a fire door and a sign was put up to inform Fire-fighters that the room contained both oxygen and nitrogen.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. We looked at the QOF data for this practice which showed it was performing in line with national standards scoring 91out of a possible 100 points.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open and transparent culture in place and their concerns were listened to. We saw there was a whistleblowing policy in place. Staff we spoke with were aware of why whistleblowing was important and who to go to if they had any concerns. They were also aware of where to locate the policy if they needed to refer to it for support.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies,

Are services well-led?

Good

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

for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the employment folder on the computer system, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

Feedback and comments by staff were encouraged, listened to and acted upon. The practice actively encouraged the participation and involvement of staff through annual appraisals. Team meetings were held for staff and they were encouraged to add items to the agenda that they wished to discuss. Staff told us they felt involved and listened to within the practice. There was a whistleblowing policy available for staff at the practice and staff we spoke with understood what whistleblowing was and why it was important. Whistleblowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected.

The practice recognised the importance of the views of patients and had systems in place to do this. This included the use of patients' comments, analysis of complaints, patient surveys and working in partnership with the Patient Participation Group (PPG). Results of patients' surveys and PPG comments were shared with patients through the practice website. The deputy chairperson for the PPG confirmed that they had a very good working relationship with the practice and that the partners were open and honest and listened to what they said.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and supervised Registrars for between four and 12 months at a time. GP registrars are fully qualified doctors who are doing additional training to become General Practitioners.

The practice was also a Research Ready Practice and was actively involved in medical research activities. Currently the practice is involved in three research projects, an observational study into the behaviour of newly-diagnosed patients with Atrial Fibrillation and at least one additional risk factor for stroke, looking at the prevention of ulcer bleeding in patients taking aspirin and finally a study comparing the effects of allopurinol with a newer treatment called febuxostat in the treatment of gout. Research is important as it is the only way that new advances in medicine can emerge to better care for everyone. The practice worked closely with the Primary Care Research Network, which is part of the NHS National Institute for Health Research (NHR) and the UK Clinical Research Network (UKCRN), which are both Governmental bodies. All the research the practice was involved with has been approved by the NHS.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and away days to ensure the practice improved outcomes for patients.

We were shown evidence that staff in all roles were provided with a thorough induction process. We saw that staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date.