

Littlebury Medical Centre

Quality Report

Littlebury Medical Centre
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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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	5
What people who use the service say	7

Detailed findings from this inspection

Our inspection team	8
Background to Littlebury Medical Centre	8
Why we carried out this inspection	8
How we carried out this inspection	8
Detailed findings	9

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Littlebury Medical Centre on 4 December 2014.

Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Urgent appointments were available the same day.
- The practice had good facilities including disabled access and was found to be clean and tidy.
- Information about services and how to complain was available.
- Patients said they felt the practice offered an excellent service and staff were friendly and caring and treated them with dignity and respect
- There were systems in place to reduce risks to patient safety for example, infection control procedures.

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles.
- Recruitment checks were carried out and the appropriate recruitment checks had been undertaken prior to employment.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.
 - Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

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.

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?

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.

Good



Are services effective?

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 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.

Good



Are services caring?

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.

Good



Are services responsive to people's needs?

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.

Good



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?

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.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice 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.

Good



People with long term conditions

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.

Good



Families, children and young people

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.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

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

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 The results showed the practice was performing in line with local and national averages. 250 survey forms were distributed and 107 were returned.

- 78% found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 86% found the receptionists at this surgery helpful (CCG average 89%, national average 87%).
- 89% were able to get an appointment to see or speak to someone the last time they tried (CCG average 87%, national average 85%).
- 90% said the last appointment they got was convenient (CCG average 92%, national average 92%).

- 75% described their experience of making an appointment as good (CCG average 78%, national average 73%).
- 83% usually waited 15 minutes or less after their appointment time to be seen (CCG average 70%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 50 comment cards which were all positive about the standard of care received.

We spoke with six patients during the inspection. All patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Littlebury Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Background to Littlebury
Medical Centre

Why we carried out this
inspection

How we carried out this
inspection

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 two 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 two years and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly 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 tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result (add in example found). 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 dealt with by the lead nurse. We saw examples of recent alerts that had been received by the practice. They had a robust system in place to identify the patients at risk and the actions taken to ensure patient safety.

We looked at meeting minutes and could not see that these had been discussed 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; for example carers and vulnerable children.

There was a chaperone policy. Notices were visible on the waiting room noticeboard and in consulting rooms.

All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

The practice had a lead for medicines management.

The dispensary had documents which they referred to as Standard Operating Procedures.

All staff involved in the procedure had signed the SOPs to say they have read and understood the SOP and agree to act in accordance with its requirements.

Standard Operating Procedures (SOPs) cover all aspects of work undertaken in the dispensary.

Are services safe?

The SOP's should consist of step-by-step information on how to execute a task and an existing SOP be modified and updated when appropriate. Such SOPs would satisfy the requirements of the Dispensary Services Quality Scheme (DSQS). SOPs also provide a basis for training and assessment of competence.

We found that the SOP's did not fully reflect good professional practice, as well as the procedures that are actually performed in the dispensary. The SOPs did not indicate the level of competency expected for each function performed by dispensers. The SOPs had been reviewed and updated in the last 12 months but no reference had been made to any dispensing procedures which had been amended. There was no written audit trail of amendments to SOPs.

Records showed that all members of staff involved in the dispensing process had received appropriate training but there were no records to demonstrate that their competence was checked regularly. We spoke with dispensary staff who confirmed that they had not had their competence checked since obtaining their qualifications.

The practice did not have a system in place to assess the quality of the dispensing process. They had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

The dispensary accepts back unwanted medicines from patients. NHS England's Area Team make arrangements for a waste contractor to collect the medicines from the dispensary at regular intervals. We found that the dispensary had secure containers to keep the unwanted medicines in but there was no records kept of the medicines received by the practice. The practice had an identified locked area of segregation for the containers when they were full which is a requirement under the Hazardous Waste Regulations. We were told by the dispensary that the waste contractor did not pick up the unwanted medicines containers in a timely manner, for example, every three months.

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 controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Staff in the dispensary were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had signed up to the Electronic Prescription Service (EPS). The (EPS) is an NHS service. It gives people the chance to change how their GP sends a prescription electronically to a place chosen by a patient. EPS gives a patient more choice about where to get medicines from. They can be collected from a pharmacy near to where a patient lives, works or shops. The practice had plans to improve their website and add details to ensure that patients had all the relevant information they required.

The practice provides a medicines delivery service two days a week for patients registered with the practice. They also deliver urgent medicines on other days were required.

We checked medicines stored in the treatment room. We found that they were not stored securely and brought this to the attention of the practice who immediately ensured that the drawers and cupboards were locked and the treatment room door was kept shut.

We checked medicine refrigerator in the dispensary and found they were stored securely and were only accessible to authorised staff. 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.

There was not 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. We spoke with the management team who advised us that they would write a cold chain policy for staff to follow and use for guidance.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line

Are services safe?

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

Blank prescription forms were not handled in accordance with national guidance as these were not tracked through the practice. They were kept securely at all times. We spoke with the management team on the day of inspection who advised us they would put a process in place to ensure they adhered to national guidance.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed staff told us they would be returned to the GP for signature.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength.

There had been four significant events for medicine errors.

Cleanliness and infection control

The practice had a lead for infection control who was in the process of undertaking further training to enable them to provide advice on the practice infection control policy and carry out staff training.

We observed the areas to be clean and tidy. We saw there were daily cleaning schedules in place and cleaning records were kept. The practice did not carry out spot checks to ensure that the practice was kept clean and tidy. We spoke with the lead nurse who told us this would immediately be put in place.

Staff we spoke with told us the practice areas used where kept clean and tidy.

All staff received induction training about infection control specific to their role and received mandatory updates.

An infection control policy and supporting procedures were available for staff to refer to.

The policy and procedures enabled staff to plan and implement measures to control infection. For example,

personal protective equipment including disposable gloves, aprons and coverings were readily 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.

The practice had not carried out infection control audits. The practice policy stated one audit and one risk assessment should be carried out each year. National guidance states that audits must be undertaken to ensure that key policies and practices are being implemented appropriately.

Each clinical room had clinical waste bins which were foot operated and lined with the correct colour coded bin liners. We found the external yellow clinical waste disposal bin was situated at the side of the surgery and visible and accessible from the car park. The bin was locked but was not within a locked compound. Department of Health guidance states that, "The practice is solely responsible for ensuring that waste is stored safely and in a secure place away from areas of public access within the premises (that is, taking all reasonable precautions to prevent waste escaping and to prevent the public getting access to it)."

We saw carpets in some consulting rooms. Where carpets are used appropriate maintenance and cleaning programmes should be in place. We spoke with the lead nurse as The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance states that GP practices should: 'Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.' The code of practice goes on to state: 'The environmental cleaning and decontamination policy should specify how to clean all areas, fixtures and fittings.'

We saw disposable curtains were in some of the clinical rooms we looked at. These ensured that patients had privacy when being examined. In the treatment room we saw that the curtains in use were of a non-disposable material and there was no information as to when they were last cleaned. We spoke with the lead nurse who told us they would add disposable curtains to this room.

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. Some of the sinks were not 'hands free' tap system which is crucial in preventing re-contamination of hands

Are services safe?

following hand hygiene. The practice was already aware that the sinks did not meet national guidance.

Sharps bins were correctly assembled and labelled. We saw that the practice used a recognised coloured coded cleaning system for mops and cloths as stated in current hygiene guidance.

The practice had blood and vomit spillage kits available for staff to use. Staff were given guidance on how to use these kits in their mandatory infection control updates.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use. Some information had not been reviewed since 2008. We spoke with the management team who told us they would contact the external company for current updates.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the 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, for example, the ECG machine. An electrocardiogram machine (ECG) records the electrical activity of the heart. The heart produces tiny electrical impulses which spread through the heart muscle to make the heart contract.

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.

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 areas of the building used, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had a health and safety policy. Health and safety information was displayed for staff to see.

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 were not shown any evidence that risks were discussed at GP partners' meetings and within team meetings.

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 confirmed that it was checked regularly.

The practice had a treatment room which had all the equipment required by staff in the event of an emergency.

Are services safe?

Emergency medicines were available in this room and all staff knew of their location. The treatment room did not have signage which identified oxygen cylinders in the event of a fire.

All medicines were in date and checked on a monthly basis. The practice had a list of medicine expiry dates and had a procedure for replacing medicines at that time. The medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

The staff we spoke with were aware of what action to take in the event of an emergency and how they could access additional help, for example 999 services, if required.

The practice had arrangements in place to deal with emergencies. We saw they had a disaster handling and

business continuity plan. This plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Areas 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, staff contact details and details of a heating company to contact if the heating system failed. The business continuity plan did not have a review date.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. A fire assembly point had been identified. On the day of the inspection the fire exits were clear. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. 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 showed us four clinical audits that had been undertaken in the last year. All four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice had a system to recall patients. The practice on a monthly basis, through the electronic patient record SystemOne, did a monthly search of all patients for specific recalls. A new recall has been set up on the system following an audit by a GP. Patients who take amiodarone and need a thyroxine blood test will get a recall through this system.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and

Are services effective?

(for example, treatment is effective)

areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were in the process of being completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of influenza vaccines and cervical cytology.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The on-call GP who saw these documents and results was responsible for ensuring that action was taken where required.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, and palliative care nurses. Decisions about care planning were documented in a shared care record. We looked at minutes

Are services effective?

(for example, treatment is effective)

from these meetings and found that they did not contain information to demonstrate what had been discussed or the actions taken. We spoke to a GP who told us they will ensure that future meetings are minuted appropriately. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the

key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example 109 care plans have been completed in the last year.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

The practice had a consent policy. This had no approved date and had not been reviewed. We were told by the lead nurse that consent training was mandatory. We spoke with the management team who told us the practice would ensure that this policy is reviewed and updated.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with a GP to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that patients in this age group took up the offer of the health check.

Are services effective? (for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 40 out of 45 patients had received a check up in the last 12 months. Carers were also invited to have a NHS health check and influenza vaccination.

The practice's performance for cervical smear uptake was 80.4% which was just above the CCG average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations for example, up to 2year olds was 96-98%. Up to 5 year old was 94%.

Register kept of patients who are identified as being at high risk of admission / End of Life and have up to date care plans. 109 out 143 patients completed. GP goes out to nursing homes to do reviews if patient unable to attend the practice.

Last year's performance for child immunisations for example, up to 2year olds was 96-98%. Up to 5 year old was 94%. Other performance was: -

- 1,135 out of 1,411 females had Cervical smears
- 96.3% people with Blood pressure checks
- 81.2% for Hypertension checks

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 93.4% of practice respondents saying the GP was good at listening to them and 94.1% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 50 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All 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 or privacy screens were provided in clinical rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Within the reception area we saw visible marking on the floor where patients were requested to wait to ensure patient confidentiality at reception. Whilst on inspection we saw patients adhering to this request.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients'

privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The 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. The results from the practice's own satisfaction survey showed that 92% of patients said they were sufficiently involved in making decisions about their care.

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 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.

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 patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, respondents to the Patient Participant Group survey said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke to on the day of our

Are services caring?

inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either

followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had 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 in the way services were delivered.

The NHS Area Team 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 practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services and two GP's and a dispenser who spoke several languages.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice actively supported people who have been on long-term sick leave to return to work.

The practice had a population of 100% English speaking patients though it could cater for other different languages through translation services.

Access to the service

Appointments were available from 8.30 am to 12.30 pm on weekdays with either GPs or nurse practitioners. Nursing appointments were then available from 2pm until 6pm, with GP appointments available 2pm until 6pm.

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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Prior to the inspection we found that the practice website was not up to date and did not include new members of staff. We spoke to the practice GP partners who told us that a new website had been designed and was due to be installed early 2015.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one when they were required.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were 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.

We saw that information was available to help patients understand the complaints system. Leaflets were available for patients advising how to make complaints. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way.

Are services responsive to people's needs? (for example, to feedback?)

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy and five year business plan.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at nine policies. Two out of the nine policies we looked at had not been reviewed annually and were therefore not up to date.

There was a clear leadership structure with 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.

Staff we spoke with told us they felt part of a team, were well supported, their views were listened to and they know who to go to in the practice if they had any concerns.

We spoke with eight members of staff and they were all clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. We saw that risk assessments had been carried out. Where risks had been identified an action plan had been produced and was in the process of being implemented at the time of the inspection. For example fire safety and manual handling.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

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, for example consent, waste management and infection control which were in place to support staff. Two of the policies we looked at were out of date. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG). The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings and supervision. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice did not have a whistleblowing policy available for staff to refer to. There was a section in the staff

Are services well-led?

Good 

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

handbook but this did not provide enough guidance for staff. We spoke with the lead nurse on the day of inspection and they told us they would look at developing a whistleblowing policy.

Management lead through learning and improvement

Staff told us that they felt well supported by the practice. Some staff had been fully supported 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 had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.