

Deddington Health Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a desktop review of Deddington Health Centre in September 2016. We requested information from the practice to be sent to us so we could undertake a review of evidence offsite. This was following a comprehensive inspection in January 2016 where we identified concerns with the monitoring of patient care and treatment and staff awareness of the Mental Capacity Act 2005. We issued a requirement notice and rated the practice as requires improvement in the effective domain. The practice sent us an action plan stating what they were going to do to make improvements. At this inspection we found:

- The monitoring of patient care and treatment had improved following an audit of diabetes related indicators as well as an audit of patients on Lithium (a high risk medicine).
- The process for medicine reviews had been changed to ensure patients received a review in a timely way.

- The nursing team had received training on the Mental Capacity Act 2005 and guidance had been introduced for mental capacity assessments.

During the previous inspection, we also reported on areas where improvements should have been considered. At this inspection we found that the practice had acted on these findings.

The practice had implemented a new alerts policy and vulnerable patients already registered were clearly flagged up on the records system. Overdue appraisals had also been brought up to date.

This report only covers our findings in relation to these requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Deddington Health Centre on our website www.cqc.org.uk

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.

In January 2016 we found that the flag for patients at risk of abuse was not always clearly coded on the records system.

In September 2016 we received evidence showing that the flag for vulnerable patients was clearly coded on the records system to alert staff. This enabled staff to respond to the needs of these patients.

Good



Are services effective?

The practice is rated as good for providing effective services.

In January 2016 we found there was not always adequate monitoring of patient care specifically in the care of diabetes and mental health. Medicine reviews were not always undertaken in a timely and there was not adequate training or guidance on the Mental Capacity Act 2005. We also reported that the practice should bring overdue appraisals up to date.

In September 2016 we received evidence showing that the monitoring of patient care and treatment had improved after the practice carried out an audit of diabetes related indicators as well as an audit of patients on lithium. A new process for medicine reviews was introduced which ensured patients received a review in a timely way. The nursing team had also received training on the Mental Capacity Act 2005 and guidance was introduced for mental capacity assessments. We also received evidence that the practice had brought overdue appraisals up to date.

Good



Summary of findings

The six population groups and what we found

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

People experiencing poor mental health (including people with dementia)

In January 2016 we found that a practice-led audit had identified that not all patients on lithium had received their medicine review but not action to mitigate this was undertaken promptly. This left patients at risk.

In September 2016 a recent audit of patients on lithium showed that all patients prescribed this medicine now had a medicine review.

Good



Deddington Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

This desk based inspection was completed by a CQC Assistant Inspector.

Background to Deddington Health Centre

Deddington Health Centre has a patient list of 9784. It is located in the village of Deddington, Oxfordshire and serves local villages and rural communities. There is a higher proportion of patients between 40 and 70 years old than the national average. The number of patients under 30 is significantly lower than the national average. The surgery was purpose built in 1971 and was extended in the early 1980s. It was accessible for disabled patients and those with limited mobility. There was parking including designated disabled parking. There were some bus services running to local villages enabling some patients to travel by public transport.

The practice is registered to provide services from: Deddington Health Centre, Earls Lane, Deddington, Oxon, OX15 0TQ.

There are four GP partners at the surgery and two salaried GPs, including three female and three male GPs. There are three female practice nurses and a female healthcare assistant. A number of administrative staff and a practice manager support the clinical team.

The practice was open between 8am and 6.30pm Monday to Friday and appointments were available during these

times. There were no extended hours appointments. When the practice was closed patients could access out of hours GP services by calling 111. This was clearly displayed on the practice's website.

The practice is registered for the correct regulated activities in relation to the services it provides and there is a registered manager in post.

This is a training practice and there was one GP in training working at the practice.

Why we carried out this inspection

We undertook a desk based inspection of Deddington Health Centre on 28 September 2016. This inspection was carried out to check that improvements had been made to meet the legal requirements, following our comprehensive inspection on 27 January 2016.

We inspected this practice against two of the five questions we ask providers; is this service effective and is this service safe? This was because the service was not meeting some of the requirements in relation to this question.

How we carried out this inspection

Before carrying out the desk based inspection, we reviewed information sent to us by the practice that told us how the breaches identified during the comprehensive inspection on 27 January 2016 had been addressed. For example, photographic and documentary evidence.

Are services safe?

Our findings

In January 2016 we found that the flag for patients at risk of abuse was not always clearly coded on the records system. For example, the safeguarding alert was not always coded properly meaning it might not appear to the appropriate staff.

Overview of safety systems and processes

In September 2016 the practice sent across their new alerts policy. This outlined what systems had been put in place to ensure the correct alerts were put on patient records and the type of patients these alerts applied to. The practice also sent across an example of how these alerts would then flag up on their record system. They were clear and visible so that they would be seen by the appropriate staff.

Are services effective?

(for example, treatment is effective)

Our findings

In January 2016 we found that there was not always adequate monitoring of patient care to ensure improvements were made. This related specifically to the care of diabetes and mental health related indicators. Medicine reviews were not always undertaken in a timely way and the practice did not have a robust system for reviewing the prescribing of high risk medicines. We also found staff appraisals were not up to date and there was not adequate training or guidance on the Mental Capacity Act 2005 for the nursing team.

Management, monitoring and improving outcomes for people

In September 2016 we were sent evidence which showed audits had been carried out after the inspection and improvements had been made in these areas where we identified concerns. The practice's action plan showed how they intended to improve attendance for diabetic checks. We reviewed unvalidated Quality and Outcomes Framework (QOF) figures from 2016. We saw that the practice had increased performance for diabetes related indicators from 83% in 2014/2015 to 94% in 2015/2016 (QOF is a system intended to improve the quality of general

practice and reward good practice). The practice achieved this by running additional diabetes related checks alongside a diabetic eye screening clinic. This enabled them to opportunistically offer patients a diabetic review while they were at the practice.

The practice had also carried out an audit of patients on Lithium which is prescribed for specific mental health problems and is a high risk medicine. The audit showed all patients on this medicine had now received the appropriate checks and that medicine reviews were to continue at regular intervals. Since the last inspection the practice had introduced new protocols for the prescribing and monitoring of high risk of medicines which ensured patient safety.

Effective staffing

We saw evidence that the appraisal system had been improved to deliver these to all staff.

Consent to care and treatment

At this inspection the practice provided a training log which showed all nursing staff had received training on the Mental Capacity Act 2005 and that another training session was to be booked in for 2016/2017 for new starters.