Eaton Socon 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
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 carried out an announced comprehensive inspection at Eaton Socon Health Centre on 11 June 2015. The overall rating for this practice is good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

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

- The practice was a friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Risks to patients were assessed and well managed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

We saw one area of area of outstanding practice:

- There was a special focus on the needs of vulnerable adults. The nurse practitioner provided examples of how they had provided extra help for vulnerable patients by arranging access to further assistance such as food parcels and assisting with housing matters at times of need, for example after hospital discharge.

However there was one area of practice where the provider needs to make improvements.

Importantly the provider should:

Summary of findings

- Implement the necessary actions resulting from the legionella risk assessment.

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 patients 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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity and promoting good health. Staff had received training appropriate to their roles but a small number of staff had some mandatory training overdue. Further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for most 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 for patients about the services available was easy to understand and accessible. 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 England 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. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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 was shared 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. Staff had received inductions and attended staff meetings.

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. Each patient receiving palliative care was allocated two named GPs to ensure continuity of care where possible.

The practice 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. Patients at risk of hospital admission were identified as a priority. 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 staff 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 on the safeguarding register. Immunisation rates were in line with local averages 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.

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

The practice is rated as good for the care of people whose circumstances might make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice provided a flexible approach to consultations for these patients, often in the evening so that parking wouldn't be an issue and carers would be more likely to be available.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and in the past had provided extra help for patients that required this by arranging access to further assistance.

Staff provided examples how they had provided extra help for patients by means of arranging food vouchers or emergency food packs from the local food bank, which the practice worked in partnership with.

A member of staff actively contacted vulnerable patients following a hospital discharge or out-of-hours service intervention to ascertain, and address, any further needs. This had led to the provision of holistic person-centred care with the aim of improving vulnerable patients' living conditions and increase their chances of a good recovery. Staff provided examples where they had assisted patients in vulnerable circumstances with accessing help for housing matters and alcohol addiction recovery programs.

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.

People experiencing poor mental health (including people with dementia)

Good

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.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We collected six comment cards; all of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. One card was positive but contained a comment around the difficulty of obtaining an appointment with a doctor of their choice.

We spoke with five patients during our inspection, including three members from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they felt the practice was clean. They reported that the practice provided a very good personal service and that GPs and nurses delivered good clinical care, which acknowledged their concerns. The comment cards reflected these views, all with very positive comments. Patients we spoke with confirmed that they could always get an urgent appointment with a doctor within 48 hours but had experienced difficulty booking routine appointments.

Areas for improvement

Action the service SHOULD take to improve

- Implement the necessary actions resulting from the legionella risk assessment.

Outstanding practice

- There was a special focus on the needs of vulnerable adults. The nurse practitioner provided examples of how they had provided extra help for vulnerable patients by arranging access to further assistance such as food parcels and assisting with housing matters at times of need, for example after hospital discharge.

Eaton Socon Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector, a GP specialist advisor, a practice manager specialist advisor and a second CQC inspector.

Background to Eaton Socon Health Centre

Eaton Socon Health Centre in Eaton Socon, Cambridgeshire provides services mainly to patients living in Eaton Socon and the surrounding area. The practice is a partnership of six GPs. The practice also employs one salaried GP and one GP on maternity leave. There are also four nurses lead by a nurse practitioner, supported by two healthcare assistants and two phlebotomists. The clinical team is supported by a practice manager, a clinical support service supervisor, a business support assistant and a team of clinical support workers and (medical) secretaries.

The practice is a training practice and provided training to doctors learning to become GPs.

The practice has a patient population of approximately 11500. The practice is open every weekday between 08:30 and 18:00.

Extended hours are provided on Thursday evenings until 20:30. The practice website clearly details how patients may obtain services out-of-hours.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with 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?

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)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. During our inspection on 11 June 2015 we spoke with a range of staff including GPs, practice nurses, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We found a number of incidents had been reported including issues relating to patient information sharing. Records of the incidents included actions that had been taken in response to the incidents to reduce future reoccurrence and improve patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last twelve months. We saw evidence that the practice had managed these consistently over time and so could demonstrate a safe track record over time. Staff attended regular meetings where the outcome of incidents and any learning was discussed. Learning from complaints was also documented and shared with staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events and complaints and the learning from them was discussed at staff meetings. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. However, we did not see evidence of monitoring for common themes and trends or an annual review of the significant events.

All clinical and non-clinical staff we spoke with were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw that staff had shared learning around the need to check patient identity before issuing prescriptions

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. The practice discussed complaints during regular meetings and kept a register of all complaints. This included actions taken as a result and learning from the complaints. The practice received 16 complaints last year, which were dealt with appropriately. We saw a summary which included whether complaints were upheld or not, and what actions had been taken as a result.

National patient safety alerts were disseminated electronically or in paper form to practice staff and discussed in person. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. The practice had a protocol in place to support the process. Alerts were also shared during regular meetings. For example, the GP prescribing lead discussed medicine management matters during Monday meetings to ensure all relevant staff were aware of any changes that were relevant to their 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. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing, administrative and reception staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. An example was provided around a safeguarding concern for a child which was referred onto a paediatrician. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. This information was available on the practice's intranet.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern. The practice held monthly multi-disciplinary meetings with other health and social care professionals during which patients with safeguarding concerns were

discussed. A member of staff actively contacted vulnerable patients following a hospital discharge or out-of-hours service intervention to ascertain, and address, any further needs.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that nursing staff were mostly used when chaperoning a patient. Disclosure and Baring Service checks had been undertaken for staff that acted as chaperone.

Medicines management

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP or nurse prescriber before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw comprehensive records of regular prescribing meetings that noted the actions taken in response to a review of prescribing data. For example, minutes of the meeting contained information about controlled drug prescribing, high cost drugs, prescribing spending of the practice, plans for medication reviews and processes around hospital issued medication.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

Cleanliness and infection control

We observed the premises to be clean and tidy but did notice some staining on the carpets, specifically in a consultation room which was not regularly used by the practice. The practice told us there were plans in place to have the room redecorated in line with infection control guidelines so that it could be used on a regular basis. We saw there were cleaning schedules in place and cleaning records were kept by the external cleaning company. These records lacked occasional recordings but it was evident cleaners attended daily. The practice informed us that they would consider changing cleaning providers if they were not happy with the standard provided.

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. The lead liaised with the local area Infection Control Lead if required. They demonstrated a good understanding of their role. This staff member had undertaken an infection control audit in November 2014. Appropriate action plans had been instigated upon the findings. For example, we saw that more suitable bins had been purchased and that posters had been laminated to make them easier to clean.

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. Personal protective equipment (PPE) including disposable gloves and aprons were available for staff to use. Staff were able to describe how they would use these to comply with the practice' s infection control policy.

Good

Are services safe?

There was also a policy for needle stick injury and waste management. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, hand gel and paper towel dispensers were available in treatment rooms. Spillage kits were available and we saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor surgery or other interventions they performed.

The practice did not have a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings) but did have an assessment survey for legionella for the premises dating back to November 2012. The survey highlighted some required actions and we asked to see evidence that these had been addressed. The practice had sought advice and information, but to date no action had taken place. The practice acknowledged that this was overdue and confirmed that the issue would be resolved in the immediate future.

No other concerns regarding asbestos were raised. The practice was in the process of developing a new member of staff into a health and safety lead role who could undertake regular checks of the water temperature accordingly. We saw evidence that training for this staff member was booked for July.

Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

During the inspection we found records of staff immunisation against Hepatitis B. We found that this was monitored to ensure staff were protected.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of May 2013. We saw evidence of calibration of relevant equipment was due in November 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were shown evidence of current DBS checks for all clinical staff. The practice had a protocol in place assessing whether non clinical staff required DBS checking or not and we found this was completed for the staff files we reviewed.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of nursing and administrative staff to cover each other' s roles. Staff we spoke with confirmed that this happened and these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

The practice had a vacancy for a GP and was temporarily covering this with a locum GP.

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 regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. The practice had recently appointed a new practice nurse who was given the role of health and safety lead as the practice had recognised there was a gap for this in its operations. The newly appointed

Good

Are services safe?

lead was due to undertake health and safety training in July 2015 and implement effective risk assessments and a risk log accordingly. At the time of our inspection this was not yet in situ.

The practice had considered certain risks of delivering services to patients and staff and had implemented systems to reduce risks. For example we reviewed policies which included fire safety and evacuation procedures and a fire risk. The practice health and safety policy did not include a review date so it was not clear if it was the most up to date version. We saw evidence that fire alarm testing was done on a regular basis.

We spoke with both clinical and non-clinical staff about managing risks and found that they had the skills to safeguard patient safety. Staff gave examples of how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment. Staff provided a detailed explanation of a serious medical emergency that had occurred in the practice recently involving resuscitation and emergency services involvement.

Safety equipment, such as fire extinguishers, was checked and sited appropriately. Health and safety information was displayed for staff to see in the staff room. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training but for some of the non-clinical staff this was recently overdue. When we raised this with the practice manager we were informed that this training was planned for the week following our inspection. The staff we spoke with confirmed this.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinicians in the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including defibrillators (a defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present) and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use, we saw evidence of this. 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 might impact on the daily operation of the practice. Each risk was detailed and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of utilities and unplanned sickness. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in December 2013 and records showed that all staff were up to date with fire training, including dedicated fire marshals. We saw records of regular fire alarm tests.

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 that guidance from local commissioners was discussed at regular meetings. 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. We saw the practice completed reviews of case notes for patients, for example those with diabetes, to show they were on appropriate treatment and had received regular reviews of their health and medicine.

We saw evidence which showed this new guidelines were discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff, at all levels, we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The practice's daily, informal coffee meetings, held for all clinical staff after the morning's surgery, also created a forum for staff to discuss clinical issues and challenges. Although these meetings were not minuted, patient files were updated with plans that were discussed during these meetings.

The GPs told us they took special interest on a variety of clinical areas such as diabetes and asthma. Clinical staff we spoke with were very open about asking for, and providing colleagues with, advice and support. Our review of the multidisciplinary team meetings and clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs. These patients had a named GP and multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, done by a nurse practitioner. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans. There was a special focus on the needs of vulnerable adults during this process. The nurse practitioner provided examples how they had provided extra help for patients that required this in the form of: arranging access to further assistance such as food parcels and assistance with housing matters.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit done to high standard on isotretinoin prescribing (a medicine which is used in treating acne) had led to an improvement in patients attending for this regularly as well as an increase in efficiency in the patient documentation. Other examples included audits around antibiotic prescribing and minor surgery.

GPs maintained records showing how they had evaluated the audits and documented the success of any changes. Following clinical audit cycles we saw that the outcomes had been discussed, shared and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit.

The practice also used the information collected for the quality and outcomes framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) and performance against national screening programmes to monitor outcomes for patients. The practice achieved 84.7% of the total QOF target in 2013-2014, which was below the national average of 93.5%. The practice informed us after the inspection that their QOF performance for 2014-2015 was 93.4%. Comparative QOF data for 2014-2015 will not be published until October 2015.

Specific examples of the practice's 2013-14 QOF included:

- Performance for asthma related indicators was better at 99.6% than the national average of 97.2%.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was lower at 78.6% than the national average of 83.8%.
- Performance for mental health related QOF indicators was lower at 88.4% than the national average of 90.4%.
- Performance for palliative care related QOF indicators was better at 100% than the national average of 96.7%.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were 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 staff were prescribing medicines. We saw evidence 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 practice had implemented systems for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, and the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. Each patient receiving palliative care was allocated two named GPs to ensure continuity of care where possible.

A member of staff actively contacted patients in circumstances that made them vulnerable, following a hospital discharge to ascertain, and address, any further needs that these patients may have.

The practice staff provided examples how they had provided extra help for other patients such as arranging access to food parcels, assistance with housing matters and arranging for sign language interpreters.

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 mandatory training such as annual basic life support. However for some of the non-clinical staff this was recently overdue, but we were informed that this training was planned for the week following our inspection.

We noted a good skill mix amongst the staff with a variety of special interests amongst the GPs including dermatology, asthma and diabetes.

All GPs were up to date with their yearly continuing professional development requirements and all, either had 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Most staff undertook annual appraisals that identified their learning needs and from which action plans were documented. Appraisals for the admin staff were overdue as the lead who undertook these had been off sick for a three month duration, which had delayed progress.

The nurses and doctors reported that they felt supported by the other clinicians on site and all had appraisals in place. The GPs worked together with other GPs in the area to complete the peer review process.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. Our interviews with staff confirmed that the practice was proactive in providing training and additional courses. Previously the practice had provided protected learning time for staff but this stopped and learning was provided through quarterly sessions together with other practices in the area.

As the practice was a training practice, doctors who were training to be qualified as GPs were offering extended appointments depending on their level and experience. They had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other services to meet patients' needs and manage complex cases, for example we saw evidence of referrals to district nurses for matters such as phlebotomy and dressings.

There were clear procedures for receiving and managing written and electronic communications in relation to

Good

Are services effective?

(for example, treatment is effective)

patients' care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and addressed on the day they were received by the GPs.

One of the clinical support team assisted in the process of referring patients to MacMillan or district nurses services as soon as the patient was aware and diagnosed with palliative care needs.

The practice provided weekly anticipatory visits to a local nursing home or on demand if required.

The practice held daily coffee breaks with staff which allowed for informal opportunities to discuss patients' care and treatment and seek advice from colleagues.

The practice held two monthly multidisciplinary (MDT) team meetings to discuss the complex needs of patients.. These meetings were attended by community matrons, district nurses and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Decisions about care planning were documented in a shared care record. There was a comprehensive system for managing results and discharge summaries and updating patient records and repeat medicines.

We saw evidence that the practice worked collaboratively with a local nursing home and was proactive in providing tailored end of life care for patients in this home. The practice had also proactively contributed to admission avoidance for long term condition patients in this home, resulting in only one patient out of 23 requiring more than one admission to hospital; this was due to complex medical needs. The remaining patients only required five admissions in total over the last year, which were all short duration (less than 24 hours). The practice explained that the care plans that were in place aided the discharge process without concern for on-going care .

The practice provided rooms for several visiting services to improve access for patients. For example, chiropody, audiology and alcohol addiction support.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the out-of-hours services.

For patients who were referred to hospital in an emergency the practice provided a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (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.

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 with 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.

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

Good

Are services effective?

(for example, treatment is effective)

plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by having developed a pathway such that working people (16 years and over) could be triaged via the telephone for urinary tract infections. Smokers were encouraged to see the practice nurse who had received training to support patients wishing to give up smoking.

The practice offered new patient health checks and advice was available on weight loss programs and alcohol consumption.. The practice used chronic disease management clinics to promote healthy living and health prevention in relation to the person's condition.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was slightly below average for the majority of immunisations where comparative data was available. For example:

- The flu vaccination rate for the over 65s was 71.6%, below the national average of 73.2%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 95.2% to 98.6% and five year olds from 91.6% to 95.8%. These were above local averages.

In addition to routine immunisations the practice offered travel vaccines and flu vaccinations. Ante- and post natal clinics were also available.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as carer support.

Good

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 2014 National Patient GP survey published in January 2015. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 265 surveys to patients, there had been a 49% response rate. Results showed the practice scored 71% for patients who rated the practice as good in comparison to the national average of 85%. The practice was above average for its satisfaction scores on consultations with doctors and nurses, with 94% (against 89% nationally) of practice respondents saying the GP was good at listening to them, 95% (against 91% nationally) saying the nurse was good at listening to them, 87% (against 87% nationally) saying the GP gave them enough time and with 96% (against 92% nationally) saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We collected six comment cards. All of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. One card was positive but contained a comment around the difficulty of obtaining an appointment with a doctor of choice.

We also spoke with patients on the day of our inspection. All the patients we spoke with told us they were very 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 noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. To aid this, music was played in the waiting areas.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice's switchboard was located away from the reception desk, which helped keep patient information private. Patients did comment that confidentiality could be an issue at the front desk when queuing. The practice acknowledged this and informed us a private room to discuss matters would always be available if requested. Additionally, 74% of patients said they found the receptionists at the practice helpful compared to the national average of 87%.

The practice 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 they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of Gillick competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act 2005 and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The results from the 2014 National Patient GP survey which we reviewed showed that patients' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 93% (against national outcome of 86%) of practice respondents said the GP was good at explaining tests and treatments and 91% (against national outcome of 82%) that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that 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. They told us that staff were caring, took their concerns seriously and spent time explaining information

Good

Are services caring?

in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also positive around involvement the care and treatment. There was one comment around difficulty in obtaining an appointment with a GP of choice.

Staff told us that the vast majority of patients registered with the practice were English speaking. Staff told us that the computer system would highlight any non-English speaking patients. Patient information was available in different languages on the practice website through a 'translate' facility.

Patient/carer support to cope emotionally with care and treatment

The patient 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:

- 94% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 97% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.

The practice had a system for ensuring that all staff were kept up to date on the status of palliative care patients. A dedicated member of staff would offer informal bereavement support if a bereaved patient attended the practice. This 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 said they were given good emotional support by the doctors, and were supported to access support services to help them manage their treatment and care.

The practice provided a flexible approach to consultations for vulnerable patients, often in the evening so that parking wouldn't be an issue and carers would be more likely to be available.

Notices and information screens in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer. The practice offered flu vaccinations to carers. At the time of our inspection there was a notice board specially dedicated to carers under the theme of "Carers Week".

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with who were deemed vulnerable. These registers were used to monitor and respond to the changing needs of patients. Patients on these registers were allocated extra appointment time if needed. The practice had a dedicated phone line for early access and on-going support for these patients; there was also a dedicated member of admin staff that maintained this register.

The practice utilised an electronic medical records system to record and collect information regarding patients. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care, vulnerable adults or those patients who were caring for others.

The practice promoted independence and encouraged self-care for patients through the provision of printed and website information about healthy living.

The practice offered on-line prescribing and appointment booking to patients.

Care and support was offered on site and at local nursing home to ensure that the needs of these patients were identified and met. These locations were attended by the doctors and nurses on a responsive and pro-active basis.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and had implemented tailored, individual care plans for them. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during specially designated monthly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including collaboration with a local hospice.

The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Patients recorded they were happy with the care and treatment they received. These findings were also reflected during our conversations with patients during our inspection.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of vulnerable adults. These patients received an enhanced service where they were recalled for an annual, face-to-face health review. The practice provided a flexible approach to consultations for these patients, often in the evening so that parking wouldn't be an issue and carers would be more likely to be available.

We also saw that the premises were designed in a way that enabled patients in wheelchairs to access their GP. There was level access throughout across ground level and the practice had purchased a specialist wheelchair for bariatric patients.

We saw that the practice website had a translation facility which meant that patients who had difficulty understanding or speaking English could gain online access to information about the practice. The practice had access to the use of translation services if required and could book extended appointments for these patients. This was also the case for patients that were hearing impaired. A hearing loop was available in the practice to support patients with hearing loss and communication with these patients was mainly done via email.

The practice dealt with some patients who were temporary visitors to the area, such as students. The practice assured us these patients could access care where this was immediately necessary and treated them as any other patient. The practice was aware of the travelling community they served and strived to keep records and immunisations up to date before the patients moved on.

Baby changing facilities were available and there was enough room for prams.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they

Good

Are services responsive to people's needs?

(for example, to feedback?)

had access to the equality and diversity training but records showed that less than half the staff had not yet completed this. We were told this would be addressed after our inspection.

Access to the service

GP appointments were available every weekday between 08:30 and 13:00 and then from 14:00 until 17:30. GPs did not routinely undertake telephone consultations but for specific queries not requiring a consultation, the admin staff were able to seek the advice of a GP and then telephone patients back.

The practice offered extended opening hours on Thursday evenings from 17:30 until 20:30.

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 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. Information on the out-of-hours service was provided to patients.

The majority of appointment times were blocked off for urgent appointments that were seen on the same day wherever possible. Patients we spoke with on the day told us that they had been able to get appointments for themselves, their family members or their children when required but that it had proven difficult to book future appointments. The practice was aware of this and actively informed patients of lost hours due to non attended appointments in the waiting room and on their website.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs.

A system was in place so that older patients and those with long term conditions could receive home visits. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could also receive home visits and these were identified on the patient record system.

The patient survey information we reviewed showed patients did not always respond positively to questions about access to appointments. Overall they rated the practice below average in these areas. For example:

- 93% of respondents say the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.
- 50% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.
- 65% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%.
- 55% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 74%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. This was managed by the practice manager who made contact with patients who had concerns. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw minutes of complaints that were discussed at practice meetings. We were not shown any evidence that the practice reviewed complaints annually to detect themes or trends but did find that all complaints were acted upon and dealt with appropriately.

We looked at 16 complaints received in the last 12 months from patients and found that they had been dealt with satisfactorily.

We saw that information was available to help patients understand the complaints' system in the form of a leaflet and posters. 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.

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. The practice stated it aimed to deliver traditional general practice with a focus on providing high quality consultations. The practice considered itself to be early adopters of new ideas and to take an interest in the wider forum of general practice. For example, GPs participated actively in the local commissioning group (LCG).

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 readily available for staff to read. We viewed several of these policies and found that not all had been reviewed annually. The content we reviewed was relevant and up to date. Policies included infection control, the use of locum GPs, whistleblowing and health and safety.

There was a clear leadership structure with named members of staff in lead roles. Staff we spoke with were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. GPs all had different special interests, for example dermatology and diabetes and they commented that they were often approached by other staff with questions around these specific topics.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. They included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing below national and local averages overall. We saw that QOF data was discussed at meetings.

Team meetings were used to discuss issues and improve practises. We looked at minutes from various meetings over the last half year and found that performance, quality and risks had been discussed.

The practice had a programme of thorough clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken and drive improvements. These included prescribing and infection control.

We were shown the electronic staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The partners and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff told us, and we saw that all staff were, encouraged to contribute their views and to have some ownership of the delivery of the practice vision.

Decision making and communication across the workforce was structured around key, scheduled meetings. Meetings covering general aspects of general practice took place weekly, with one of these a month being the whole practice meeting. Business meetings took place monthly, during these meetings topics such as premises, education and human resources were discussed. The practice held separate monthly palliative care multidisciplinary (MDT) and vulnerable patients MDT meetings. Another weekly meeting took place during which referrals, admissions and Accident and Emergency usage were discussed. The practice also attended occasional prescribing meetings and meetings with the local commissioning group.

In addition to staff meetings, the practice featured a daily, informal coffee meeting that took place for a short time each morning. All clinical staff attended. Any incidents and concerns arising from the previous day or morning's work were discussed and dealt with immediately or escalated for further investigation or more detailed discussion and consideration in a more thorough formal meeting.

Are services well-led?

Good

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

We noted that staff were positive in their attitudes and presented as a content workforce. Staff commented that they felt well supported and appreciated in their roles. We considered this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through a patient participation group (PPG), surveys and complaints received. The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The practice had a PPG which previously existed of six to seven members but had recently turned virtual. We met with three representatives from a limited variety of population groups; they were actively trying to recruit more members. The representatives were generally positive about the practice stating they felt involved in making decisions about their care and claimed the standard of care they received was excellent overall. There was general agreement amongst the representatives that the booking system made it difficult to obtain routine appointments; urgent appointments were always available. All mentioned that these challenges were not unique to this practice but for general practice nationally.

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to staff development. For example through the use of daily coffee breaks which were used to discuss patient cases.

As the practice was a training practice, doctors who were training to be qualified as GPs were offering extended appointments ranging depending on the level and experience. They had access to a senior GP throughout the day for support. The practice informed us that they had been reapproved recently (April 2015) for a further five years as training practice.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of good quality clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working.