Over Surgery

Quality Report

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Date of inspection visit: 28 August 2014
Date of publication: 05/02/2015

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.

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Summary of findings

Overall summary

Over Surgery has a practice population of approximately 4800 patients. We inspected the practice at 1 Dring's Close, Over on 28 August 2014. During the initial inspection we spoke with three doctors, the practice manager, the practice pharmacist and a dispenser, two nursing staff, reception and administration staff. We also spoke with nine patients who were visiting the practice. For two weeks prior to the inspection, patients had completed comment cards giving their views on the service provided at the practice. We also looked at the systems, procedures and polices the practice had in place. The information we gathered supported our judgement on whether the practice was safe, effective, caring, responsive to patient's needs and well-led.

During the inspection we looked to see how the practice met the needs of six specific population groups. There groups are; older people, people with long term conditions, mother, babies and young people, the working age population and those recently retired, people in vulnerable circumstances who may have poor access to care and people experiencing poor mental health.

We found that Over Surgery had procedures in place for the safeguarding of vulnerable adults and children. There was effective recording and analysis of significant events and incidents and the learning was shared with relevant staff to improve practice. There were reliable systems in place to manage medicines effectively.

The practice had systems in place to ensure that care and treatment was delivered to patients in line with the appropriate standards. The practice had a strong culture of clinical audit and used the results as part of a continuous improvement cycle. We also saw evidence of effective working with other members of the multidisciplinary team. Recruitment procedures required some improvements.

We spoke with nine patients; they all described staff at the practice as caring and helpful. The comment cards we received gave positive feedback and our observations on the day of the inspection were that patients visiting and telephoning the practice were treated appropriately by staff.

The practice was responsive to patients' needs. Patients were able to access an appointment within a few days or more quickly if the matter was urgent. They also had the opportunity to give their views through a patient survey, a comments box or via members of the Patient Participation Group.

While aspects of the service were well led, further improvements were needed to some aspects of quality monitoring procedures. This was because some checks such as infection control and cleanliness were not formally monitored and recorded. It was not clear who had overall clinical leadership and this made it difficult to measure and monitor quality outcomes for patients.

The provider was in breach of regulations related to: requirements relating to workers, supporting staff and assessing and monitoring the quality of the service.

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.

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 service at Over Surgery was not always safe. There was effective recording and analysis of significant events to ensure that lessons learnt were shared among relevant staff. There were appropriate safeguarding procedures in place to help protect children and vulnerable adults. There were reliable systems in place to manage medicines effectively. However recruitment procedures required some improvement to ensure they were always effective.

Are services effective?

The service at Over Surgery was effective. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines. The practice had carried out a number of audits and were able to demonstrate that learning had been used to improve practice and re-audits had been completed. There was evidence of effective multi-disciplinary working to benefit patient care.

Are services caring?

The service at Over Surgery was caring. All the patients we spoke with during our inspection were very complimentary about the service they received. We saw staff interacting with patients in a caring and respectful way.

Are services responsive to people's needs?

We found the practice staff were very knowledgeable about their local population and were responsive to patient's needs. There was good access to the service and the practice were able to offer a range of appointments to ensure that patients did not need to wait more than a few days to get an appointment. There was an open culture within the organisation and a clear complaints policy.

Are services well-led?

Further improvements were needed to some aspects of quality monitoring procedures. This was because checks were not always formally monitored and recorded. For example health and safety checks, infection control monitoring procedures and details of patients who were also carers, were not recorded. It was not clear who had overall clinical leadership and this made it difficult to measure and monitor quality outcomes to improve services that patients received.

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
A multidisciplinary co-ordinator (funded by the local clinical commissioning group (CCG)) provided support to the practice to help monitor the on-going needs of their older and more vulnerable patients. Patients with the most complex needs were reviewed at regular practice meetings to ensure that their needs were being met and to avoid any unnecessary hospital admissions. These patients had access to a named GP.

People with long-term conditions
The practice held registers of patients with long term health conditions and management of these patients was done by the practice nurses and GPs. A member of the administration team checked each register on a monthly basis and contacted patients in order to arrange a convenient appointment for a review of their condition with either the practice nurse or GP.

Mothers, babies, children and young people
The practice had taken steps to ensure that when children were unwell, they were seen quickly. Parents that we spoke with confirmed this. One parent told us the GP had visited their child in hospital following urgent admission and they had appreciated this additional level of support. There was regular support to the practice from health visitors, midwives and school nurses. Young people that we spoke with felt they had access to appointments and were treated respectfully.

The working-age population and those recently retired
The practice offered extended opening times two days a week to provide easier access for patients who were at work during the day. Telephone consultation and a book online facility helped to improve access for these patients.

People in vulnerable circumstances who may have poor access to primary care
There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. Staff told us that patients who were living with a learning disability were offered annual health checks. We found that the

Summary of findings

register for people with a learning disability was reviewed annually to ensure the checks were being completed. Some people who were eligible may not have been invited to attend the practice for their annual health check.	
People experiencing poor mental health Regular health checks and health promotion advice was offered to people with long term mental health conditions. Doctors had the necessary skills and information to treat or refer patients with poor mental health.	

Summary of findings

What people who use the service say

We spoke with nine patients during the inspection visit, a member of the patient participation group (PPG) before our visit and we received two comments cards from a comments box placed in the surgery prior to our visit. The patients we spoke with ranged in age and the length of time they had been registered with the practice. They all spoke very highly of the service, the commitment and professional approach of the staff and did not raise any concerns with us.

The practice had conducted a patient survey within the last year and the results had been made available on their website. This showed a high level of satisfaction with the service. The practice had considered the results and formed an action plan. This included improving patient awareness of the online services for booking appointments and requesting repeat prescriptions.

Areas for improvement

Action the service MUST take to improve

The practice must take immediate action to ensure its recruitment arrangements are in line with Schedule 3 of the Health and Social Care Act 2008 to ensure that all necessary employment checks are in place for all staff.

The practice must have suitable arrangements in place to ensure that all staff receive an appraisal. All relevant staff must have knowledge and understanding of the Mental Capacity Act 2005.

The practice must strengthen its governance structure so that the management team are clear about their responsibilities for monitoring the clinical and non-clinical aspects of the service and can evidence that robust procedures are in place to improve the quality of the service provided. For example by;

- Providing evidence that health and safety checks (including infection control procedures) are completed and resulting actions taken.
- Ensuring that all relevant staff are protected against Hepatitis B through completed vaccination programmes.

Action the service SHOULD take to improve

The practice should take action to improve the security of refrigerated vaccines and the storage of blank prescriptions.

Induction training records should be retained on staff files and made available for inspection if required.

The practice should develop a register of patients with caring responsibilities to monitor their needs and ensure they are proactive in providing advice and support where necessary.

The practice should monitor infection rates in patients who have attended the practice for a minor surgical procedure.

The practice should ensure that people who have a learning disability are offered annual health checks in a timely way.

The process for identifying patients who are recently bereaved should be improved so that appropriate support can be offered.

The practice should ensure that information on how to raise concerns or complaints about the service is more widely available to all patients when they visit.

Over Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Lead Inspector. The team also included a GP advisor, a second CQC Inspector and a practice management advisor.

Background to Over Surgery

Over Surgery provides a service to approximately 4803 registered patients from Over and other surrounding villages. The service is led by four full time GP Partners and a Practice Manager. Additional staff include four Practice Nurses, a Health Care Assistant and a small administration team. The practice also provides support to trainee GPs.

The practice owns a pharmacy service which is staffed by two qualified pharmacists and two dispensers. They are able to dispense prescription medicines to some of their registered patients and supply over the counter medicines to any member of the public.

The practice offers patients a range of services that include minor surgery, vaccinations (including travel vaccinations), family planning, health checks and clinics for people with long term conditions such as asthma, diabetes and coronary heart disease. The out-of hours service is provided by a separate local provider.

This was the first inspection of the practice since registration.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 August 2014. During our visit we spoke with a range of staff

Detailed findings

including GPs, the practice manager, nurses, reception and administrative staff. We also spoke with patients who used the service and observed how people were being cared for. We also reviewed two comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate that it had a good track record on safety. Records that we saw showed that performance had been consistent over time and that relevant issues were reviewed and addressed appropriately. The practice kept a record of any incidents or significant events and staff were familiar with their role and responsibilities as part of the reporting process.

The staff showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

The doctors completed audits of their work on a regular basis and ensured that the findings were used to improve the safety of clinical care that was provided to patients.

Learning and improvement from safety incidents

There was a system in place to ensure that any safety issues or incidents were addressed in a timely way to reduce the risk of harm. We found that any learning actions were discussed at team meetings so that staff were informed and involved in any changes. In addition, significant events were used as part of the training provided to trainee GPs who were based at the practice. Records that we saw showed that relevant external agencies were involved in any significant events that impacted upon other local services. This ensured that learning was shared more widely to benefit patient care.

Reliable safety systems and processes including safeguarding

Staff that we spoke with had attended safeguarding training for children and vulnerable adults; they were knowledgeable in safeguarding procedures and knew how to recognise signs of abuse. GPs had attended level three safeguarding training. Staff were aware that a named member of staff had lead responsibility for safeguarding. Contact numbers for the local social services team could be easily accessed if they were required. There had not been any reported safeguarding incidents for more than a year.

The practice manager told us that patients with safeguarding alerts were not automatically flagged up to practice staff who accessed their records either during or following a consultation. This required further consideration by the practice so that the information was shared with staff who needed to know about the concerns as part of the assessment completed for each patient consultation at the practice.

Posters were clearly displayed in the waiting room to inform patients they had the right to request a chaperone during consultations or intimate examinations.

Monitoring Safety & Responding to Risk

We spoke with the practice manager who told us they had completed regular health and safety checks, raised concerns on an informal basis and ensured action was taken. However, there were no records in place to evidence these checks had taken place or that the required actions had been completed.

We saw evidence that all medical equipment at the practice was tested and calibrated within the last six months to ensure that it was safe for use. Other electrical items and fire prevention equipment had been suitably checked for safety. A electrical wiring test had identified concerns about external wiring and the practice were taking further action and advice on the issue to seek a resolution as soon as possible.

Medicines Management

The practice had its own pharmacy that provided a dispensary service as well as medicines advice to patients. We looked at all areas where medicines were stored, observed practice, talked to staff and looked at records.

We found that medicines were stored correctly and at safe temperatures. We also looked at the process for the safe storage and monitoring of controlled drugs. Controlled drugs are medicines which by law, are required to be stored in a separate and secure cupboard and their use recorded in a register. The practice followed effective storage and monitoring procedures.

We asked about the arrangements in place for the security of medicines. We found that the fridges used to store vaccines were not locked and the door to the nurse's treatment room (where the fridges were located) was also not locked when the room was not in use. Medicines were therefore accessible to unauthorised people.

Cleanliness & Infection Control

The practice had a contracted cleaning service in place. We found the practice had agreed cleaning schedules and protocols for each room of the premises although there

was no process in place to ensure this was being completed to a satisfactory standard. Some of the consultation rooms were fully carpeted and there was no process in place to ensure these were deep cleaned on a regular basis to ensure that carpets were clean and hygienic. An annual infection control audit had been completed and action had been taken on the findings. For example, privacy curtains had been changed to washable materials and a programme to wash them was in place. We noted that some of the lighting fitments throughout the premises had not been cleaned.

Infection rates following minor procedures were not formally recorded so that any patterns or trends could be reviewed to improve practice. However, we were informed no infections had been reported. A member of staff had designated responsibility for leading and advising the staff on infection control within the practice. They had not had any infection control training in the last three years to ensure their knowledge remained up to date.

Areas were visibly clean and free from dust, dirt and debris. Hand hygiene facilities were appropriate and easily accessible to staff. In another consultation room several items were being stored underneath an examination couch which could impact on the ability to clean the room to an acceptable standard.

We asked if the practice had assurance that staff had received vaccination and were immune to Hepatitis B. The records indicated that this was not known for three members of staff. This should be checked so that the practice can be assured that their staff and patients are fully protected.

We asked for a legionella risk assessment to see how the practice ensured that the water supply was safe. A comprehensive assessment had not been done because the practice had considered the national guidelines and assessed the risks of legionella as low.

Staffing & Recruitment

We looked at the recruitment records for two of the most recently recruited members of staff and found that recruitment checks were inadequate. Employment references and proof of identification had not been sought in both cases. There was no indication as to whether the staff members required or had completed criminal records checks with the Disclosure and Barring Service (DBS). When we checked the recruitment policy it did not give sufficient detail to help determine which staff required DBS checks before they commenced employment and which staff did not. This must be improved so that patients can be assured that staff are appointed as a result of effective recruitment procedures.

The practice employed staff with a wide range of skills and this ensured that patients had access to appointments when they needed them. Staff retirements were planned in the near future and the practice were planning ways to ensure that continuity of service provision was maintained. As a training practice, there were also two trainee GPs who supported service needs.

The nursing team consisted of four part time nurses. Staff told us they were able to meet the demand for clinic appointments. This included a part time phlebotomist who saw patients who required blood tests. Staff told us they usually covered for each other during any periods of planned or unplanned absence. Patients that we spoke with who were treated by the nursing team told us they felt confident in their knowledge, skills and ability.

The practice also provided a pharmacy and dispensing service which was adequately staffed by relevant trained and experienced pharmacists and dispensers.

Reception and administrative staff were skilled in a range of roles so that they were able to provide adequate cover in all areas.

Dealing with Emergencies

An emergency kit bag was accessible to staff and contained relevant equipment and medicines to deal with an emergency situation. In addition the practice kept a small supply of medicines for use in an emergency which were safely stored, and records demonstrated these were checked regularly by staff to ensure they remained safe to use.

In recent months, two patients had been treated at the surgery following anaphylaxis (sudden allergic reactions that could cause them to collapse if untreated). Information that staff shared with us about each incident showed that these emergencies had been dealt with very efficiently.

Equipment

A range of relevant clinical equipment was available for use, was kept clean and well maintained. This included equipment to record electrical activity of the heart (ECG or

Are services safe?

Electrocardiogram), measurement of oxygen levels in the blood (oximeter) and for measuring the volume of air being inhaled and exhaled (spirometer). This equipment was used by clinical staff who had been trained to use it in a safe way.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found that there were appropriate systems in place to ensure that patients received effective care and treatment. Staff described how they monitored the needs and progress of patients and their families who were nearing the end of their lives and those who had more complex health and support needs. Weekly clinical meetings took place for the GPs and nurses to discuss on-going concerns. We saw that monthly meetings took place with key members of the multidisciplinary team such as Macmillan nurses and district nurses, community psychiatric nurses and doctors who specialised in the care of older people. This ensured that each patient's assessed needs and care was managed effectively.

Information was accessible to the out of hours health provider through a shared records system. This meant that up to date and relevant information about the changing needs of complex patients could be easily accessed by health staff when the practice was closed. This ensured that patients could be assessed quickly and appropriate actions taken to support their needs.

The practice nurses run clinics for patients with long term conditions such as; asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease. These clinics monitored disease symptoms and supported patients to manage their own conditions so that they were able to stay well. We found that administrative staff arranged recall appointments for patients who had not attended annual checks. Non attendance was reviewed annually by the practice manager and patients were discussed with the GP who had overall responsibility for managing specific long term conditions for patients such as diabetes and asthma.

We asked four staff about the ways they ensured patients had capacity to give their consent to care or treatment. Staff told us they checked a patient's level of understanding and were aware of the principles of promoting choice. When a patient did not have the capacity to make decisions this was formally assessed and an appropriate advocate approached for supporting the patient. Two staff had completed online training on The Mental Capacity Act, but the other two staff had either not received training or had not received any updated training for several years. The staff would all benefit from completing this training.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing full clinical audit cycles. We saw examples of completed two cycle audits including medicines management, hypertension control in people with diabetes, renal function in people with diabetes and the management of people with atrial fibrillation who were taking warfarin. We found that the results were shared with clinical staff and used to improve patient care and treatment.

We found the practice shared their area of good practice at regular meetings with other practices within their local area. This meant that staff could also learn from their colleagues and adapt the service they provided to meet patients' needs to best affect.

The practice offered minor surgical procedures to patients but did not formally monitor infection rates following a procedure to ensure that procedures were followed effectively.

Effective Staffing, equipment and facilities

The practice manager told us that newly appointed staff received an induction to help them settle into their role. Although there was a policy in place to support this, the induction records were not kept on file as evidence of the process. These records should be kept as evidence of training and information supplied to the employee should performance issues arise in the future.

Staff files that we reviewed showed that three members of staff had not had an appraisal for nearly two years. We were also informed that the practice manager had never received an appraisal. These staff were not being given the opportunity to receive feedback about their work performance and discuss development opportunities to further enhance their knowledge and skills to benefit the service.

Dispensary staff had received appropriate training to undertake dispensing tasks. The practice manager told us that the competence of staff to dispense medicines had been assessed, and we saw documentary evidence to support this.

Are services effective?

(for example, treatment is effective)

We observed that the clinical equipment was appropriate and fit for use.

The practice manager did not monitor the due dates for the GPs appraisals. However when we asked for this information, they were able to provide assurance that they were up to date.

Working with other services

We spoke with staff, spoke to patients and looked at documents that demonstrated the practice worked well with other services to meet patient's needs. For example patients who had been referred for specialist care or treatment told us their experience had gone smoothly prior to and following their treatment. Staff also described the ways they involved external professionals to help support and plan patient care. This was evidenced in meeting minutes.

The practice used an information records system that linked with other local health and support services. For example blood test results were sent by email to the GP who requested them and they were prompted to review and take any appropriate action in a timely way. It also meant that information was accessible to other professionals who needed to provide treatment to the patient such as the out of hours doctors or community nursing teams. Practice staff were alerted through the system when patients had received care or treatment so they were able to remain updated about their particular needs.

There was a system in place to ensure that all hospital discharge summaries were passed to the patients' GPs in a timely manner. We spoke with one patient who had attended the practice the day after their discharge from hospital who told us they were surprised to find their doctor already knew why they were there.

Health Promotion & Prevention

Health promotion literature was readily available to patients who used the practice and was up to date. This included information such as reducing cholesterol, child immunisation schedule, cancer support, preventing and recognising symptoms of a stroke.

People were encouraged to take an interest in their health and to take action to improve and maintain it. For example smoking cessation schemes were available for access.

We noted that a sign in the waiting area asked patients to notify the practice if they were a carer. There was also a range of information to put them in touch with carer support and information groups.

All newly registered patients were offered a consultation to have a basic health check to help them identify any health risks and receive health promotion advice. For patients who took regular medicines an appointment with a GP or nurse was arranged for further assessment of their needs.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All of the patients that we spoke with said they were treated with privacy and dignity by all of the staff at all times. Their opinion of the service they received was without exception, very positive and complimentary. They told us that staff discussed their personal information quietly so it was not overheard by others in the reception or waiting areas. The consultations were private, the doors to each room were always closed and patients felt staff talked to them in a friendly and respectful way and put them at ease.

Reception staff were described by patients as 'helpful' and 'encouraging' and helped patients to get where they needed to be. We saw examples of this during our inspection.

From our conversations with staff we found that they used their local knowledge of their patient's needs to contact those who were experiencing bereavement to offer support. One patient who had experienced bereavement told us she had chosen to seek her own bereavement support. However she felt support would have been available through the practice if she had asked for it.

We found that some staff had completed equality and diversity training. This could be extended to other practice staff so that staff were more aware of recognising diverse needs of their patients and being responsive to their needs.

Staff we spoke with were knowledgeable about the local community and knew their patients well. Although the practice asked patients to let them know if they were a carer for a relative this was not formally recorded. This meant the practice could not ensure that they monitored the needs of carers on an on-going basis to be proactive about providing them with advice and support.

We also spoke with two young people who were still in full time education. They told us they felt respected by staff who listened to their needs and provided appropriate information and advice.

Involvement in decisions and consent

Patients felt the staff were all very approachable, listened to their needs and preferences and involved them in decisions about their care and treatment. For example one person who had needed a change to their medication told us the GP agreed to delay the change until they had completed an important trip.

Three patients we spoke with had been referred by their GP for further assessment by a health care specialist. They told us they felt involved in the decision and their experience went smoothly which enabled them to receive treatment in a timely manner at a location of their choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We found there were a sufficient number of appointments available to meet the needs of registered patients. There were a number of advance appointments as well as appointments made available to book on the day. Patients could also have telephone appointments and home visits were available for those who were too frail or unwell to visit the practice. On two mornings each week, early appointments were available to patients to improve access to appointments for working age patients.

One afternoon a week the practice was closed and emergency cover was provided by a neighbouring practice. We spoke with a patient who had experienced using the emergency cover and they told us they had received a timely and efficient service.

We found that staff responded to patients' individual needs and requests. For example a mother we spoke to told us her child had once become increasingly unwell while waiting for a booked appointment later that day. She took the child to the practice two hours early and was seen within ten minutes of arrival. The child required hospital admission which was swiftly arranged. In addition to this, the GP visited the child on the hospital ward the following day. The child's mother used this example to illustrate how she felt the practice staff would 'go the extra mile' to support their patients.

We spoke with a member of the Patient Participation Group (PPG). The role of the PPG is to represent the views of the registered patients and work with the practice to shape and inform improvements. The group at Over Surgery had four members and met with practice staff every three months. They told us the practice listened to the views of the group and made decisions that would benefit all patients. They were able to tell us about a complaint and comments received in the suggestions box that related to the process for repeat prescriptions. The practice considered the issues raised, listened to the views of the group and reviewed the processes they had in place to make improvements.

Access to the service

Patients all told us they had access to appointments when they needed them and the availability of appointment times met their needs. One person was appreciative of a home visit from their GP when there were no appointments available and they needed to be seen quickly. We also found that patients were happy with the supply of their repeat prescriptions and reported no delays in obtaining their medicines.

The practice opened early two mornings a week and extended appointment times until 6.00pm one evening a week to improve access for patients who worked. Working age patients accounted for more than half of the registered patients at this practice. When the practice closed one afternoon each week, a neighbouring practice provided emergency cover and patients were aware of this arrangement.

Appointments could be booked by phone and some appointments slots were available online (GP telephone appointments and face to face consultations, blood tests).

The practice occasionally treated travellers who presented at the surgery for treatment. The GPs told us they would not turn away a patient who required an appointment.

Meeting people's needs

The practice used the 'Choose and Book' system to enable patient choice about which health provider they wished to attend for further tests or treatment. Most GPs completed these bookings online while their patients were with them. This ensured that the patient had a choice in arranging a convenient time and location and could raise any questions they had with their GP at the time. This was confirmed by patients that we spoke with during the inspection.

The practice had a clear system in place for managing patient's test results. This ensured that any abnormal results were seen by the GP, communicated to the patient by phone or letter and any appropriate action was taken.

Weekly multidisciplinary meetings were held to discuss patients with complex care needs. This included relevant community professionals to ensure that patient's needs and preferences were identified and addressed.

Concerns & Complaints

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

We looked at the complaints log that was kept by the practice manager. There had been 10 complaints received

Are services responsive to people's needs?

(for example, to feedback?)

in 2014 and all of them had been considered, reviewed and actioned in a timely way. However, one complaint received in May had resulted in recommended change to a patient information leaflet. This action had not been fully completed at the time of our inspection.

All of the patients we spoke with had not had any reason to complain or raise concerns about the service. Information on how to raise concerns or complaints was available on the practice website and new patients received an information leaflet when they registered. We noted there was no information in the reception or waiting room that informed patients about the complaints process or who they should speak to if they were unhappy with the service. This could be improved so that all patients have sufficient information to access the complaints process if they had a concern.

The Patient Participation Group (PPG) had a suggestions box in the reception area to invite patient feedback. A PPG member had the key to the box so that feedback went directly to the group for consideration. We heard about one example where feedback had been used to inform a review of repeat prescription requests.

Are services well-led?

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

Our findings

Leadership & Culture

We spoke with a range of staff during the inspection which included the practice manager, GPs, nursing and administrative staff. We found that the practice were committed to providing a caring and responsive service to meet the needs of their registered patients.

Most of the staff we spoke with felt they were very supported by the management team and described that they had an open and honest working culture. They were able to attend regular practice meetings which were a good forum to share information. Staff knew who their line manager was and told us they enjoyed working at the practice. Several members of staff had been employed there for a number of years.

Governance Arrangements

The governance arrangements at the practice required some improvement. It was not clear who was responsible for monitoring and developing the systems in place to ensure that patient's needs were managed in a way to ensure they received a consistent level of high quality care. It was not clear who had overall clinical leadership and this made it difficult to measure and monitor quality outcomes to improve services that patients received.

We also found that a number of processes were informal or not recorded. Health and safety checks, infection control monitoring procedures and a carer's register were not recorded. Criminal records checks during the recruitment process were not recorded and there was no written process for staff to follow. The register of patients living with a learning disability was not up to date to ensure that on-going health needs were monitored in a proactive way. This made it difficult to measure quality outcomes for patients or to monitor the delivery of the services provided.

Systems to monitor and improve quality & improvement (leadership)

The clinical auditing system used by the GPs was effective. The GPs we spoke with were able to share examples of the complete audit cycles that had been completed. These examples included medication audits such as the management of people with atrial fibrillation who were taking warfarin. We found that the results were shared with clinical staff and used to improve patient care and treatment.

Significant events, clinical incidents and complaints were recorded, investigated and actions were shared with staff to ensure that learning and improvement took place. This included any issues that involved medicines in the dispensary.

The recruitment process at the practice had not been monitored to ensure it was effective. References and identification checks were not always sought before staff were appointed to their role. Although there was a recruitment policy in place this needed to be reviewed to include more detail about the specific checks that should take place for all groups of staff.

Patient Experience & Involvement

The patients we spoke with were all very positive about their experience of using the service. We observed that staff treated patients based on their individual need and adopted a person centred approach to care.

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

The practice held meetings with their Patient Participation Group (PPG) every three months and the meetings were always attended by a GP and the practice manager. We found that the PPG were used as a patient voice to help make decisions that would impact upon the practice population such as the introduction of earlier opening for working age patients to improve their access. The group did not lead on identifying and managing any issues although they did have control of the comments box that was located in the waiting area and this was used to help influence improvements to the service.

The results of the last patient survey were published in March 2014 on the practice website. Feedback was received from 62 patients and the results were very positive overall. The PPG considered the results and agreed an action plan. This is now available on the practice website.

Management lead through learning & improvement

Staff that we spoke with told us they felt supported in their professional development and that they had access to training. We found that the practice manager had a system in place to record the training that staff were required to attend. This was regularly monitored to ensure that staff attended and completed the training so that staff were competent in their roles.

Are services well-led?

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

Some staff had received a performance appraisal but three administrative staff had not received an appraisal within the last year. The practice manager had never received an appraisal by the GP partners. An incomplete appraisal process meant that some staff did not have the opportunity to receive formal feedback about their performance or the opportunity to discuss their learning and development opportunities.

Identification & Management of Risk

There was a robust system in place to review significant events and ensure that learning was shared and used to improve upon practice. Although the practice could demonstrate ways they identified and managed risks we found this could be further improved.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice did not have their own register of vulnerable older people who were registered with them. However, a multidisciplinary co-ordinator (funded by the local commissioning group) had got one in place which the practice could access through the information system. In addition, when staff accessed the information system an alert was present on the home screen so that they were aware of each person's needs. All older people over the age of 75 had a named GP chosen by the practice although this could be changed if a patient requested an alternative GP.

Pharmacists in the dispensary conducted regular medication reviews for older people. In addition the practice hoped to receive funding for an older people's clinic which would enable dedicated time for those patients who would benefit from more lengthy consultations. The practice intends to identify a lead GP for older patients.

Older people that we spoke with in the surgery spoke very highly about the care and treatment they received from practice staff. The practice also offered home visits to frail, housebound patients.

The practice did not provide any regular support to any local nursing or residential care homes. There was a day centre adjacent to the practice and the GPs told us they provided support to anyone attending the centre if they became ill.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice held registers of patients with long term health conditions and management of these patients was done by the practice nurses and GPs. A member of the administration team checked each register on a monthly basis and contacted patients in order to arrange a convenient appointment for a review of their condition with either the practice nurse or GP.

A named nurse or GP was identified as the lead for some of the key long term conditions such as diabetes and chronic obstructive pulmonary disease. This meant they were able to develop expertise that could be shared with other colleagues to benefit patient care. A diabetes specialist nurse also ran a clinic at Over Surgery once a month.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Reception staff received some training to help them identify when a child required urgent attention from clinical staff and ensured that appointments were prioritised in a timely way by escalating concerns to the clinical team. The practice had also devised a leaflet to help parents identify urgent and non-urgent health needs for their children to help promote the appropriate use of appointments.

The practice offered baby and child immunisation programmes and the schedule for these was clearly displayed in the waiting room. The immunisation uptake was high. Baby clinics were not provided with the exception of checks for six week old babies that were scheduled at the end of surgery to allow additional time for both mother and baby.

The practice worked well with other health professionals to support this group of patients. This included a midwife who provided weekly clinics at the practice and school nurses. However the practice told us they struggled to receive health visitor support and this was a countywide issue due to low numbers employed by the local NHS Trust who were responsible for the service in that area.

We spoke to a mother and two young people who accessed services at the practice. They were very satisfied with the level of service they received that was tailored to their individual needs.

Actions following the last patient survey included the practice seeking better ways to gain feedback from young people.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice had reviewed opening hours to provide access to appointments for people of working age. This had resulted in early opening at 7.30 am for two days each week. The practice also extended appointments times one day each week until 6.00pm. Some book online appointments were also available and this included telephone consultations with the GPs. Staff told us they would always accommodate patients who required an urgent appointment.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The register of the most vulnerable patients at the practice was managed by the multidisciplinary co-ordinator who was employed by the local clinical commissioning group. This included the safeguarding issues of vulnerable adults. The practice manager told us that patients with safeguarding alerts were not automatically flagged up to practice staff who accessed their records either during or following a consultation. Further exploration of the need to share this information where it was relevant, required further consideration by the practice so that patients were protected.

The practice had a small number of travellers registered with them. Practice staff told us they had the same access to appointments and were not aware that there were any issues for this group.

There were a very small number of patients registered at the practice who had a learning disability. The practice told us they had annual reviews and were offered health checks. When we asked them about the register of patients with a learning disability we found it was reviewed annually and patients were then invited for their annual health check.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had a register for patients with long term mental health conditions so that they could offer on-going support or health promotion advice for issues such as substance misuse or smoking cessation. There were very low numbers of patients on the register.

When patients experiencing poor mental health became unwell they were included for discussion in clinical meetings so that staff could review the management of their health needs and to raise awareness of the potential need for the practice to be more flexible in response to appointment times.

Timely referrals were made to memory clinics for older patients with dementia to access assessment, advice and support. However, referrals for patients in other age groups did not often result in timely access to specialist services. The response to such referrals was beyond the control of the practice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not always protected against the risks of inappropriate or unsafe care and treatment because quality monitoring processes were not always effective. Regulation 10 (1) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Appropriate checks had not been undertaken before staff began working at the practice. Regulation 21 (a) (i) (ii) (iii) (b) (c) (i) (ii)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The practice did not have suitable arrangements in place to ensure that all of their staff received an appraisal. The practice had not taken steps to ensure that relevant staff had knowledge and understanding of the Mental Capacity Act 2005. Regulation 23 (1) (a)