Cornford House Surgery

Quality Report

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Date of inspection visit: 7 September 2017
Date of publication: 04/10/2017

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This inspection was an announced focused inspection carried out on 7 September 2017 to confirm that the practice had carried out improvements that we identified in our previous inspection on 11 August 2016. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is still rated as good, and requires improvement for the safe domain. Our key findings were as follows:

- The systems and processes to systematically record safety alerts had been improved and showed the alerts had been recorded, actions had been taken, and learning shared. This had improved the oversight of safety.
- Annual infection prevention and control audits had been undertaken. However, we found out of date items in a clinical room and there was no system in place to check expiry dates of equipment.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment.
- We found that there was a system to code patient records on the clinical system for children who did not attend a hospital appointment.
- We reviewed three policies and found them to be up-to-date and reflective of current practice.
- We reviewed the system for staff appraisals and found there was a comprehensive log to track when appraisals were due. We checked five staff appraisals and found these had all been completed in the last year.
- The practice had improved the support offered to carers. There were leaflets in the waiting room which signposted carers to support groups and the practice had developed a 'carer's prescription'. This ensured that if a carer became unwell, the practice had systems in place to support both the carer and the person being cared for. The practice had identified 54 patients as carers (0.5% of the practice list).
- The practice had recognised that results from the GP patient survey, published in July 2017, were in line with or below local and national averages for access. The practice had previously been using locum GPs but had employed two new partners in June 2017 to improve continuity of care. The practice had also employed a minor illness nurse. Other details of the

Summary of findings

action plan to improve patient satisfaction were; employing an emergency care practitioner, employing a pharmacist and changing the phone lines to a queue based system. They planned to complete a patient survey to assess whether their action plan was effective. The practice planned to complete these actions by the end of 2017. We spoke with nine patients on the day of inspection and eight of these were satisfied with access to the surgery. One reported difficulty accessing the same GP for continuity.

The areas where the provider should make improvements:

- Continue to proactively identify and offer support to carers.
- Continue to assess the impact of improvements made relating to patient's access to services.
- Implement a system to monitor expiry dates of equipment in clinical rooms.

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 systems and processes to ensure safe management of patient safety alerts had been improved.
- There were up to date infection prevention and control audits and appropriate action had been taken in response to these. However, we found out of date items in a clinical room there was no system in place to check expiry dates of equipment. The out of date bandages were removed immediately and the provider reported a system would be implemented.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment.
- We found there was a system to code patient records on the clinical system for children who did not attend a hospital appointment to ensure they were followed up appropriately.
- We reviewed three policies and found them to be up-to-date and reflective of practice.

Summary of findings

The six population groups and what we found

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

Older people
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People with long term conditions
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Families, children and young people
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Working age people (including those recently retired and students)
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People whose circumstances may make them vulnerable
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People experiencing poor mental health (including people with dementia)
The provider had resolved the concerns for providing safe services identified at our inspection on 7 September 2017, which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Continue to proactively identify and offer support to carers.
- Continue to assess the impact of improvements made relating to patient's access to services.
- Implement a system to monitor expiry dates of equipment in clinical rooms.

Cornford House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist adviser.

Background to Cornford House Surgery

Cornford House Surgery is situated in Cambridge, Cambridgeshire. The practice provides services for approximately 11,300 patients. It holds a General Medical Services contract with the local Clinical Commissioning Group (CCG). There is a branch site in the nearby village of Fulbourn which we did not visit as part of this inspection.

The practice has two male and four female GP partners and one male and two female salaried GPs. The team also includes four practice nurses, two health care assistants and one phlebotomist. They also employ a practice manager, 16 reception and administrative staff and two secretaries. The practice is a teaching and training practice and had one registrar at the time of the inspection.

The practice is open between 8.15am and 6pm Monday to Friday. Appointments can be booked up to six weeks in advance with GPs and nurses. Urgent appointments are available for people that need them, as well as telephone appointments. Online appointments are available to book up to one month in advance. During out-of-hours GP services are provided by Herts Urgent Care via the 111 service.

We reviewed the most recent data available to us from Public Health England which shows that the practice has a lower than average practice population aged between 10-24 and a higher than average practice population between 35-44 and over 85 compared with the national England average. The deprivation score is significantly lower than the average across England.

Income deprivation affecting children is 9%, which is lower than the CCG average of 16% and the national average of 20%. Income deprivation affecting older people is 13%, which is equal to the CCG average of 13% and lower than the national average of 16%. Life expectancy for patients at the practice is 81 years for males and 84 years for females; this is higher than the CCG and England expectancy which is 79 years and 83 years respectively.

Why we carried out this inspection

We undertook a comprehensive inspection of Cornford House Surgery on 11 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing safe services and was rated as good overall. The full comprehensive report following the inspection on 11 August 2016 can be found by selecting the 'all reports' link for Cornford House Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Cornford House Surgery on 7 September 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care.

How we carried out this inspection

During our visit we:

Detailed findings

- Spoke with a range of staff including GPs, the practice manager and an administrator.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.
- Observed how patients were being cared for in the reception area and talked with patients.

Good

Are services safe?

Our findings

At our previous inspection on 11 August 2016, we rated the practice as requires improvement for providing safe services as the practice had not completed regular infection control audits. We also found that not all of the appropriate recruitment checks had been undertaken for all staff prior to employment. For example, five members of staff had proof of identification missing and three had no evidence of conduct in previous employment, such as references recorded. We found that patient safety alerts were logged, shared and initial searches were completed and the changes effected but the necessary subsequent repeat reviews were not regularly conducted to ensure that medicines that were subject to safety alerts continued to be adequately monitored. Lastly, the practice did not read code on their clinical system children who failed to attend a hospital appointment to ensure they were appropriately followed up.

Many arrangements had significantly improved when we undertook a follow up inspection on 7 September 2017. However, the practice is still rated as requires improvement for providing safe services due to there being no system in place for the monitoring of expiry dates of clinical equipment in clinical rooms. We found out of date items in a clinical room.

Safe track record and learning

- We reviewed the systems and processes used to manage safety alerts and found that these had been improved. The practice had a system to ensure that the alerts were actioned by a GP. Searches were run on a regular basis and the practice. We reviewed three alerts and found that the practiced had undertaken all necessary actions and reviewed patients appropriately. For example, an alert had been received regarding the use of a medicine, sodium valproate, and we found that two patients were identified. On review of these patients, we found that both had been reviewed by the GP and were being treated appropriately.

Overview of safety systems and process

- Annual infection prevention and control (IPC) audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result there was no system in place to ensure that devices and equipment available for use in clinical rooms was within the expiry date and safe to use.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Arrangements for safeguarding reflected relevant legislation and local requirements. We found that there was a system to code patient records on the clinical system for children who did not attend a hospital appointment. These children were discussed in the monthly safeguarding meeting with the health visitor and outcomes from these meetings were appropriately documented.
- We reviewed three policies including chaperoning, safeguarding and infection prevention and control. We found these to be detailed and reflective of the current practice. They had all been reviewed, had clear review dates and had been signed. The policies were readily available and staff knew how to access them.