Cadbury Heath Healthcare

Quality Report

Cadbury Heath Health Centre, Parkwall Road,
Cadbury Heath, Bristol, BS30 8HS
Tel: 0117 980 5700
Website: www.cadburyheathheaklthcare.co.uk

Date of inspection visit: 21 April 2015
Date of publication: 02/07/2015

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.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 Cadbury Heath Healthcare on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older patients, those with long term conditions, patients of working age, students and the recently retired. In addition, it was good for providing services for families, children and young people, those whose circumstances make them vulnerable and patients with poor mental health, including those with dementia. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- 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 needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Summary of findings

Importantly the provider must:

- Ensure the security of blank prescriptions including instalment (blue) prescriptions.
- Review how hygiene and infection control is managed and maintained to ensure appropriate standards of hygiene are achieved. Standards should include the cleanliness of all areas of the practice; updating the infection control policy and ensuring all staff have received role specific training in infection control.
- Ensure equipment for use in emergencies is available at all times so that staff have access to it if needed.
- Ensure staff are aware of the location of emergency equipment so they are able to access it if needed.

In addition the provider should:

- Review how risk assessments are recorded and maintained to ensure it is clear who is responsible for taking action to minimise risks to patient and staff safety
- Review processes for checking GPs bags to ensure equipment is in date and safe to use.
- Ensure staff are aware of the staff with responsibility for child protection and safeguarding vulnerable adults so that in the event of cause for concern they know who they should report to.
- Make training available in relation to the Mental Capacity Act 2005 so staff are aware of their responsibilities when dealing with patients who lack the capacity to consent to treatment.
- Ensure staff training records are complete to reflect the training staff have completed.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, not all areas of the practice were cleaned to a good standard. Infection control arrangements needed improvement. Staff were not aware of the location of the emergency equipment and there were items which had not been returned to the trolley so it was unavailable if needed in emergency situations. Portable electrical equipment had not been tested to ensure it was safe to use and medical equipment had not been calibrated to ensure its effectiveness. We found some out of date syringes and needles in GPs bags.

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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent

Summary of findings

appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised, learning from complaints with staff and other stakeholders.

Are services well-led?

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 some policies and procedures in place to govern activity, however others in regard of patient safety needed improving. Regular meetings were held in the practice to keep all staff informed and updated with regard to the management of the practice.

The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active. Staff had received induction, performance reviews 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. It 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 named GP 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for them. It offered longer appointments for patients with a learning disability.

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

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

Summary of findings

What people who use the service say

We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Several patients commented on their being able to get a same day appointment. Two comments received were less positive but they related to different issues. We spoke with the practice manager about these so they could be addressed.

We also spoke with seven patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient referred to the thorough check they had when they first registered with the practice. Others told us about the speedy referral to secondary health care services and management of their long term condition. A young patient we spoke with told us the GP always treated them like an adult and spoke to them rather than their parent.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room.

We looked at the patient comments book at the reception desk. One patient had written about the "fantastic" GP they had seen, how they had helped them and how they felt they were an asset to the practice.

Areas for improvement

Action the service MUST take to improve

Ensure the security of blank prescriptions including instalment (blue) prescriptions.

Review how hygiene and infection control is managed and maintained to ensure appropriate standards of hygiene are achieved. Standards should include the cleanliness of all areas of the practice; updating the infection control policy and ensuring all staff have received role specific training in infection control.

Ensure equipment for use in emergencies is available at all times so that staff have access to it if needed.

Ensure staff are aware of the location of emergency equipment so they are able to access it if needed.

Action the service SHOULD take to improve

Review how risk assessments are recorded and maintained to ensure it is clear who is responsible for taking action to minimise risks to patient and staff safety

Review processes for checking GPs bags to ensure equipment is in date and safe to use.

Ensure staff are aware of the staff with responsibility for child protection and safeguarding vulnerable adults so that in the event of cause for concern they know who they should report to.

Make training available in relation to the Mental Capacity Act 2005 so staff are aware of their responsibilities when dealing with patients who lack the capacity to consent to treatment.

Ensure staff training records are complete to reflect the training staff have completed

Cadbury Heath Healthcare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, a practice manager specialist advisor and practice nurse specialist advisor.

Background to Cadbury Heath Healthcare

Cadbury Heath Healthcare is based in Cadbury Heath Health Centre in Parkwall Road, Cadbury Heath, Bristol, BS30 8HS. It is newly registered with the Care Quality Commission following the merge of the former practices known as The Park Medical Practice and The Oaks Medical Practice on 1 January 2015.

The practice is a partnership of three GPs with three associate GPs and a GP registrar. The practice regularly used the same two locum GPs to cover vacant GP posts. Together they provide services to 11,000 patients with the support of the practice nursing team, reception and administrative staff and the community teams.

The practice is open between 8.30 am and 7.30 pm on Monday and from 8.30 am and 6.30 pm on Tuesday to Friday. Appointments are from 9.00 to 12 noon every morning, every afternoon between to 2.00 pm and 6.00 pm daily. Extended hours surgeries are offered on Monday from 6.30 pm until 7.30 pm and additional early morning appointments from 7.30 am are available on Friday for patients who work.

Information about the Out Of Hours arrangements are contained within the practice leaflet and included on the practice website. The Practice contracts it's Out Of Hours service with Brisdoc and patients are advised to access this through the NHS 111 service.

The practice is a registered teaching practice and supports the training of medical students; there was one registrar GP working in the practice at the time of our inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is 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.

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:

Detailed findings

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- 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. We carried out an announced visit on 21 April 2015. During our visit we spoke with a range of staff including GPs the practice manager, nurses, reception and administrative staff. We also spoke with patients who used the service.

We observed how people were being treated and spoke with relatives and carers. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

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. For example, we saw a record of an occasion when a patient was given a prescription which was not meant for them. We saw evidence from practice records that reception staff had been reminded to check more than the patient's name when issuing prescriptions.

We reviewed safety records, incident reports and minutes of a meeting where these were discussed. The meeting included a review of significant events that occurred at The Oaks Medical Practice and The Park Medical Practice. This showed the practice had managed these consistently and so could show evidence of a safe track record over time. The minutes of the meeting recorded there were no recurring themes.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred and we were able to review these. Significant events meetings were held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with all GPs and other relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of a significant event included carrying out an audit of patients with similar conditions across the practice. 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 to improve.

National patient safety alerts were disseminated, by one of the GP partners who took the lead in this area, to share these with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care and treatment they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at the policy relating to the protection of vulnerable adults and child protection. It defined vulnerable adult and described the action to take and who should be contacted to raise an alert. There was information on the function of the local children's safeguarding board and similarly how concerns should be reported. The document contained a flowchart to guide staff through the process.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, how to record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We saw the practice policies displayed on the staff noticeboard.

The practice had appointed a dedicated GP as the lead for safeguarding vulnerable adults and children. All clinicians were trained to level three in child protection. Not all staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We discussed a safeguarding report with one of the GPs who told us there had been extensive discussion at staff meetings.

There was a chaperone policy, which was visible in consulting rooms. (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).

Requires improvement

Are services safe?

There were codes for staff to use in patient records to indicate when a chaperone was offered, whether there was a chaperone, if one was refused and whether the chaperone was a nurse. Some non-clinical staff had received training to be a chaperone and we saw a list of these staff was kept at reception.

Medicines management

We checked medicines stored in the medicine refrigerators and found they were stored securely and kept locked all of the time when not in use. Medicines were only accessible to authorised staff. There was a clear policy for maintaining the 'cold chain' and ensuring that medicines were kept at the required temperatures. There was a back-up battery operated thermometer and the policy described the action to take in the event of a potential power or equipment failure. The practice staff followed the policy. Fridge temperatures were recorded and we saw how these had been recorded over time.

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. We found some out of date syringes and needles in two GPs bags. This presented a risk to patients if they were used and they were disposed of.

We spoke with a GP regarding guidance for prescribing. They told us guidelines were cascaded through the practice by email and that these were not yet stored on the practice computer system. They said they had discussed guidelines with the staff team informally but would be initiating regular education meetings in the near future. This would formalise the application of guidelines within the practice.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Where the health care assistant administered vaccines such as influenza vaccinations these were carried out in conjunction with patient specific directions which were signed by the GP. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We checked the arrangements for safe management of prescription paper. There was no clear policy or procedure for the secure receipt, storage and control of blank printer prescription paper. It was stored in a locked cupboard in the office and stock in consulting rooms was replenished when needed. There was no system for recording the issue of prescription paper making it difficult to track who had received the prescription paper. We were told the doors to consulting rooms were locked when not in use however, when we checked them with the practice manager we found one to be unlocked with prescription paper left unattended in the printer.

Cleanliness and infection control

We observed the premises to be generally clean and tidy although, there were some areas such as corners of treatment rooms that were dirty and not cleaned. There was dust under some of the treatment couches. We saw there were cleaning schedules in place and audits were conducted by a representative of the cleaning contractor. We looked at the audits carried out on the day of our visit. Two of the rooms had been rated as 'unacceptable' by the auditor however, there was no follow up action recorded and it was unclear whose responsibility it was to take action to rectify the issues noted. The examination couch in room six was rated as 'exceeds' (the specification) however there was dust on the couch.

One of the clinical staff told us they had complained to the practice manager about the standard of cleaning in the past when the cleaning contractor was changed. They said they remained unhappy about the standard of cleanliness. One of the patients we spoke with said they felt the practice was always clean and tidy, other patients we spoke with made no comment about this area.

The practice had identified a lead GP for infection control. There was an infection control policy however we found this had not been reviewed since January 2013. Staff training in infection control was variable with some clinical staff having had no training and others completing on-line training. Staff knowledge and understanding of hand hygiene had not been checked. The last audit of infection control arrangements was carried out in November 2012 and related to The Parks Medical Practice.

Notices about hand hygiene techniques were displayed in patient toilets however, they were susceptible to splashing in the male patients' toilet and were unhygienic. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Requires improvement

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. However we noted records showed on many occasions the blood glucose meter was missing from the emergency trolley and there were other occasions when it was not recorded as being available when the trolley contents were checked.

The practice manager told us that all equipment was tested and maintained regularly however, they could not produce equipment maintenance logs or other records to confirm this on the day of our visit however, it was supplied at a later date. We reviewed the fire safety log book and saw there was regular weekly testing of the alarm system.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, for GPs there was proof of identification and right to work, evidence of General Medical Council (GMC) registration, specialist qualifications, and criminal records checks through the Disclosure and Barring Service (DBS). In addition for nurses there was evidence of registration with the Nursing and Midwifery Council (NMC) and references. References were also obtained for administrative staff.

Some GPs covered holidays and if this was not possible locum GPs were used. There were two locum GPs contracted to work at the practice that were described as associates. One of them worked eleven months and took a month off and the other was employed by a company and had worked in the practice for eight months. The registered manager told us these locums did not have any specific lead roles in the practice. They said they monitored the locums' appraisal for the General Medical Council (GMC) registration, were included in basic life support training and attended significant event and clinical meetings. We were told their work was monitored and the practice checked their DBS status and the GMC performers list annually.

Monitoring safety and responding to risk

The practice had a comprehensive risk management policy that stated a register of identified risks was held in the practice however, a register was not in place. The policy was compiled in July 2012 and due for review in July 2015. However, the policy itself stated that it should be reviewed, at the most, bi-annually; consequently the review was out of date.

We saw risks were assessed thoroughly and six actions were identified but there was no evidence of ownership and no evidence of any actions having been completed. It is the responsibility of Sirona Care & Health to deal with the landlord about issues relating to premises. Cadbury Heath Healthcare staff report issues to the Strategic Business Manager who then contacts Sirona Care & Health or staff can speak directly to the Sirona Care and Health administrator who is based in the Sirona Care & Health reception area.

There was a detailed health and safety policy.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, falls risk assessments were carried out and patients were referred to the local falls clinic if needed. The practice had also carried out reviews of patient at risk of falls taking certain medicines. The practice worked with other services to provide a multi-disciplinary approach for patients at risk of hospital admission. Patients at risk of domestic violence were flagged on the computerised records system. Any vulnerable patients were discussed in primary healthcare team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We saw records and staff confirmed they had completed training in resuscitation and basic life support in April 2014.

When we asked staff about the location of the emergency equipment and medicines there was some confusion. Some staff thought there were two supplies of medicines and one thought there was only one. There were two supplies one kept in the reception area and a trolley kept in a secure area that also contained the emergency equipment.

We checked the trolley and saw its contents were checked weekly. The defibrillator was tested in November 2014 and

Requires improvement

Are services safe?

pads which are used with this piece of equipment were in date. There was oxygen and an oxygen pulse oximeter, medicines and single use equipment were within their expiry date for safe use.

The emergency medicines kept in the reception area were in place and the practice had stated that these were checked monthly. However, we saw these medicines had not been checked in February 2015. The medicines were in date except for one, for treatment of infections, this had expired in February 2015. The record of checks showed this monthly check as being 'on order' in March 2015.

The practice had a disaster handling and business continuity plan that was recently compiled,copies of which were kept off of the premises. It outlined risks in respect of the premises, the computer systems, telephones, supplies, medical records, loss of essential services and incapacity of staff. There was a list of key contacts and suppliers.

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 and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as substance misuse, which allowed the practice to support patients appropriately and focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of health conditions.

When patients were discharged form hospital the care coordinator from the practice contacted them to ensure arrangements for their care were in place and in line with their care plan.

The practice had completed reviews of case notes for patients in respect of medicines management. These identified where changes in prescribing were required to ensure the patient was receiving the most effective medicine for their condition. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, there was an audit to determine whether prescribing of anti-psychotic medicines were in line with local guidelines and another to ensure they had been reviewed at the appropriate intervals for patients with dementia. The results of the audit indicated they were in line with local guidelines and patients were reviewed appropriately.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a 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). For example, we saw an audit regarding the prescribing of ACE inhibitors, for high blood pressure, diuretics and non-steroidal anti-inflammatory drugs. (ACE inhibitors are medicines that are used mainly in the treatment of high blood pressure (hypertension) and heart failure). Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 96% of patients with diabetes had a foot examination in the preceding 12 months which was higher than the England average of 88%. Similarly, the percentage of patients with diabetes who had an influenza immunisation was similar to other practices. The practice was in line with other practices for QOF in mental health related indictors, atrial fibrillation therapy and cervical screening. For example, the notes of 84% of women aged between 25 and 65 years had a recorded cervical screening within the preceding five years compared to the England average of 82%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly

Good

Are services effective?

(for example, treatment is effective)

checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that 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 GP was prescribing medicines.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. However we saw evidence which indicated other aspects of training were incomplete for example, about hygiene and infection control.

We noted a good skill mix among the doctors with three having additional diplomas in obstetrics and gynaecology, and one with a diploma in sexual and reproductive health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff indicated the practice was proactive in providing training and funding for relevant courses. For example, one of the receptionists told us how in their appraisal it was identified they could undertake training in phlebotomy (taking blood samples) which they completed in February 2015 and they were now performing this task in addition to their reception duties.

As the practice was a training practice, doctors who were training to be qualified as GP had access to a senior GP throughout the day for support. The practice supported medical students through all five years of their training.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in regard of the monitoring and supporting patients minor illness, telephone triage and smoking in pregnancy, supporting patients with smoking cessation.

The practice was training two staff to undertake minor illness clinics to improve patient access and remove some of this work from GPs. Part of the motivation for merging The Oaks Medical Practice and The Park Medical Practice was ti combine GP recruitment. The practice was in the process of recruiting an additional GP for a further six sessions per week to increase the number from 39 to 45 sessions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, the emergency care practitioner, community matron and social worker and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

record, EMIS, to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We were told the practice was still using the systems from The Oaks Medical Practice and The Park Medical Practice however, they were to be merged into one system at the end of June 2015.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had not completed training in relation to mental capacity with the practice. One of the staff we spoke with had undertaken training in a previous role however.

One of the clinical staff we spoke with 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).

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed a member of staff showed a good understanding of the needs of patients with learning disabilities.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and there was a record to show the relevant risks, benefits and complications of the procedure were discussed.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers during routine appointments. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check, including home visits if required. The practice actively offered nurse-led smoking cessation clinics to patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese, those with diabetes, those living with dementia and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84%, which was similar to others in the CCG area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practices performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice.

All patients over the age of 75 years had been sent a letter advising who their named GP was. There was a register of patients who were considered to be at high risk of admission to hospital or at the end of life. The practice held a monthly meeting with a representative to discuss the needs of these patients.

Older patients were asked if they had any concerns about their memory and if appropriate they were referred to the dementia clinic for cognitive testing.

Patients with long term conditions were monitored by their usual GP to ensure their medicines and condition were reviewed. Those with diabetes were seen every six months and patients with chronic heart disease, asthma and chronic obstructive pulmonary disease were seen annually. If patients had multiple conditions they were reviewed in a single appointment for the patient's convenience. To ensure reviews were carried out home visits were arranged, if required.

The practice had systems in place to monitor the well-being of children and young patients. It maintained a register of those for whom the practice had concerns and

Good

Are services effective?

(for example, treatment is effective)

there were flags on the patient record system to alert staff when there were concerns. The practice maintained close links with health visitors who were based in the same building and attended monthly meeting to discuss patients and their families in order to promote the best health outcomes for them.

One of the GPs had a special interest and was the lead GP for addictions such as substance misuse. They provided outreach services to other practices and referred the patients they saw to organisations specialising in addiction recovery.

The practice enabled self-referral of patients for counselling, cognitive behaviour therapy and stress/mood management workshops. It provided self-help leaflets for patients with poor mental health and had access to the primary care liaison service.

We saw there was a television monitor in the waiting room showing patient care information and there were a range of leaflets available for patients to take away. There was a public information notice board and the practice had copies of the manual 'Your health guide to common ailments' for patients to look at.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey for 2014/2015. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data showed the practice was rated being similar to other practices for patients who rated the practice as good or very good. The practice was also above the England average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at involving them in decisions about their care and 92% saying the nurse they saw was good or very good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Several patients commented on being able to get a same day appointment. Two comments were less positive but they related to different issues. We spoke with the practice manager about these so they could be addressed.

We also spoke with seven patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient referred to the thorough health check they had when they first registered with the practice. Others told us about the speedy referral to secondary health care services and management of their long term condition. A young patient we spoke with told us the GP always treated them like an adult and spoke to them rather than their parent.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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 switchboard was located away from the reception desk which helped keep patient information private. We saw a sign asking patients to respect others privacy by keeping back from the reception desk when they were speaking with the receptionist. We saw this in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2014/2015 showed 85% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good or very good at treating them with care and concern. Both these results were above the England average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services and interpreters were available for patients who did not have English as a first language. One of the reception staff told us they had some British Sign Language skills.

Patient/carer support to cope emotionally with care and treatment

The practice carer's policy defined 'carer' and 'young carer' and outlined how the practice would identify carers. We saw there was a dedicated notice board to provide information to carers about support organisations and adult care services. There were carer referral forms at the reception desk to encourage carers to identify themselves. Prescriptions carried a message requesting appropriate patients to complete a form and new patient registration forms included questions about being a carer.

Good

Are services caring?

Electronic records identified individual patients with caring responsibilities so this could be taken into account when treatment was being considered. The practice maintained a register of carers and they were offered annual health checks.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the PPG discussed the best position for a GP to be sat when patients entered the consultation room for their appointment to make the greeting more welcoming and friendly. In addition the PPG worked with the practice on the content and layout of the information shown on the TV monitor in the waiting room.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. It maintained registers of patients whose circumstances make them vulnerable such as patients with learning disabilities, dementia and those nearing the end of their life. It offered extended hours appointments for those patients of working age and students to enable access to the practice. Patients with hearing or sight impairment and those with limited English were flagged on the patient record system so GPs and nurses could collect them from reception.

The practice had access to translation services and interpreters if necessary.

The premises and services had been adapted to meet the needs of patients with disabilities. There were designated parking spaces for disabled drivers, a ramp led to the reception and waiting area and there was level access throughout the practice. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was an induction hearing loop in the reception area. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open between 8.30 am and 7.30 pm on Monday and from 8.30 am and 6.30 pm on Tuesday to Friday. Appointments were available from 9.00 to 12 noon every morning, every afternoon between to 2.00 pm and 6.00 pm daily. Extended hours surgeries were offered on Monday from 6.30 pm until 7.30 pm and additional early morning appointments from 7.30 am were available on Friday for patients who worked.

The practice website provided information about appointment times and the Out Of Hours arrangements. There was also information relating to registration with the practice and health promotion and preventative medicine. Appointments could be booked in person, on-line or by telephone.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home and to those patients who needed one who lived in their own home.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Some patients did comment on the length of time it took for telephone calls to the practice to be answered sometimes.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. It was outlined briefly in the practice leaflet and more fully on the practice website Some of the 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.

The practice had two forms for registering a complaint, one of which was for when another person was making a complaint on behalf of a patient. We saw this form required the patient to give consent for the complaint to be made.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the handling of a complaint received in February 2015 and found the complaint made by telephone was fully recorded by the practice manager, acknowledged the same day in writing and a full response sent within 10 days as stated in the practices complaints policy.

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values were outlined in the patient charter. It stated that patients were entitled to be given the most appropriate care or treatment, by suitably qualified staff, after discussion with them. In addition it outlined how patients would be offered appropriate advice on exercise, diet and immunisation along with information about the steps they could take to lead a healthy lifestyle and avoid illness.

We spoke with 16 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 17 of these policies. Most of the policies and procedures we looked at had been reviewed and were up to date. The exceptions were the infection control policy, risk policy and the arrangements for the management of prescription paper which were not up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. However staff also told us there was a feeling of unsettlement amongst the staff since The Oaks Medical Practice and The Park Medical Practice had merged. Some staff told us the merger had not gone as smoothly as planned and this along with staff changes had left them feeling unsettled.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw information relating to audits in medicines prescribing, minor surgery and contraceptive implants. Audits were conducted following the issue of new guidance or following significant events so lessons could be learned and outcomes improved for all patients in a similar position. For example following a significant event when a patient was prescribed the wrong type of intrauterine device an audit of all patients with the device was carried out to check it was suitable fpor them.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us information relating to risk assessments which addressed a range of potential issues. However, there was no risk log and no ownership or evidence of action taken to minimise risk.

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

Leadership, openness and transparency

Staff told us that team meetings were held regularly, at least monthly for nurses but there were no regular meetings for administrative or reception staff. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Staff said the GPs were approachable and they felt supported. They spoke about good team working within the practice.

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

The practice had gathered feedback from patients through patient reference group (PRG) feedback, the friends and family test and complaints received. We reviewed a report on the activity of the patient reference group that identified three priority areas for 2014/2015. These related to obtaining feedback from patients about the merger of The Oaks Medical Practice and The Park Medical Practice, recruiting more volunteers to the PRG and spreading surgeries throughout the day.

To obtain feedback from patients about the merger two open meetings were held with patients. Feedback indicated patients felt the merger was a pragmatic decision

Are services well-led?

Good

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

and was positive. The PRG actively tried to recruit more volunteers, was successful and this was on-going. The practice implemented an on-going trial of early afternoon surgeries.

We met with the chair of the PRG. They told us how the group met every four months with the practice manager and one of the GPs. They said around 10 to 15 patients of all ages and backgrounds attended the meetings to give a focussed view of the practice. They spoke about how the PRG had been involved in the development of services and how it had raised money for equipment including blood pressure monitors for patients to use at home and high backed chairs for older patients and those with back problems.

Staff told us they felt they could give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both themselves and patients.

Staff were aware of the practice whistleblowing policy and said they felt they would be supported if they had cause to report a colleague.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at four staff files and saw that information relating to training was missing from each of them. Appraisals took place which included a personal development plan in most cases. Staff told us that the practice was very supportive of training.

The practice was a GP teaching practice and regularly had medical students as part of their training. The practice leaflet outlined how, depending on the stage of their training, they may observe, be supervised by a GP or consult on their own. The leaflet asked patients to be supportive of this but explained they could request to not have a student present.

The practice had completed reviews of significant events and other incidents and shared outcomes with staff to improve outcomes for patients. We saw the significant event log recorded the actions taken and learning from events but did not record the dates of these discussions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation: 12 (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph must include- (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. Regulation 12(2) (a)(b)(g)(h).