Kimbolton Medical Centre

Quality Report

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

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Summary of findings

Overall summary

Kimbolton Medical Centre provides primary medical services to patients in Kimbolton, Cambridgeshire and the surrounding areas. The practice is led by five general practitioners (GPs) who form the partnership management team. One of the partners is the registered provider of services at the practice.

We spoke with patients during our inspection, who were complimentary about the services they had received from the practice. We also received many positive comments from patients who had completed comment cards prior to our inspection. All patients expressed a high level of satisfaction with the practice and the staff. Staff we spoke with told us that the management team were supportive, open and approachable.

The practice was well-led and provided caring, effective and responsive services to a wide range of patient groups, including those of working age and recently retired, mothers, babies, children and young people, patients with long term conditions and complex needs, people in vulnerable circumstances and people who were experiencing poor mental health.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements with regard to medicines were needed. The practice demonstrated that changes had been made when things had gone wrong. The information about incidents had been shared amongst the team and measures had been put into place to reduce the risk of re-occurrence. There were detailed safeguarding systems in place and all staff were trained to recognise signs of abuse and what to do if abuse was suspected. The practice was clean, tidy and hygienic. Staff followed guidelines to ensure high standards of hygiene were maintained. We found that the practice did not have sufficient controls and procedures in place to manage medicines. Staff were trained and equipped to deal with medical emergencies.

Are services effective?

The practice was effective. There were enough suitably trained and experienced staff to meet the needs of the patients who used the practice. We saw evidence that the practice worked well with other healthcare providers and the practice held and participated in a number of multidisciplinary meetings with other health and social care professionals. We saw a varied selection of information was supplied to patients or was on display in the waiting area that included information on health promotion, prevention and health related travel advice.

Are services caring?

The practice was caring. Patients told us that they were always treated with dignity and respect when using the practice. We heard how compassionate the GPs were with regard to end of life care and how they had supported patients through bereavement. Patients commented on how they were involved in their own care and had their care and treatment options explained to them. Staff we spoke with were able to demonstrate their understanding of the consent process.

Are services responsive to people's needs?

The practice was responsive to patient's needs. There were systems and processes in place to respond and take action when things did not go as planned. The practice had a complaints procedure and complaints had been responded to in a timely manner. Patients were able to make suggestions to improve the services they received. Patients had been listened to and we saw that actions had been taken as a result of their comments and feedback.

Summary of findings

Are services well-led?

The practice was well-led. The management team provided structured leadership for staff. Staff told us that there was an open and supportive culture at the practice. They said they were comfortable approaching the senior and other partners for anything they needed and the management team listened to them. There were monitoring and risk management systems in place that ensured lessons were learned and the service improved as a result.

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

We saw that the practice offered relevant care to older patients, this included blood tests, blood pressure monitoring and general well man/woman consultations.

Older patients were seen annually, or sooner depending on the complexity of their needs, by the nursing or medical team for health checks and to review their medicines. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it.

We saw that flu and shingles vaccinations were routinely offered to older patients to help protect them against these viruses and associated illnesses.

The practice was caring in the support it offered to older patients and there were effective treatments and on-going support for those patients identified with dementia. The practice was responsive in meeting the needs of older patients and in recognising future demands on the practice for this age group. The practice was well led in relation to improving the provision of services for patients and their families who were receiving end of life care.

People with long-term conditions

The practice offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, electro cardiography (ECG) (a test that measures the electrical activity of the heart) and spirometry (to measure breathing). The practice offered nurse led asthma, chronic obstructive pulmonary disease (COPD) and diabetes clinics and patients with these conditions were seen at least annually for health checks.

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illness were seen annually or sooner depending on the complexity of their conditions, for a medicines review. The practice held clinics for patients taking medicine for diabetes, rheumatoid arthritis, asthma, and chronic obstructive pulmonary disorder (COPD).

Summary of findings

Staff from the community palliative care team and the district nurses attended meetings with the GPs and the nursing staff, which enabled practice staff to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed by telephone of the care arrangements if emergencies arose. These patients therefore received the care relevant to their circumstances regardless of when they needed it. The practice received, electronically each morning, details of any patients who had received a service from the out of hours service and this was checked by one of the GPs.

The practice was well-led in relation to identifying a named lead GP trained in specialist dementia care and in recognising symptoms to enable early detection.

The practice was caring in the support it offered to patients with long term conditions. The care this group of patients received was effective and treatment pathways were monitored and kept under review by a multidisciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in terms of improving outcomes for patients with long term conditions and complex needs.

Mothers, babies, children and young people

Mothers, babies, children and young people received relevant care from the practice. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife. Mothers were seen routinely for a postnatal check at the six to eight week stage. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations. The practice worked closely with both midwives and health visitors

The practice was caring in its approach to mothers, babies, children and young people and provided effective services and treatment, offering dedicated clinics at the practice and referrals into community based services to provide additional support. The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice followed best practice by naming a staff member with lead responsibility for children's safeguarding.

Summary of findings

The working-age population and those recently retired

The working age population and those recently retired were offered relevant care by the practice. The practice was open later on a Tuesday so that patients had the opportunity to attend after work.

We saw that flu vaccinations were routinely offered to the working age population and those recently retired to help protect them against the virus and associated illness. Saturday morning clinics were available for flu vaccinations. The practice also offered travel vaccinations and NHS travel advice and some travel vaccinations on a private basis.

The practice was caring in the support it offered to working age and recently retired patients. The management team completed clinical audit cycles to evaluate outcomes for patients in this group.

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

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care.

We saw that flu vaccinations were routinely offered to patients who were in vulnerable circumstances to help protect them against the virus and associated illness.

The practice was caring about vulnerable patients, the homeless and travellers, by providing access and support. There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in people's homes who found it difficult to attend the practice premises. The practice had a very small number of patients with a learning disability registered with them and all of them had received regular annual health checks.

People experiencing poor mental health

We saw that the practice offered relevant care to patients experiencing poor mental health. Patients were offered same day or pre-booked and follow up appointments. Where possible every effort was made to make appointments with the same GP.

Patients experiencing poor mental health received support, care and treatment at the practice and in the community when they needed it. The practice held multidisciplinary meetings which were attended by staff in the community mental health team where they discussed arrangements for individual patients and ensured the out of hours service was informed by telephone of the care arrangements if emergencies or crises arose.

Summary of findings

The practice was caring in relation to patients experiencing poor mental health and the practice had effective procedures for undertaking routine mental health assessments. The practice was responsive in referring patients to other service providers for ongoing support. The practice had effective systems in place to identify and manage risks to patients who may be experiencing poor mental health.

Summary of findings

What people who use the service say

All of the patients we spoke with on the day of our inspection were very positive about the services they had received at Kimbolton Medical Centre. They were particularly complimentary about the staff, and said that they were always caring, supportive and sensitive to their needs. Patients told us that they felt safe when visiting the practice or when the GPs visited them in their homes

Patients indicated that they had no concerns with regard to hygiene and the cleanliness of the practice. They told us that staff always washed their hands when examining them or carrying out a procedure.

We heard how patients felt that they were involved in their care and treatment and that options were always explained and discussed with them. They told us that staff always gave them enough information to be able to make decisions with regard to their care and that they could make these decisions in their own time.

Patients said that they were treated with dignity and respect when using the practice and that they could request to speak to one of the reception staff privately if they wished.

Patients we spoke with told us that they could always get an appointment when they needed one and with the GP of their choice. They said that the online booking system allowed them to look at appointment availability and choose the time, day and which GP they preferred to see.

We also received positive comments from patients who had completed 14 comment cards prior to our inspection. All comment cards indicated that patients were more than satisfied with the support, care and treatment they had received from the practice.

Areas for improvement

Action the service MUST take to improve

We found that patients were not fully protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the safe keeping and dispensing of medicines.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

There were excellent governance and risk management procedures in place.

The service was very responsive to concerns and comments.

There was a clear vision and strategy that was effectively communicated.

There was a strong culture of patient centred care and patients could access the practice at a time to suit them.

There were very good recruitment, induction and training processes in place

Kimbolton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and accompanied by a GP, two CQC inspectors, a pharmacy inspector and the team included a specialist advisor who was a practice manager.

Background to Kimbolton Medical Centre

Kimbolton Medical Centre provides primary medical services Monday to Friday from 8.30am to 6pm, with extended opening hours on certain mornings/evenings, for patients in Kimbolton, Cambridgeshire and the surrounding areas. The practice provides a service for approximately 6000 patients in the locality and has a dispensary service for those patients who may find it difficult to access a local pharmacy.

Routine health care and clinical services are offered at the practice, led and provided by the clinical and nursing team. There are a range of patient population groups that use the practice.

The practice has six GPs, two trainee GPs, three practice nurses, a practice manager and three dispensing staff. There was also three health care assistants who carried out blood tests, blood pressure tests, ECG's, new patient checks and NHS health checks. A team of community nurses and the health visitor service also have a base within the practice, which provides ease of access for patients referred to these services.

Daily clinician meetings were held and we saw evidence of how decisions were made about on-call and cover arrangements to ensure there were sufficient hours provided for patient sessions, including emergency appointments. Each day the GPs consider a list of patients who have been admitted to hospital and where they are. Discussions are then had to determine if any imput from the practice could speed up their discharge and what their needs will be once they return home.

Emergency cover outside of normal surgery hours was provided by Urgent Care Cambridge, based at Hinchingbrooke Hospital in Huntingdon.

Why we carried out this inspection

We inspected Kimbolton Medical Centre 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions

Detailed findings

- Mothers, children and young people
- 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 our visit to Kimbolton Medical Centre, we reviewed a range of information we hold about the practice. This included information about the patient population groups, results of surveys and data from The Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. We asked other organisations to share what they knew about the practice, this included the Local Commissioning Group and local Healthwatch.

We carried out an announced visit on 05 September 2014. Prior to our visit we provided comment cards for the practice to place in their waiting area so that patients could share their views and experiences of using the practice. During our visit we spoke with a range of staff which comprised of two of the GP partners, the practice nurse, the health visitor, two health care assistants, the practice manager, three administration staff. We also spoke with seven patients who used the practice. We observed how people were being cared for and talked with carers and family members and reviewed practice records, policies and protocols.

Are services safe?

Our findings

Safe track record

The practice had systems to report, record and analyse significant events with outcomes being shared at clinical meetings daily and every fortnight. Staff told us about and we saw examples of the online reporting form that was completed as soon as possible after an event occurred. Completed forms were sent to either the lead GP or the practice manager. Depending on the content the form was then sent for annual review by the management team. Clinical significant events were included in the daily clinical meetings. Dispensing significant events were discussed immediately by dispensing staff. All other significant events were dealt with by the practice manager and GP lead in that area.

Learning and improvement from safety incidents

We saw that 13 significant events had been recorded this year. Records we saw included detailed information regarding each event, but some did not include what follow up action had been taken or what changes had been made as a result. Staff told us that follow up action was in the process of being arranged or had taken place when external professionals were involved. We saw records that confirmed this. Action plans had been created and completed for other significant events. We saw that the practice made positive changes as a result of significant events. For example, incorrect medication had been dispensed Once identified it was immediately discussed with one of the GPs. The error pertained to dispensing staff being busy as demand for the issue of prescriptions had increased. In response to the reported medication error the dispensing staffing hours had been increased and were currently under review to see if this action was sufficient in reducing the risk of this error being repeated. We also saw evidence that the practice had learned from significant incidents such as practice security incidents and had made changes to improve the service.

Reliable safety systems and processes including safeguarding

Patients we spoke with told us that they felt safe when visiting the practice or when they had a home visit. They told us that if they had any concerns they would speak to the practice manager or directly to their GP. The practice offered a chaperone option where a member of staff would be available to escort patients during intimate examinations at their request. We saw notices in the waiting area and in consultation rooms to that effect. All of the clinical staff had completed safeguarding training that was appropriate to their role. Staff we spoke with were aware of their responsibilities with regard to identifying and reporting any concerns of patient abuse. The practice had a designated safeguarding lead and quarterly meetings were held with health visitors and social care professionals.

Staff were able to give examples of appropriate safeguarding considerations in a clinical scenario. They were able to give examples of the types and signs of abuse and knew who to report any concerns to including the local authority reporting procedures. Staff were familiar with the practice's safeguarding policy and knew where to locate it.

Staff had been recruited safely, with robust checks being carried out before staff began to work at the practice. Employment files we looked at confirmed that relevant staff had been checked and were safe to work with vulnerable people.

Monitoring safety and responding to risk

The practice had systems and procedures for responding to emergencies. All staff within the practice had received training in emergency life support and fire training. Daily clinician meetings were held and we saw evidence of how decisions were made about on-call and cover arrangements to ensure there were sufficient hours provided for patient sessions, including emergency appointments.

We spoke with clinical staff experienced in prioritising appointments who worked with the GPs to ensure patients were seen according to the urgency of their health care needs. An 'on-call' GP was also available in the practice each week-day to support service demands, providing greater flexibility amongst the GPs to respond to busy periods and any emerging risks to patients throughout the day.

We saw the practice had panic buttons and a safety alert system in all treatment areas to enable staff to summon assistance if needed. The practice was therefore able to respond quickly when an emergency situation arose and staff told us they were aware of the emergency procedures to follow.

We looked at the practice fire policy and fire drill protocols. All of the staff we spoke with were aware of their roles and responsibility in the event of a fire and we saw evidence

that regular testing and checking of the alarm and fire equipment had taken place. To ensure that care would not be compromised and patients would still have access to a GP at all times, we saw the practice had a comprehensive contingency plan in the event of a fire, flood, extreme weather and loss of utilities.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. Patients had indicated to us during our inspection that they received a good service from the pharmacy. We noted the dispensary was tidy and operated calmly with adequate staffing levels. We saw that repeat prescriptions were handed to patients without proper authority and that the medicines were supplied to patients before prescriptions were signed by the doctors.

We looked at the arrangements in place for the security of medicines. We found refrigerated medicines including injectable medicines were kept securely in clinical areas of the surgery. We found there were not appropriate arrangements for the security of some medicines. Although the dispensary was locked, and medicines secured when it was not being used, we saw that there were a large number of dispensed medicines waiting to be collected which were stored on open shelves outside the dispensary. This area was accessible to non-clinical staff.

Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. The practice nurse on duty described adequate arrangements for maintaining the cold-chain for vaccines following their delivery. We saw the surgery had a small supply of medicines for use in emergency which were safely stored, and records were available about expiry date checks so we were assured that staff monitor and check emergency medicines to ensure they remain safe to use.

We checked a sample of controlled drugs and found we could account for them in line with records. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register.

We found there was a comprehensive range of standard operating procedures relating to medicines for staff to follow and that these were regularly reviewed and updated.

We found that dispensing staff working at the practice had received training to undertake dispensing tasks. We saw evidence that dispensary staff had annual appraisals of their performance and the staff told us that the competence of staff to dispense medicines had been assessed and there were regular weekly checks of the procedures in place. However, this had not been formally recorded.

Cleanliness and infection control

During our inspection we visited patient waiting and treatment areas, administrative and office spaces. We saw that the practice was clean and tidy. There was hard flooring in the treatment and consultation rooms which was clean and intact. We saw there were body fluid spillage kits in all of the clinical rooms, which enabled staff to clean any contamination or spillages efficiently and effectively.

Staff were able to tell us about the infection control policy and their roles with regard to infection control practices and the importance of strict adherence to the policy. Infection control topics were discussed at staff meetings. We looked at the most recent minutes of a staff meeting where staff had been reminded to read the infection control policies and procedures to refresh their knowledge. This was to ensure that staff had up to date familiarity with the practices infection control procedures.

The treatment and consulting rooms were clean, tidy and uncluttered. Each room was stocked with personal protective equipment including a range of disposable gloves, aprons and coverings. This enabled the clinical staff to follow clean processes. We saw that there was a supply of antibacterial hand wash, gel and paper towels available throughout the practice. Patients told us that the staff always washed their hands and the practice was always cleaned to a high standard. Patients told us that they had no concerns with regard to the cleanliness of the practice.

We saw there was a system for handling, storing and disposing of clinical waste in line with current legislation. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. There were cleaning schedules in place and we saw there was a supply of approved cleaning products. Treatment rooms were

Are services safe?

fitted with hard flooring so spillages were easily cleared up. A person was employed to clean the premises daily to ensure that people were treated and cared for in a clean hygienic environment.

A legionella risk assessment had been carried out and the practice water lines had been checked and maintained regularly. The checks demonstrated that patients were protected from the risk of an infection associated with the legionella bacteria.

Staffing and recruitment

Staff were recruited safely with relevant checks being carried out on all clinical and non-clinical staff. The practice had a recruitment policy that reflected a robust recruitment and selection process. We looked at a selection of staff files and saw that appropriate safety checks had been carried out with the Disclosure and Barring Service (DBS), as well as professional registration checks for all clinical staff with the Nursing and Midwifery Council (NMC) or the General Medical Council (GMC). Through the available processes and procedures the provider was able to ensure that staff had been checked thoroughly to work with vulnerable people and that they had the right qualifications, skills and experience necessary for them to perform their work.

Dealing with Emergencies

The practice was prepared and could respond confidently in the event of a patient suffering a medical emergency. Staff had received Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) training on an annual basis and we saw evidence that this had taken place. The practice had a supply of emergency medication and oxygen which had been checked and were all in date.

Equipment

We saw that staff had taken steps to protect patients against the risk associated with the equipment they used. We saw evidence of appropriate maintenance of the equipment including electrical checks and calibration of clinical apparatus such as the blood pressure monitor and nebuliser. All had been checked, tested and passed as fit for purpose

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We spoke with clinical staff who told us that patients' needs and potential risks were assessed at initial consultations with the clinicians, individual clinical and treatment pathways were agreed and recorded on a computerised system. There was evidence that the practice carried out medicine audits that had been initiated by NHS commissioners/stakeholders in line with national guidelines and standards. For example, we saw a change had been made to the prescribing regime for patients with a specific condition, following updated best practice guidelines.

We spoke with clinical staff who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. They told us mental capacity assessments were carried out by the GPs and recorded on individual patient records and mental health reviews were undertaken when patients visited the practice for other routine checks. We saw evidence the practice had a protocol for the consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, immunisations or minor surgery. We saw evidence some staff had undertaken mental capacity awareness training.

Management, monitoring and improving outcomes for people

The practice used information to analyse the effectiveness of some of the treatments provided to patients and registers were kept to identify patients with specific conditions/diagnosis, for example, patients with dementia. We saw evidence of completed clinical audits cycles and benchmarking opportunities had been pursued. The information was shared and discussed at clinical meetings and actions agreed regarding changes to specific treatments and therapies that would potentially achieve improved outcomes for patients.

Staff told us of a medicines audit that had been carried out recently. The results of the audit had been shared during a team meeting with the clinical team. Each GP had completed other clinical audits relevant to their practise. We saw evidence of previous audits concerning a certain medicine, dementia and coronary heart disease. The results had been shared during clinical meetings and had been used to check the standards of clinical services that patients had received. New processes were re-audited to ensure that the changes made improvements to patient care.

Effective Staffing, equipment and facilities

We found there were enough staff available to cover the needs of the patients using the practice. The practice provided bookable clinical sessions and offered emergency appointments, telephone consultations and home visits. This was above the national average required for the patient population who used the practice. Patients had their health and welfare needs met by sufficient numbers of appropriate staff with the right knowledge, skills, experience and qualifications to support their needs.

We looked at a selection of staff files and saw appropriate professional registration checks for all clinical staff had been carried out with the National Midwifery Council (NMC) or the General Medical Council (GMC) and that all registrations for clinical staff were up to date.

Working with other services

Patients' health, safety and welfare were protected when more than one provider was involved in their care and treatment, or when they moved between different services. The practice had protocols and systems in place for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. Regular multidisciplinary meetings took place between other health professionals and staff at the practice. We looked at the minutes of these meetings and saw individual cases had been discussed and plans put in place to meet patients' needs and keep them safe. The local hospice held meetings with the GPs and the nursing staff. This enabled the GP to discuss the needs of patients with chronic and terminal illness. Arrangements for individual patients on advanced care plans were also discussed. Staff ensured the out of hour's service was informed by telephone of the care arrangements if emergencies or crisis arose. Patients had the care and treatment they needed and that advanced decisions were upheld when using other services.

There were arrangements for sending referrals and receiving various test results and feedback from other health professionals. The staff we spoke with told us of the training they had received to enable them to audit and ensure that the system for results and referrals was working

Are services effective?

(for example, treatment is effective)

effectively. All test results were seen by a GP first, and then scanned into the patient's records. Results were checked and any further arrangements made for patients in a timely manner.

Health, promotion and prevention

Patients were given appropriate information, support and advice regarding their care and treatment. We saw there were a range of information leaflets in the waiting area and posters detailing services provided by the practice and external clinics. Patients were given further written information, if needed to encourage independence, self-treatment, and advice regarding health promotion and support services such as smoking cessation and healthy living. We were shown a copy of the practice leaflet, which contained useful information for patients about the practice, including how to access GP support when the practice was closed. Patients were encouraged to treat minor ailments or injury at home and had information about when it would be necessary to attend the practice. The practice website and practice leaflet held information and advice for patients that they could refer to, such as what to do and how to manage common ailments such as back pain, cuts and bruises, burns and scalds and how to recognise the signs and symptoms of meningitis.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that all staff spoke to patients in a friendly, professional and helpful manner. All staff spoken with demonstrated a good understanding of how patient's privacy and confidentiality was preserved. Reception staff explained how patients could request a private room to discuss anything they did not wish to discuss in the waiting area and this would be arranged. Patients we spoke with confirmed that they had requested to speak to staff in private and this was always arranged promptly. Consultation rooms had examination couches with surrounding privacy curtains and blinds at the windows that were used when consultations or treatments were undertaken. We noted that during a consultation the doors were closed and no conversations could be overheard in the corridor outside. Staff were able to explain how they would preserve 'a patient's dignity when carrying out intimate examinations. Patients were also able to request a chaperone and details regarding the chaperone service were displayed in all of the consultation rooms and the waiting area. Patients told us that when they attended the practice, staff were always caring and never rushed.

The practice had a community of patients where English was not their first language. We looked at what measures were in place to accommodate patient's equality, diversity and information needs. The practice provided a wide range of health information in a number of languages. The practice also used an interpreter service. Staff told us that patients often brought a family member or friend to translate for them. The measures in place showed that patient's equality and diversity needs were supported to enable them to make an informed decision about their care and treatment needs.

Involvement in decisions and consent

The practice routinely involved patients with their care and treatment and their choices were respected. Patients told us that they had time to discuss their concerns or treatments when they attended for appointments and that it was possible to book a double appointment when they needed to discuss more than one concern or complex problems. If a patient needed to be referred to another service or specialist this was discussed during their appointment and they were given a choice of location, where possible.

Staff we spoke with were able to demonstrate their understanding of consent and that patients had the right to withdraw it at any time and that this would be respected.

Where patients did not have the capacity to consent to treatment, staff were able to demonstrate that they acted in accordance with legal requirements. Mental capacity is the ability to make an informed decision based on understanding the options available and the consequences of decisions made. If patients were unable to make a decision for themselves, staff told us that they involved relatives to support patients in their treatment options. All staff had received Mental Capacity Act (2005) training and could explain what measures would need to be followed in patient's best interests where they could not consent. Therefore patients who were unable to make decisions for themselves were given appropriate support.

We saw that there was a suitable consent policy in place which showed that consent would be either implied or would be asked for and then it would be recorded. We also saw the policy showed the surgery had followed the published Fraser guidelines and observed the Gillick competency test when providing contraceptive advice to under 16 year old females, or when young patients could consent to their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice maintained links with local area commissioners and we were told meetings took place on a regular basis to review and plan how the practice would continue to meet the needs of the patients and potential service demands in the future.

The staff we spoke with explained that a range of services and clinics were available to support and meet the needs of different patient groups and that they would refer patients to community specialists or clinics if appropriate. For example, referring mothers with babies and young children to the community health visitor and older people to specialist groups who supported people with dementia and associated physical problems. The practice worked closely with community nursing teams, including the long-term conditions nurse and the mental health nurse who undertook mental health assessments. Patients said they were referred promptly to other services for treatment, test results were available quickly and some patients spoke positively about minor surgical procedures and operations that they had undergone at the practice.

The practice was aware of patients individual access needs and had put the necessary measures in place to support them. Treatment and consultation facilities were located on the ground floor. There were also toilet facilities for disabled patients and for baby changing available.

The practice had systems in place to seek and act upon feedback from patients. The practice promoted a virtual Patient Participation Group (PPG). The group was made up of practice staff and patients that represented the patient population.

We saw that the practice responded to issues or concerns raised by patients in a positive way. We looked at the most recent patient satisfaction survey carried out in January and February 2014 which had received 100 responses. This survey had been amended to make it more meaningful to the patients and asked questions such as "What do you feel would improve the waiting room?" Patients had responded that they thought it should be redecorated and we saw that this had been actioned. The results of the survey were published on the website.

Access to the service

The practice had ensured that patients could access the practice at a time to suit them. Patients told us that they could always get an appointment when they needed one. Appointments could be booked in advance, on the day or online. Patients also had the option of attending the daily open access clinic where pre booked appointments were not required. The practice offered emergency appointments, telephone consultations and home visits as required. The practice had extended opening hours and was open later on a Tuesday so that patients had the opportunity to attend after work. All of the patients we spoke with praised the practice for the ease they experienced when attending or booking appointments with the clinical team. They said it helped to reduce anxiety about getting an appointment at a time to suit them and that the practice was very flexible.

Meeting peoples needs

Individual diversity, values and human rights were respected. Patients told us that could request a chaperone. Information on chaperone use was displayed in the waiting area and in each of the consultation rooms. We saw that there was access to interpreters though an NHS approved agency. This was available over the telephone, although the practice very rarely used this service as patients whose first language was not English usually brought a friend or family member to translate for them.

The premises were seen to be accessible for disabled patients, having level access and disabled parking spaces close to the entrance door. A toilet wich is accessible to people with limited mobility was available and there were also baby changing facilities for mothers with babies to use. We saw that the reception desk did not have a lowered area to accommodate patients using wheelchairs. We observed staff coming out to greet patients who had limited mobility and helped them throughout their visit.

Concerns and complaints

The practice had a system 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.

The practice took steps to make patients aware of the complaints system. We saw there was information in the practice leaflet and on the practice website to alert patients to the comments and complaints process. We looked at the

Are services responsive to people's needs?

(for example, to feedback?)

practice complaints policy and procedures. The policy detailed the timescales for responding to any complaint received and the details of who to complain to if the patient was not satisfied with the response from the practice. This included reference to the Health Service Ombudsman. The Health Service Ombudsman is a free service set up by parliament for individuals and the public to investigate complaints about healthcare. Staff we spoke with were aware of their responsibilities in the event of a complaint being received. We looked at the complaints the practice had received this year, we saw that the complaints procedure had been followed and that issues had been raised directly with the GP concerned. Learning points had been shared with the clinical team and in the responses to the patients. Patients we spoke with said that they had not had any reasons to make a complaint. However, they all told us that they were not aware of the complaints procedure but would speak to the practice manager or their GP if they were not happy with anything.

Are services well-led?

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

Our findings

Leadership and culture

We spoke with members of the management team at the practice, who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs were the providers at the practice, being equal partners, to promote shared responsibility in the working arrangements and commitment to the practice. Group lunches were regularly held to promote a group ethos. The staff we spoke with told us that they felt there was an open door culture and that the GPs were visible and approachable. Staff said that they felt supported and were able to approach the senior staff about any concerns they had. They said that there was a good sense of team work within the practice and communication worked well. We saw that a named GP had a pastoral lead role in supporting the clinical team.

Governance arrangements

There were delegated responsibilities to named GPs, such as a lead for the safeguarding of vulnerable adults and children, a prescribing and a clinical governance lead. This provided structure for staff and clear lines of who to contact for support and guidance when needed. Staff undertook clinical governance as part of their personal learning development and revalidation process.

Systems to monitor and improve quality and improvement

Governance/management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring of complaints, comments and suggestions received from patients and issues raised by the patient participation group. Information from the practice 'Quality and Outcomes Framework' (QOF)(QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries) was analysed and reviewed to enable the practice to make comparisons to national performance and locally agreed targets. Information from clinical audits was reviewed and actions taken to achieve potential improved outcomes for patients.

Patient experience and involvement

We saw that engagement with patients was managed through the patient participation group and we spoke with their representative during the inspection. They told us that management were responsive to suggestions and supported regular patient surveys to consider ways to improve the practice and make changes where it was practicable to do so. We saw examples of where changes had been made in response to comments and feedback received from patients, including changes to improve the reception and waiting area for patients.

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

Staff were encouraged to attend and participate in regular staff meetings and we saw evidence that regular meetings took place. The meetings included discussions about changes to procedures, clinical practice and staff cover arrangements. We saw that the practice had a whistleblowing policy that included details of outside agencies for staff to contact if they wished to report any concerns they had. Staff had a forum to highlight and discuss areas of their role that were going well and influence change when things were difficult. The practice discussed issues that arose on a casual on-going basis. Issues raised included problems with workloads and more administration time especially for the dispensary staff. The management team had responded by arranging a meeting to discuss what areas of the workload were causing the issues and what could be done to alleviate problems and how more protected time could be allocated to complete the increasing dispensary work, such as increasing the dispensary staffing hours.

Management lead through learning & improvement

We saw that patient referrals were discussed at clinical team meetings and learning points considered and shared between clinicians. The practice was designated as a 'learning practice' where trainee GPs were offered placements to develop their knowledge, skills and clinical competencies. We were told by the GPs that this was considered important to the practice in strengthening and supporting an exchange of learning and innovation amongst all clinicians.

Records showed that clinical staff were supported to access on-going learning to improve their skills and competencies. For example, attending specialist training for diabetes, childhood immunisation and opportunities to attend external forums and events to help ensure their continued

Are services well-led?

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

professional development. Non-clinical staff were also supported to improve their skills and knowledge, for example, attending specific courses in relation to prescription documentation and processing.

Identification and management of risk

We saw that the practice had systems and processes to identify and manage risks. Risk assessments were used to consider individual risks to patients, staff and visitors to the practice, equipment and the environment. Assessments had been undertaken to consider and determine likely risks to patients, staff and visitors such as fire assessments and environmental hazards. Also disruption to the practice had been risk assessed such as continuity of the service in the event of disruption or loss of the premises.

The practice had been carefully considering the impact of two of the GPs planned retirement and had already employed new GPs so that patients would have time to build relationships with them. They had also considered increasing their training capacity which would involve some building re-modelling or extension so that the current availability of accessing a GP would not be interrupted.

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

We saw that the practice offered relevant care to older patients, this included blood tests, blood pressure monitoring and general well man/woman consultations.

Older patients were seen annually, or sooner depending on the complexity of their needs, by the nursing or medical team for health checks and to review their medicines. The practice also held clinics for patients on medication for rheumatoid arthritis and blood clotting problems. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it.

We saw that flu vaccinations were routinely offered to older patients to help protect them against the virus and associated illness.

The practice was caring in the support it offered to older patients and there were effective treatments and on-going support for those patients identified with dementia. The practice was responsive in meeting the needs of the older patients and in recognising future demands on the practice for this age group. The practice was well led in relation to improving the provision of services for patients and their families who were receiving end of life care.

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for vulnerable older people.

We found that the practice had scope to improve upon the management of medicines to ensure older patients were protected from the risks associated with medicines.

We looked at staff files and saw that appropriate safety checks had been carried out for all of the staff employed. All staff had undergone Disclosure and Barring Service checks (DBS). The practice had a robust recruitment policy for all staff including locums.

The practice had formal links with a local care home and provided regular and ongoing care and support to the residents as patients. This enabled the residents to receive continuity of care in supporting them with ongoing routine and more complex health care needs.

The practice acknowledged that the patients they supported included a significant number of older people at Kimbolton Medical Practice, who may place higher demands on the practice as an ageing population group in the future, with associated health care needs and complex conditions.

We found the practice to be responsive by working closely with a Health and Social Care co-ordinator provided by the local community health trust that supported older people with things like having some company to alleviate loneliness, transportation issues and helping them to obtain the finances that they were entitled to.

We saw evidence that the practice undertook clinical audits to improve outcomes for older patients. The results were reviewed against national data to determine any changes that could be made to care/treatment pathways and clinical therapies to improve outcomes for older patients.

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 offered relevant care to patients with long term conditions which included blood tests, blood pressure monitoring, electro cardiography (ECG) and spirometry (to measure breathing) at the surgery. The practice offered nurse led asthma, chronic obstructive pulmonary disease (COPD) and diabetes clinics and patients with these conditions were seen at least annually for health checks.

The practice was well-led in relation to identifying a named lead GP trained in specialist dementia care and in recognising symptoms to enable early detection.

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illness were seen annually or sooner depending on the complexity, by the nursing or medical team to review their medicines. The practice also held clinics for patients on medication for rheumatoid arthritis, asthma, chronic obstructive pulmonary disorder (COPD). Where their medication was monitored to ensure their wellbeing.

Staff from the community palliative care team and the district nurses attended meetings with the GPs and the nursing staff, which enabled practice staff to discuss the needs of patients with chronic and terminal illness. They discussed arrangements for individual patients on advanced care plans and ensured the out of hours service was informed by telephone of the care arrangements if emergencies or crises arose. These patients therefore received the care relevant to their circumstances regardless of when they needed it. The practice receives electronically each morning details of patients who have attended out-of-hours services and this was checked by the duty GP.

The practice was caring in the support it offered to patients with long term conditions. The care this group of patients received was effective and treatment pathways were monitored and kept under review by a multidisciplinary team. The practice was responsive in prioritising urgent care that patients required and the practice was well-led in terms of improving outcomes for patients with long term conditions and complex needs.

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable young people and adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for vulnerable adults.

We found that the practice had scope to improve upon the management of medicines to ensure patients with long term conditions were protected from the risks associated with medicines.

We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients with long term conditions.

We spoke with patients who had long-term conditions and they were consistently positive about the care and support they received from the practice and the staff. They told us that their well-being was monitored and they were re-called for routine checks and follow-up appointments on a regular basis.

Patients with long-term conditions and complex needs were supported by the clinical nursing team at the practice, who provided specialist care and treatments for specific conditions and attended the weekly multi-disciplinary meetings. The GPs held fortnightly clinical meetings to discuss and share best practice in relation to patients with long term conditions to ensure they received consistent high levels of care. Patients with long-term conditions were monitored and their treatment pathways kept under review.

Patients we spoke with who had long-term conditions told us that when they required an urgent appointment, the practice ensured they were prioritised and were able to see a GP quickly.

People with long term conditions

We saw evidence that the practice undertook clinical audits to improve outcomes for patients with long-term conditions. The results were reviewed against national data to determine any changes that could be made to care/ treatment pathways and clinical therapies to improve outcomes for patients with long term conditions.

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

Mothers, babies, children and young people received relevant care from the practice. Expectant mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife. Mothers were seen routinely for a postnatal check at the six to eight week stage. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations. The practice worked closely with both midwives and health visitors

The practice was caring in its approach to mothers, babies, children and young people and provided effective services and treatment, offering dedicated clinics at the practice and referrals into community based services to provide additional support. The practice provided a responsive service, prioritising appointments for mothers with babies and young children. The practice was well-led in relation to having a named lead with responsibility for children's safeguarding.

The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had scope to improve upon the management of medicines to ensure mothers babies and young people were protected from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for mothers, babies, children and young people.

We looked at staff files and saw that appropriate safety checks had been carried out for all of the staff employed. All staff had undergone Disclosure and Barring Service checks (DBS). The practice had a robust recruitment policy for all staff including locums.

The practice supported the Patient Participation Group to engage with mothers who had babies and young children. They had been asked for their views, comments and suggestions during the most recent patient survey about the type of clinics, services and information they would like to see developed at the practice, for example, maternity issues, childhood illness and immunisation.

The practice had links and routinely made referrals for mothers with babies and young children to the community health visitor, providing an additional level of support. The practice also offered regular baby and child immunisation clinics as well as ante/post-natal clinics provided by the clinical team. They also referred young people to the appropriate service such as the sexual health clinic for care and advice when required.

The practice operated a system where babies and young children were prioritised so as not to be kept waiting to see the clinical team.

The management team at the practice had identified a named lead for safeguarding children who had specific responsibility for disseminating information and training to other staff within the practice.

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 working age population and those recently retired were offered relevant care by the practice. The practice was open later on a Tuesday so that patients had the opportunity to attend after work and held open access clinics Monday to Friday.

We saw that flu vaccinations were routinely offered to the working age population and those recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and NHS travel advice and some travel vaccinations on a private basis.

The practice was caring in the support it offered to working age and recently retired patients and were responsive by extending opening hours to provide access for patients later in the day. There were effective monitoring services and clinics and the management team completed clinical audit cycles to evaluate outcomes for patients in this group.

The practice had a safeguarding policy that reflected the arrangements for protecting vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for vulnerable adults.

We found that the practice had scope to improve upon the management of medicines to ensure working age patients and those recently retired were protected from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for working age patients and those recently retired.

The practice supported the Patient Participation Group to engage with working age patients and those recently retired. They had been asked for their views, comments and suggestions in the most recent patient survey about the type of clinics, services and information they would like to see developed at the practice, for example, keeping healthy, prevention of heart disease, diabetes awareness and health related travel advice.

The practice offered a range of services and clinics to provide monitoring and routine support for patients in this age group, including lifestyle well man and woman clinics, smoking cessation, alcohol intake advice, healthy living checks, blood pressure and diabetes checks. The practice attended the local university to offer students a GP service and to advise young people on the various services available to them at the practice and elsewhere. This included healthy living and sexual health service and advice.

The practice had introduced extended opening hours and surgery times for working age patients who may find it difficult to attend appointments during core working hours. This included later appointments on two days each week.

The practice management team had systems to ensure clinical audit cycles were completed to highlight/identify where improvements could potentially be made for working age patients and those recently retired.

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 practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care.

The practice had a small percentatge of patients with learning disabilities. All of the patients in this group had received annual health checks.

We saw that flu vaccinations were routinely offered to patients who were in vulnerable circumstances to help protect them against the virus and associated illness.

The practice was caring about vulnerable patients, the homeless and travellers, by providing access and support. There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in people's homes who found it difficult to attend the practice premises.

The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had scope to improve upon the management of medicines to ensure patients in vulnerable circumstances who may have poor access to primary care were protected from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for vulnerable patients who may have poor access to primary care.

We looked at staff files and saw that appropriate safety checks had been carried out for all of the staff employed. All staff had undergone Disclosure and Barring Service checks (DBS). The practice had a robust recruitment policy for all staff including locums.

We observed that the premises enabled easy access for patients with reduced mobility. Although the reception desk did not have a lowered area to accommodate patients using wheelchairs, but the staff told us that they physically moved from behind the reception desk to the patient.

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care. The practice worked closely with a Health and Social Care co-ordinator provided by the local community trust that provided social care support and advice to people in vulnerable circumstances.

The practice had a system where patients who were in vulnerable circumstances such as being homeless, were provided with any immunisations they needed when they attended for a new patient check.

The practice recognised that some vulnerable patients may find it difficult to attend the surgery for care and treatment. The GP or the district nurse would support and treat patients at home if they were housebound, enabling patients with limited access and mobility to receive appropriate care and treatment in their homes. There was access to translation services for patients whose first language was not English.

The practice recognised and acknowledged that it had few identifiable vulnerable patient groups within the locality of the practice. However, where patients were identified as particularly vulnerable, mechanisms had been put in place to help ensure equality of access to the practice and the services provided.

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

We saw that the practice offered relevant care to patients experiencing poor mental health. Patients were offered same day pre-booked and follow up appointments. Where possible every effort was made to make appointments with the same GP.

Patients experiencing poor mental health had received support, care and treatment at the practice and in the community when they needed it. The practice held multidisciplinary meetings which were attended by staff in the community mental health team where they discussed arrangements for individual patients and ensured the out of hours service was informed by telephone of the care arrangements if emergencies or crises arose.

The practice was caring in relation to patients experiencing poor mental health and the practice had effective procedures for undertaking routine mental health assessments. The practice was responsive in referring patients to other service providers for ongoing support. The practice was well-led with their approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults from the risks of abuse. We saw evidence that staff had received safeguarding training for children and vulnerable adults. Staff were therefore able to recognise or have awareness to the risks of abuse for children and vulnerable adults.

We found that the practice had scope to improve upon the management of medicines to ensure patients experiencing poor mental health were protected from the risks associated with medicines.

The practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients experiencing poor mental health.

We looked at staff files and saw that appropriate safety checks had been carried out for all of the staff employed. All staff had undergone Disclosure and Barring Service checks (DBS). The practice had a robust recruitment policy for all staff including locums.

We saw that flu vaccinations were routinely offered to patients experiencing poor mental health to help protect them against the virus and associated illness.

We were told by staff that the practice undertook mental health assessments as part of other routine health checks. This helped to identify mental health issues and early detection for patients who were then referred to specialist services and receive on-going support.

The practice held multidisciplinary meetings to consider individual patient's needs, including those who may be experiencing poor mental health. If concerns were indicated, a referral was made to the specialist mental health nurse or the Health and Social Care co-ordinator who was able to provide appropriate support/ interventions.

The management team had systems and procedures to identify and manage risks to individual patients which included those who presented with poor mental health.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe management of medicines.** Regulation 13