The Cottons Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We visited The Cottons Medical Centre on the 24 October 2014 and carried out a comprehensive inspection.

The overall rating for this practice is good.

Our key findings were as follows:

- Patients reported being treated with kindness, dignity and respect and GPs and nurses spent time listening to and dealing with patients' medical problems.
- There were systems in place to provide a safe, effective, caring and well run service.
- The practice had taken steps to engage with patients to address access issues and improve services.
- There was a good understanding of the needs of the practice population and services were offered to meet these.

There was one area of outstanding practice:

- One GP had developed their own patient information leaflet to help patients attending the practice to understand their cholesterol levels and help them to reduce and control these.

However, there were some areas of practice where the practice could make improvements.

The practice should:

- Identify a programme of audit and a date to re-audit and complete the audit cycle to determine the effectiveness of any actions or changes made.
- Develop a risk log to evidence that a process is in place for identifying, discussing and mitigating risks.
- Ensure that any staff who are to act as a chaperone at any time receive the appropriate chaperone training.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs were assessed and care planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age appropriate way and recognised as individuals. During our inspection we observed several children being dealt with appropriately by staff. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students).

Summary of findings

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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had been offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. The majority of the patients we spoke with expressed satisfaction with the service they received. Almost all patients told us that they were treated with kindness, dignity and respect and reported that doctors and nurses took time to explain their condition and treatment.

Comment cards which were left remarked on the cleanliness of the surgery, the helpfulness of the reception staff, and provided details of positive experiences of treatment received. Some patients had commented on the turnover of doctors which had resulted in a lack of continuity of care. However, overall patients reported receiving a good service.

Areas for improvement

Action the service SHOULD take to improve

- Whilst there was evidence of some clinical audit having taken place this was minimal and the audit had not been revisited to determine if any changes had been effective. The practice should identify a programme of audit and identify a date to re-audit and complete the audit cycle to determine the effectiveness of any actions or changes made.
- The practice assessed risk but did not have a formal process to demonstrate this. The practice should consider developing a risk log to evidence that a process is in place for identifying, discussing and mitigating risks.
- The practice should ensure that any staff who are to act as a chaperone at any time receive the appropriate chaperone training.

Outstanding practice

One GP had developed their own patient information leaflet to help patients attending the practice to understand their cholesterol levels and help them to reduce and control these.

The Cottons Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and two other CQC inspectors.

Background to The Cottons Medical Centre

The Cottons Medical Centre covers a large area in Northamptonshire which includes many rural villages. There are approximately 9,250 patients registered with the practice and there are high number than average of elderly patients over the age of 85 and the practice provides services to all of the care homes in the area. There are also a higher than average number of patients in the working age group.

There are three GP partners and two salaried GPs, two nurse practitioners, three practice nurses and a health care assistant. In addition, there is a range of administrative and reception staff to support the service as well as a practice manager.

The practice have a Personal Medical Services (PMS) contract and have performed consistently over time delivering local and directed enhanced services and have participated in the Quality and Outcomes Framework to drive quality in patient care.

The practice service for out of hours care is via the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 practice 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG) and NHS England, the manager at a local care home and the chair of the patient participation group.

We carried out an announced visit on 24 October 2014. During our visit we spoke with a range of staff, including GPs, the practice manager, a nurse practitioner, practice nurses, administration and reception staff. We observed how people were dealt with by practice staff and we spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. The practice manager told us that they disseminated all alerts via email and all staff we spoke with confirmed this and that they received these.

We reviewed the significant event log and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw that the practice had kept a summary of significant events detailing the actions taken and learning points and follow up necessary and had identified a member of staff to be responsible. We also saw minutes from practice meetings showing that they had been discussed. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example one staff member described an incident they had reported which had been investigated and changes in practice implemented to prevent a recurrence.

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 staff training records which showed that all clinical staff had received relevant role specific training in safeguarding, however, some staff required an update in training and we saw that this was due to take place in January 2015 we asked members of staff about their training who confirmed this. We spoke with GPs, nurses and administrative staff who knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible and the staff know where to locate this.

The practice had a dedicated GP and nurse appointed as leads in safeguarding vulnerable adults and children who confirmed they had received the appropriate level of training to enable them to fulfil this role. All staff we spoke with were aware who the leads were and who to speak to in the practice if they had a safeguarding concern.

Safeguarding concerns were discussed at the practice meetings to ensure that all staff were aware of any safeguarding issues. We saw the agenda of a meeting held the week prior to our inspection which showed two cases of safeguarding for discussion. Staff we spoke with confirmed that any safeguarding concerns were shared at practice meetings and minutes of the meeting were shared with all staff.

Staff demonstrated the system which highlighted vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

We saw that a chaperone policy was in place and available to all staff. There was a notice in the waiting area informing patients that a chaperone was available should patients require one. This was also included on the practice website. Staff told us that nursing staff almost always acted as chaperone and reception staff would rarely be asked to undertake this role as they had not received chaperone training. Reception staff told us that they knew what to do but had not received any formal training.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system called Emis Web which collated all communications about the patient including scanned copies of communications from hospitals.

We spoke with the lead nurse practitioner who told us that they access information from the system to identifying children and young people with a high number of A&E attendances. The health visitor from the NHS Trust

attended the surgery and they were able to discuss any issues arising from frequent admissions or children who persistently failed to attend for immunisations to determine whether further support or advice was required.

The practice safeguarding lead told us that a report would be sent if there was a child protection case conference and they were unable to attend but this had not been required in recent months.

The nurse practitioner described the new software system called 'Patient Chase' which had been implemented. This identified patients with multiple long term conditions which allowed them to co-ordinate their appointments and required patients to attend only once and included a review of all conditions during one appointment. This resulted in a more convenient, holistic and systematic approach to care.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The key to one refrigerator lock could not be located therefore it was not being locked. However, as the refrigerator was stored in a lockable room this ensured that medicines could be kept securely when the room was not in use. The risk of anyone accessing medicines in the refrigerator was minimised as access was restricted to authorised personnel only when not in use. The practice confirmed they would be replacing the refrigerator for a lockable one when it became no longer serviceable. We saw that there was a record showing that medicines were kept at the required temperatures and staff we spoke with who knew their responsibilities for ensuring safe storage and maintaining the cold chain.

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 saw records of practice meetings that noted the actions taken in response to review of prescribing data. For example, we saw evidence that the practice had carried out audits on night sedation which had been documented and discussed at a clinical meeting.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness & Infection Control

During our inspection we observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We spoke with patients who told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nominated a lead nurse for infection control who had undertaken a recent audit which identified some areas for action, for example the flooring. We saw that the practice was working to address these. We spoke with nursing staff who told us they were up to date with training and we saw records to confirm this.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that all portable electrical equipment was routinely tested and displayed stickers

indicating the last testing date. We saw that a schedule of testing was in place. A complete medical equipment test report and calibration report for all equipment in the practice had been carried out in June 2014 and was made available to us. There was a fire safety logbook in place which detailed that fire alarm checks had been carried out at appropriate intervals.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. We saw from the staff records that DBS checks had been carried out for the reception staff as well as clinical staff. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff and we saw that there was a completed new employee checklist in the three staff records we looked at.

We spoke with staff about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager told us that in the event of staff absence then the practice would re-organise clinics and try to accommodate patients with other nurses or doctors on duty that day. Staff we spoke with confirmed that they would cover when staff were off unexpectedly.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. We saw that there was a health and safety policy and manual in place for staff to access. A health and safety risk assessment had been completed in March 2014 and action points had been identified and completed and we saw minutes of a practice meeting where health and safety had been discussed.

The practice also have a health and safety committee meeting which was held six monthly and outcomes were shared with the whole practice via minutes.

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, the practice had two nurse practitioners whose training enabled them to triage patients and identify those who needed immediate medical attention. The reception staff demonstrated that they always referred any patient to the triage nurse if they presented or telephoned stating they needed urgent attention.

The nurse practitioners told us that they were able to discuss any concerns immediately with the doctors if there were any patients who required urgent medical attention. They demonstrated this via a message alert. We spoke with reception and nursing staff who told us that sick children and elderly patients would always be a priority and that they had criteria for urgent appointments. They told us that they could ring through to the doctor or nurse practitioner if they were concerned about a patient.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines for the treatment of cardiac arrest and anaphylaxis were available in a secure area of the practice and all staff knew of their location. There was a process in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice did not routinely hold stocks of medicines for the treatment of any other condition or keep medicines in the GPs bags. The GPs told us that the reason for this was that as the pharmacy was within the building and was always open at the same time as the practice then they would always be able to access any medication that they anticipated they may need on a home visit.

Good

Are services safe?

We saw that the practice had a disaster recovery plan in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and evidence we reviewed confirmed that both GPs and nurses assessed patients in a way that ensured that each patient was given support to achieve the best health outcome. The practice had GP leads for different conditions and disease areas. The GPs and nurses were able to demonstrate that thorough assessments of patients' needs took place and were reviewed when appropriate. For example, patients experiencing poor mental health received annual health checks and advanced care plans had been developed for patients with dementia. Patients who had attended A&E were recalled to the surgery for follow up by their GP if it was deemed necessary by the GP.

Nurses we spoke with told us that the GPs in the practice were always available and approachable for clinical advice and provided support and advice readily. We saw minutes of weekly clinical meetings at which clinical issues were discussed in the practice where all clinical staff attended.

The GPs told us that their prescribing patterns were always comparable to similar practices and local CCG prescribing data confirmed this. The practice used computerised tools to identify patients with complex needs who had care plans documented in their case notes.

When speaking to all clinicians and administrative staff we noted no evidence of discrimination when making care and treatment decisions. From interviews with GPs and nurses and observation of how patients were treated by all staff, it appeared that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

All staff had specific roles within the practice and were aware of their responsibilities to ensure improvement of outcomes for patients.

The practice showed us five clinical audits that had been undertaken in the last two years. Three of these were completed as a requirement of monitoring of local enhanced services for example reporting to the commissioners that the practice had a protocol for minor surgery, how many serious incidents or infections had occurred to determine if changes were needed. No changes had been required. The other two were relating to prescribing and another aspect of minor surgery. Whilst these had identified a change in practice there was no plan to revisit the audit at a later date to identify if changes had been successful and complete the audit cycle. The practice acknowledged that audit was an area which could be more structured in the future and include re-audit to evaluate effectiveness of changes.

The practice used information they collected for the Quality and Outcome Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool.

The practice had been an outlier in some areas of the QOF clinical targets and had not achieved such a high number compared to some other practices in the clinical commissioning group. For example, patients with diabetes who had received a cholesterol check in the preceding 12 months. However, the practice had recently introduced new software to identify patients with multiple chronic diseases which would enable them to have one appointment and receive a review of all their conditions at one appointment and prevent the need to be called for several separate appointments. This would reduce the risk of patients failing to attend.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We saw that they had met with the CCG prior to our inspection. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

During our inspection we spoke with staff and looked at staff records to confirm that all staff had the appropriate qualifications and training to carry out their role. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as

Good

Are services effective?

(for example, treatment is effective)

annual basic life support safeguarding, and health and safety. We saw a training programme for all staff which was completed and up to date. This included training in cardio pulmonary resuscitation, safeguarding, health and safety and the Mental Capacity Act 2005. Staff were able to access training on-line as well as attend external courses.

We spoke with the practice manager who told us that all staff had annual appraisal and this process had commenced for this year. Staff we spoke with told us that they found this beneficial and were able to discuss concerns and identify training needs. Staff records we looked at confirmed that appraisal had taken place and objectives had been identified and documented.

Nurses that we spoke with told us that they received supervision from the senior partner and had formal weekly meetings with all the doctors. They told us they were supportive regarding meeting training needs.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. Nurses were trained in administration of vaccines and childhood immunisation as well as cervical cytology. There were two nurses who were trained nurse practitioners who were able to triage patients and assess their immediate health needs. This enabled them to attend the local care homes daily to assess patients and determine whether the doctor was required and provide on-going health advice and support.

Working with colleagues and other services

The practice worked closely with the district nurses, health visitors and palliative care nurses and meeting were held monthly with them. We saw evidence in the minutes of practice meetings that this took place. The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries and were dealt with by one member of staff who was responsible for disseminating the information to the appropriate person. The practice also used a system for viewing hospital documents to determine what treatment taken place and by whom. All staff we spoke with understood their roles and felt the system in place worked well.

The nurses told us that they had links with Diabetes UK and MIND (MIND is an organisation which provides support and advice to people experiencing mental health problems) and signposted patients to the Well Being service if they wanted additional support with mental health issues. We saw leaflets and information regarding these services during our inspection.

The senior GP partner told us they had good communication with secondary care and other services. For example, the practice nurse ran a diabetes clinic jointly with the diabetes nurse specialist from secondary care. The advanced nurse practitioners also visited the local care homes daily from Monday to Friday to determine if there were any issues or concerns. We spoke with the manager from one care home who expressed that they had good links with the practice and found it very beneficial for patients to have this level of contact. The CCG prescribing advisor also met with the lead GP to discuss review of medications for patients who lived in the home.

The practice held monthly multidisciplinary team meeting to discuss the needs of complex patents e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented. We saw minutes of meetings to confirm this. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Consent to care and treatment

We saw that all staff had recently undergone training in the Mental Capacity Act 2005 and therefore were able to demonstrate an awareness of their duties in fulfilling it. The Mental Capacity Act 2005 covers people in England and Wales who can't make some or all decisions for themselves.

We spoke with GPs and nurses who were able to demonstrate knowledge and understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

All clinical staff were able to demonstrate the need for gaining consent prior to treatment and told us of the importance of ensuring the patients understanding prior to consent. We spoke with patients who told us that the clinicians sought consent prior to carrying out procedures and took time to explain and make sure they understood what the procedure entailed and why it was being carried out.

Good

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

We spoke with the nurse practitioner and GPs. They had a range of health promotion literature available to them and described how they would provide an explanation to patients when giving leaflets to ensure their understanding. One GP had developed their own patient information leaflet to help patients attending the practice to understand their cholesterol levels and help them to reduce and control these.

Patients with learning disabilities were offered health checks and care plans were developed with the patients at this time. The practice also offered all new patients a health check with the health care assistant. Any patients with chronic long term conditions were referred to the nurse who dealt with these or if medication reviews were required they would be referred on to the GP. Patients with poor mental health were also given an annual health check and advanced care plans were in place for patients with dementia.

The practice provided cervical screening in line with the national programme. The practice had a nurse trained in family planning and sexual health. They described how they provided opportunistic advice regarding chlamydia infection and offered screening packs to patients where appropriate. They also provided contraceptive products and advice to young people when required. Smoking cessation was also offered to any patients who smoked.

There was a clinic held weekly where the health visitor from the local primary health care team attended who would provide advice and support regarding child health and development. The practice nurses gave childhood immunisations and babies received a medical examination by the GP at eight weeks old. The nurses were able to clearly demonstrate the process for following up children who had not attended for immunisation. This included discussion with the health visitor following the third non attendance.

All patients over 75 years of age had a named GP. The practice had also recently started to offer dementia screening as identified in a local enhanced service and this work was on-going. Patients were offered the Shingles vaccine when they met the national criteria and flu vaccinations were offered to all patients over the age of 65 years. Any housebound patients were visited by the nurse practitioners to administer their flu vaccinations.

The practice had taken up the new enhanced service and had a process in place to follow up patients discharged from hospital. They had an admission avoidance nurse who would review patients who had been admitted to hospital (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). During the weekly nurse practitioner visits to care homes they would provide any health care advice or support they saw was required. In addition one GP carried out a weekly review of all prescriptions issued to patients in care homes. The practice also offered NHS Health Checks to all its patients aged 40-75.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with eight patients who all spoke positively regarding how they were treated at the practice. They told us that they were treated with respect and dignity and that they had sufficient time during their consultation to discuss their needs with the doctors and nurses.

Patients commented that the reception staff were polite and helpful when they attended the reception. During our inspection we observed that staff were courteous and discrete when speaking to patients at the reception desk. We noted that the reception area was open and that patients could hear other patients' discussions at the desk. However, reception staff told us that if patients needed to speak in private there was an area separate from reception that they could go to which was private. We saw that this was the case.

Nursing staff we spoke with told us that they always used modesty blankets when carrying out intimate examination and that they locked the door during the procedure. We also saw that there were privacy curtains available. Discussions with staff demonstrated that they considered reassurance and kindness to be part of their role.

The practice had two female GPs therefore patients who had a preference for a specific gender of GP had a choice. We saw that there was availability of a chaperone advertised in the reception area for those patients who required it.

Care planning and involvement in decisions about care and treatment

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 also confirmed this.

Staff told us that translation services were available for patients for whom English was not their first language. However, there were very few patients registered at the practice met this criteria.

We spoke with GPs and nurses who were aware of the Mental Capacity Act 2005 and the need to ensure patients understanding of procedures and treatment offered.

Patient/carer support to cope emotionally with care and treatment

The eight patients we spoke with on the day of our inspection expressed that they were happy with the treatment and care they received. We received 12 comment cards which over all also demonstrated satisfaction with care and treatment. For example patients commented on being listened to, treated in a caring manner and having their condition explained to them.

The practice computer system alerted staff to when a patient was a carer. Staff we spoke with told us that when a carer became known to them they registered them, signposted them to the carer's support group and provided them with literature. We saw in the waiting room that information was available for carers. Staff also told us that they referred patients to the counselling service which attended the practice when necessary. The nursing staff told us that patients with mental health, alcohol or addiction problems were referred to the community mental health service when necessary.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations.

Staff told us that there was no formal process for contacting families who had suffered bereavement but that if their GP knew them well they would usually call the family to determine if additional support was needed and offer an appointment. GPs, nursing staff and reception staff told us that the GP would visit if they felt it was appropriate. The reception and administrative staff told us that if they were notified of a patient's death it was put on the notice board in reception so that staff were aware if relatives called they may need to be dealt with sensitively. They also put a notice on the computer screen to alert staff.

The administrative staff showed us that they had a direct line designated for patients receiving palliative care to ensure that they could access an immediate response to any medical issues. They told us that a list was printed off monthly so that staff were aware who may be calling in.

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 people'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. The practice provided services to eight care homes and responded by employing nurse practitioners in order that they could regularly attend the homes and assess patients' needs. The nurses visited care homes daily and were able to work with the home managers to identify patients with high medical needs and provide health promotion support and advice on how to manager their conditions. They also assessed patients in care homes to determine if they needed to see a doctor that day.

The practice had purchased new software called 'Patient Chase' to identify patients with several long term conditions and called them for review of all their conditions instead of individual appointments for each one. This was more convenient for patients and allowed the patients to be cared for more holistically and provided a more seamless patient journey.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice manager showed documentation that this had taken place that week.

Staff told us that longer appointments were offered more complex conditions or patients experiencing mental health and communication difficulties. For example patients with learning difficulties were allocated a 20 minute appointment. Home visits were made to local care homes by the doctor if required, following triage by the advanced nurse practitioner.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). A patient participation group is a group of patients registered with the practice who have no medical training but represent the views of patients and make suggestions to the practice to consider for improvement. The main issue was booking appointments and the PPG worked with the practice who introduced a new telephone system using more lines, which reduced the wait on the telephone considerably. The PPG also identified that patients were not aware of the online booking system and they arranged to raise awareness of this service. They also suggested that they used text messaging to remind patients of appointments which would reduce the number of patients who fail to attend appointments (DNAs). The practice had implemented this and it had been audited and found to have reduced DNA rates.

The practice also responded to patients' difficulty in getting appointments by offering an Acute Illness Clinic which allowed patients who had acute symptoms to be seen on the day between 8:30 and 10:50 by the nurse practitioner. If they required treatment from the GP they could be accessed for advice or consultation in the surgery.

The practice offered home visits to housebound patients and acutely ill patients would were unable to attend the surgery particularly the elderly and sick children.

Extended hours appointments were offered on Wednesdays between 6.30pm and 8pm for those patients who worked or were unable to attend the surgery during normal hours.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services.

The premises and services had been adapted to meet the needs of people with disabilities. We saw that there were electronic doors to allow access to patients using wheelchairs and a lower area of reception was available to allow patients using wheelchairs to communicate with reception staff. The reception staff told us that patients who had hearing difficulties were able to fax through for an appointment and we saw that there was an induction hearing loop system in place to assist those patients when they arrived at the surgery.

There was a higher than average number of patients aged over 85 registered with the practice and in response to patient feedback, the practice had provided some high backed raised chairs to assist very elderly patients with mobility difficulties. The advanced nurse practitioners attended local care homes daily to assess any patients who

Good

Are services responsive to people's needs?

(for example, to feedback?)

were unwell and offer advice and healthcare to patients and staff. We saw that there was a system in place to ensure that patients with learning disabilities were invited to attend for health checks .

The practice had access to telephone translation services and staff explained the process to obtain this, but told us that this was not required often due to the majority of the practice population having English as their first language.

Access to the service

Appointments were available from 8.30am to 11.30am and 2.30pm to 6.30pm on weekdays with the exception of Wednesdays when the practice offered additional extended hours appointment times from 6.30pm until 8pm for those people who could not attend the surgery during the daytime.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet which was available in the surgery and could be downloaded from the website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. It also included information about the Acute Clinic and other services available to patients. The Acute Clinic allowed patients with an acute medical problem to call the surgery between 8.00am and 10am and 1.30 until 3pm where they would be assessed over the telephone or be given a time to attend the surgery. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had introduced a new telephone system which directed patients more easily to the person they needed and more lines had been introduced. Patients we spoke with told us that this had improved access to the service considerably and the wait on the telephone was less than previously. Patients we spoke with told us that confirmed that they could see a GP on the same day if they needed to and 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.

All consultations rooms were on the ground floor of the building which enable patients with mobility problems access without difficulty.

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. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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 which was displayed on the notice board in the patient waiting room. There was also a complaint and suggestions leaflet available from reception which contained the process and who to contact. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at complaints received in the last two years and found that these had been dealt with appropriately in line with the policy and actions taken in a timely manner.

Minutes from practice meetings showed that complaints were discussed regularly and minutes were disseminated to staff to ensure they were aware of any actions.

We saw the complaints log for the last two years but no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 vision to deliver high quality care and promote good outcomes for patients. We saw details of the vision and practice values. We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Conversations with staff demonstrated a commitment to putting patients first and how they viewed ensuring a positive patient experience and outcome as the most important aspect of their role.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at policies, for example the health and safety and complaints policy. Staff demonstrated that they were all aware of the policies and how to access them. We saw that the policies had review dates which were appropriate.

The practice held monthly governance meetings. We looked at minutes from the practice meetings and found that performance, quality and risks had been discussed. For example safety notices, medicine alerts and significant events.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measurement tool. The QOF data for this practice showed it was in line with national standards with the exception of three indicators. For example cholesterol monitoring in patients with diabetes. However, the senior partner told us that they had been addressing these and should have a better achievement this year. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had arrangements for identifying and managing risks. The practice manager was able to demonstrate how they assessed risk and would highlight these at practice meetings but we did not see a formal risk log. The practice manager described events where risk had been identified and dealt with appropriately. Other staff we spoke with were also able to demonstrate awareness of these events. The practice manager explained that recently a new telephone system had been introduced. We did not see evidence that a formal risk assessment and been carried out to demonstrate what would happen if the system failed. However, the practice manager told us that the telecommunications company had carried out a risk assessment to deal with any system failures during installation and that this was full documented. The practice may wish to develop a formal risk log to help ensure that all risks were documented and managed appropriately.

Leadership, openness and transparency

We saw there was a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner and nurse practitioner were the leads for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture and that all the GPs were approachable within the practice. They told us and that they felt they could approach them at any time with any concerns.

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

The practice had gathered feedback from patients through patient surveys and the patient participation group, comment cards and complaints. We spoke with the representative from the patient participation group (PPG) who reported that the practice was very proactive in listening and addressing patients comments. A patient participation group is a group of patients registered with the practice who have no medical training but represent the views of patients and make suggestions to the practice to consider for improvement. We saw an extensive plan which had been developed with the practice and the PPG and saw that actions had been taken as a result of patient suggestions and improvements made in the practice. For example, automated doors had been upgraded, the practice leaflet had been updated, the telephone system had been upgraded.

We saw a report of actions and improvements carried out in collaboration with the PPG for 2014/15 which demonstrated acknowledgement of the benefits and

Are services well-led?

Good

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

importance the practice placed in patient involvement and feedback. The reception staff and PPG chair showed us improvements which had been made to the waiting area in response to patient feedback, which included new chairs and new toys for children.

The practice had an active PPG which had increased in size. The PPG were carrying out a patient survey to gain a broader patient view as the national survey response was only 42%. This survey was due to be completed by the end of November 2014.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurses told us that they spoke with the GPs at any time if they had clinical issues they wished to discuss. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that requests for training were always supported and they also had access to e-learning.

The practice was a GP training practice and the senior partner told us they had students from Cambridge University who worked under supervision of the partners. The practice leaflet informed patients of this and told them that they would always be notified if a trainee doctor was in attendance. There were no students present during our inspection.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients through learning from incidents.