Wellington House Practice

Quality Report

Wellington House Practice, Wades Field, Stratton Road, Princes Risborough, Buckinghamshire HP27 9AX
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Wellington House Practice on 17 December 2014. This was a comprehensive inspection. The practice has a branch location which was not inspected as part of this inspection.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing caring, responsive and effective services and for being well led. It requires improvement in order to ensure safe services are provided.

Our key findings were as follows:

The practice provided good care and treatment to its patients. National data showed the practice performed above the national average in managing long term conditions. Patients reported that they could access the practice and the system of phone triage worked well, (the triage system was usually a phone consultation with a GP to determine what assistance a patient needs), although some patients who worked said the system could be difficult for them. The premises were accessible, clean and safe. Medicines were checked and stored safely. Staff were aware of the needs of their patients including small numbers of vulnerable patients such as those who were homeless or travellers. The practice was responsive to potentially vulnerable patients and considered their needs in the planning of its services. The practice achieved the best outcomes for managing diabetes in the clinical commissioning group (CCG). The practice used telehealth which can assist GPs in gaining specialist advice on treating and caring for long term conditions and can reduce the need for referrals to hospitals or other services. There were clear leadership structures and an open culture which was inclusive and encouraged staff to participate in the running of the practice. A patient participation group (PPG) was consulted to assist the leadership in making improvements to the service.

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

Importantly, the provider must:

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- ensure employment checks are undertaken for all staff as required, including criminal record checks, references and employment histories.

In addition the provider should:

- ensure staff know the phone translation service is available to support patients to access the service who do not speak English
- ensure patients are aware that appointments can be booked in advance in order to provide greater flexibility in seeing GPs and nurses

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough, lessons learned and communicated widely support improvement. The practice had made changes and provided further training to staff in response to safeguarding concerns with patients. Risks to patients who used services were assessed and systems and processes were in place address these risks. However, staff checks were not always adequate to ensure that staff were safe to work with patients. The practice was clean and hygienic. Medicines were managed properly and stored safely.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both NICE guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG). The practice was using innovative and proactive methods to improve patient outcomes such as telehealth and means of detection of dementia. External services were used to help treat specific conditions such as obesity and support patients with mental health problems.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and secured improvements to services where these were identified. Although there was low levels of social deprivation locally, the practice was

Summary of findings

aware of groups who may be vulnerable such as travellers and the homeless. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. Patients were not always aware that they could book appointments in advance and this had some impact on those who worked. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and an open and inclusive culture which enabled staff to contribute to the running of the practice. 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and involved. Staff had received inductions, regular appraisals and attended staff meetings and training 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and undertook an enhanced service in dementia. External professionals were included in the planning and delivery of patients' care including palliative care nurses and staff at local care and nursing homes. It was responsive to the needs of older people, and offered home visits and quick access to appointments for those with complex needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients were offered periodic reviews of their conditions and health in line with national guidance. Nurses led the management of long term conditions and they were involved in planning the protocols and monitoring of the practice's performance. 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. National data showed the practice was performing very well in managing chronic conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, 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. Staff were aware of the legal requirements of gaining consent for treatment for those under 16. Sexual health checks were promoted. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Safeguarding children and domestic abuse training was provided to staff.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Temporary registrations were available for students returning from university. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Some patients who worked reported the appointment triage system meant taking a longer time off work than it might if they could book an appointment quickly, but this was partly due to the lack of awareness among some patients that appointments could be booked in advance.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice took steps to make its services accessible to patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability, could access the practice. Homeless patients and travellers were able to register. Annual health checks for patients with learning disabilities were offered. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety one per cent of patients experiencing poor mental health had a care plan in place and the update of health checks among this group of patients was higher than the national average. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice provided access to talking therapies and other mental health support services on site.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of approximately 187 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 78% of nurses were good at listening to them. The survey also showed 86% said the last GP they saw and 81% said the last nurse they saw was good at giving them enough time. These results were slightly below the regional average. The practice received positive feedback regarding how GPs and nurses treated patients with care and concern and this was above the regional average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and all comments except one were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas on the national and practice survey. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above the regional average. The results from the practice's own satisfaction survey showed that over 90% of patients said they were sufficiently involved in making decisions about their care.

Patients understood the appointment system and were generally very satisfied with the ability to book an appointment. They said the call back system worked well and was normally within the two hour time period. However, some patients were not aware of the ability to book appointments in advance. This meant patients who worked told us that the system meant having to take a morning off work in order to receive a call back as they could not be guaranteed when the GP call back would be. This was reflected in some comments on the practice survey. Comments from the patient survey predominantly rated the appointment system highly. Patients valued being able to get an appointment quickly and to access advice through GP phone consultations. The national GP survey found that 91% of patients were able to get an appointment to see or speak to someone the last time they tried at the practice and 94% said the last appointment they got was convenient. Seventy nine per cent described their experience of making an appointment as good

Areas for improvement

Action the service MUST take to improve

- ensure employment checks are undertaken for all staff as required, including criminal record checks, references and employment histories.

Action the service SHOULD take to improve

- ensure staff know the phone translation service is available to support patients to access the service who do not speak English
- ensure patients are aware that appointments can be booked in advance in order to provide greater flexibility in seeing GPs and nurses

Wellington House Practice

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 specialist adviser who was a practice manager at another GP practice.

Background to Wellington House Practice

Wellington House Practice is a purpose built practice located in Princes Risborough and has a population of approximately 9000 patients. There is a branch practice Wellington House Practice, 5 Station Road, Chinnor, Oxfordshire OX39 4PX. The practice population had very little economic deprivation and there is very little ethnic diversity. The local community has an older population and the staff were aware of the needs of this section of the population. Patient services were located on the ground floor and adaptations have been made to ensure the practice is accessible for wheelchair users, mobility scooters, buggies and prams. There was an appointment triage system which enabled phone consultations with GPs prior to booking any appointment. Appointments with named GPs were also available for over 75s. There was an active patient participation group (PPG).

We spoke with six patients during the inspection, three GPs, three members of the nursing team, the practice manager, receptionists and a trainee GP.

Wellington House Practice was a training practice. The practice has a General Medical Services (GMS) contract. GMS contracts are subject to national negotiations between the General Medical Council and the practice.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

This was a comprehensive inspection and we visited one location where services are provided. This was:

Wellington House Practice,

Wades Field,

Stratton Road,Princes Risborough,

Buckinghamshire

HP27 9AX

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice and on the website.

Why we carried out this inspection

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

Detailed findings

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.

This provider had not been inspected before and that was why we included them.

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

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Buckinghamshire Healthwatch, NHS England and Public Health England. We visited Wellington House Surgery on 17 December 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff and patients. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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 patients' needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients living in vulnerable circumstances
- Patients experiencing poor mental health (including patients with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice manager told us that staff were encouraged to report any incident no matter how minor and staff confirmed there was a culture of recording incidents.

Minutes of meetings where incidents were discussed showed learning outcomes were shared with staff. This showed the practice managed these consistently and so could show evidence of 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 learning from significant events. There were records of significant events that had occurred during recent years and we were able to review these. Significant events was a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Events were discussed at relevant meetings including clinical or governance meetings. Minutes were made available and relevant staff were informed of outcomes. We saw that two significant events from 2014 had led to change in practice protocols to improve patient safety. We saw a record of one significant event review which followed a safeguarding concern regarding a child and the practice became active participants in a serious case review as a consequence. The practice had no part in the alleged abuse associated with the safeguarding concern but a learning outcome for all staff was identified and delivered. This related to greater awareness of domestic violence in pregnancy and the protection of unborn children.

The practice manager showed us the system used to manage and monitor significant events. The reviews of events we saw were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. The practice did not hold periodic reviews of significant events to identify trends that may indicate a need to change in policy or procedure over time. The practice did review individual events to ensure that any proposed action was completed.

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 training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible through the safeguarding policies which were located on a computerised file accessible to all staff. The policies contained flow charts for staff to use in order to decide what action they needed to take in the event of identifying a safeguarding concern.

The practice had a GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. As a result of a safeguarding concern raised in the past the practice had implemented new safeguarding measures including better communication with midwives and health visitors via monthly meetings to discuss new children to practice and safeguarding issues. There was a system to highlight vulnerable patients on the practice's electronic records. This included children on the at risk register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Only GPs and nurses performed chaperone duties and they had relevant training. Signs were visible advertising the chaperone service to patients in some but not all consultation and treatment rooms. There was no sign in reception.

Are services safe?

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which also described the action to take in the event of a potential fridge failure. The policy had been amended following an event where a large amount of vaccines had been lost due to a power failure preventing the functioning of a fridge used for their storage. The practice changed the way it ordered vaccines to ensure that if this occurred again the loss of medicines would be minimised. 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.

The nurses and the health care assistant administered vaccines in line with recognised protocols including the correct directives related to their roles. They had also received the training required to administer vaccines. Medicines stored in fridges were colour coded to enable nurses to identify them easily and reduce the risk of using the incorrect medicines.

There was a process for ensuring action was taken in response to medicine safety alerts. Any staff would be alerted via the electronic records system if a medicine on alert was received. Blank prescriptions were stored securely to ensure that unauthorised staff or members of the public could not remove them.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. Cleaning checks were undertaken by an infection control lead. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. All staff had undertaken training on infection control. We saw hygiene and infection control audits were undertaken. The last audit from September 2014 had produced an action plan and log of actions completed. Nearly all action had been completed other than some maintenance work which had required longer to complete. The lead told us that interim measures had been put in place to reduce the risk to patients while the outstanding action was being completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff had access to a sharps injury policy which was available on the intranet. This was to ensure that the policy was always up to date with correct contact details, rather than being printed and potentially becoming outdated. This was in response to a significant event.

Notices about hand hygiene techniques were 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 tested their water systems for legionella (a germ found in the environment which can contaminate water systems in buildings) annually.

Equipment

Staff we spoke with told us they had the equipment they needed to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was well maintained and we saw that all portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as blood pressure monitors.

Staffing and recruitment

Records we reviewed contained evidence that most recruitment checks required had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and some criminal records checks through the Disclosure and Barring Service (DBS). However the practice did not carry out DBS checks on nurses employed before a certain date. Practices are required to undertake a risk assessment on which staff require DBS checks and this should be consistent. Immediately following the inspection the nurses without DBS checks had them undertaken and we saw evidence to verify the checks had been completed. One staff member did not have a reference prior to starting work and two had gaps in their employment history which were not accounted for. One GP employed within the last year did not have proof of their identity on their file. All employment checks required under legislation had not been completed.

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. 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 keep patients safe. The practice used low numbers of agency staff such as locums because they had recruited the staff mix they required to ensure consistent staffing levels were maintained.

Monitoring safety and 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 various checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Staff received health and safety training. There was a log of health and safety action that required attention and staff could use this to report concerns. There was an accident book for staff to report any accidents.

The practice identified, assessed and managed risks. Risk assessments for fire safety and control of substances hazardous to health (COSHH) were in place. Testing and maintenance on fire alarms and fire fighting equipment were undertaken.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen, a pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We saw records detailing when this equipment was checked and we found it to be in working order. When we asked members of staff, they all knew the location of this equipment. Emergency medicines were available in a secure area of the practice and all staff knew of their location. They included medicines for the treatment of cardiac arrest, anaphylaxis as well as other medicines available which related to potential medical emergencies associated with treatments and examinations provided on-site. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included 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 if the heating system failed. Risks associated with service and staffing changes, both planned and unplanned, were included on the business continuity plan. There was an emergency box located at the reception desk which contained equipment which may have been useful in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and changes to the practice's protocols and procedures were discussed and required actions agreed. The staff we spoke with confirmed that nurses and GPs were proactive in identifying best practice and ensuring the care provided to patients matched national guidelines. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We looked at templates used in diabetic, hypertension and respiratory care reviews and found they were comprehensive and matched best practice. Nurses told us they were fully involved in the design of health check review templates for a number of medical conditions.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the nurses supported this work, which allowed staff to focus on specific conditions. Clinical leads had specific training to support them in these roles. Nurses and GPs we spoke with were very open about asking for and providing colleagues with advice and support. For example, nurses felt involved and supported by clinical leads in delivering reviews of specific conditions to patients. Nurses were fully involved in planning patients' care and contributed to policies and procedures regarding management long term conditions. This meant that patient care was planned by all staff who delivered their care. Nurses also led in managing specific conditions. We spoke with nurses who led in diabetes and asthma care and found they received specific training and support to fulfil these roles.

Patients aged over 75 had a named GP to help provide continuity in care planning and delivery. Patients with long term conditions, such as diabetes, were offered 30 minute health reviews to assist in management of their condition. This enabled staff to provide comprehensive checks and offer advice to patients. There were personalised long term condition management plans recorded on patients' notes.

Reviews of chronic conditions were planned around patients' birthdays to help them remember when they needed to attend the surgery and also to spread the demand on the practice over the year. We saw that templates used for reviewing long term conditions included some checks beyond what was required by national guidelines. For example, asthma checks included additional checks on patients' lifestyle which may impact on their ability to self-manage the condition. The practice achieved the best outcomes for managing diabetes in the clinical commissioning group (CCG).

The practice used telehealth which can assist GPs in gaining specialist advice on treating and caring for long term conditions and can reduce the need for referrals to hospitals or other services. Advanced dementia care planning and reducing unplanned admissions enhanced services were undertaken by the practice (a service above that expected within the usual GP contract).

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. There was a process the practice used to review patients recently discharged from hospital and this ensured GPs reviewed the needs of these patients, according to need.

Despite having a significantly older population national data showed that the practice had similar referral rates to secondary and other community care services as the national average. GPs used national standards for the referral of specific conditions including two week referrals. The practice undertook reviews of referrals to determine whether GPs' referrals were appropriate and whether patients could be seen by a GP with a specialism in order to prevent an external referral.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included

Are services effective?

(for example, treatment is effective)

data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The clinical team of nurses and GPs was integrated and well organised in managing patients' care.

The practice showed us several clinical audits that had been undertaken in recent years. We saw evidence audits were completed and the practice was able to demonstrate the changes resulting since the initial audit. We saw audits on specific conditions and the use of specific medicines. For example, one audit on medicines used to treat patients with dementia had been undertaken initially in 2013 and repeated in 2014 with a plan to undertaken again in 2015. Audit outcomes were discussed at clinical team meetings. Nurses were involved in audits and the outcomes of audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, specific health checks for patients with diabetes were above national averages such as foot and eye checks plus information on lifestyle advice. The practice achieved nearly 100% on its QOF score in 2013/14. This indicated that chronic conditions were well managed and this was important as 67% of the practice had a long standing health condition compared to 54% of patients nationally.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. Regular meetings were held for nurses and GPs to discuss cases of concern regarding long term conditions. This included six weekly meetings for review of respiratory conditions and two to three month reviews of diabetes.

There was a protocol for repeat prescribing which was in line with national guidance. GPs reviewed patients on long term prescriptions in line with national standards. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. There was a process for communicating medicine alerts to GPs and nurses.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice had a significantly higher number of over patients over the age of 65 and as a result end of life care planning and providing care in care and nursing homes were significant elements of the service the practice provided. The practice had processes in place to manage care in nursing and care homes.

Effective staffing

Practice staffing included GPs, nurses, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with those performing clinical lead roles having additional diplomas in diabetes for example. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, nurses were enabled to undertake external training in areas of clinical interest. The nursing team ensured such training was a benefit to all staff by having sharing what they learnt following external events. The lead nurse told us this was an efficient means of delivering training to the nursing team. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local

Are services effective?

(for example, treatment is effective)

hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers and we found no concerns regarding delays in how this system worked.

The practice held multidisciplinary team meetings regularly to discuss the needs of patients with complex needs, for example, those with end of life care needs, patients with mental health concerns or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. This information could be found through minutes if staff were not able to attend the meetings.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made use of the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had guidance to help staff. Patients we spoke with reported being informed and feeling involved in decisions about their care so they could consider making informed choices when providing consent to their care. GPs and nurses we spoke with had a good understanding of the Gillick Competency principles which relate to gaining consent from patients under 16.

Health promotion and prevention

It was practice policy to for newly registered patients to have a medical check including height, weight, blood pressure, urine test, medical history and a discussion of any concerns. NHS Health Checks were offered to all patients aged 40-75.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and provided care to patients in a learning disability home. All the registered patients with a learning disability were offered a health check once a year, which most patients at a local care home accepted. The practice offered smoking cessation to 98% of patients with certain conditions which is above the national average. The smoking status was recorded for 89% of patients. Smoking cessation appointments were offered by nurses and healthcare assistants.

Public health initiatives were offered at the practice including cervical screening and chlamydia testing. The practice's performance for cervical smear uptake was over 80%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Travel advice was offered and available during extended hours appointments. Last year's performance for all childhood immunisations was either above or close to the locality average. One patient reported that they were concerned there had not been a follow up when their child had not attended for their vaccines, but when they saw a GP for a different reason they followed this up. Flu vaccinations were offered to patients and the uptake among those aged 65 and older was slightly above the national average. The uptake among those with medical conditions which put them at significant risk of health problems associated with flu was slightly below national average.

Patients being monitored for hypertension were offered a home blood pressure monitor to assist in diagnosing any concerns. This means of monitoring blood pressure is more

Are services effective?

(for example, treatment is effective)

accurate and reduces the need for patients to attend the practice very regularly during their monitoring. There was a blood pressure monitor in the reception area for patients to use independently.

A talking therapies service is run on-site for patients with mental health conditions. Healthy minds was also available to patients on site. This was not only to support patients with depression and anxiety but also as part of an obesity support service. Links with elderly mental health teams helped in planning dementia patients' care and treatment. The practice invited patients in 'at risk groups' for dementia for memory assessment. An obesity service was available to refer to in order to help patients' who needed to lose weight for health reasons.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of approximately 187 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice received positive feedback for treating patients with care and concern. The practice satisfaction scores on consultations showed 85% of practice respondents said GPs were good at listening to them and 78% of nurses were good at listening to them. The survey also showed 86% said the last GP they saw and 81% said the last nurse they saw was good at giving them enough time. These results were slightly below the regional average. The practice received positive feedback regarding how GPs and nurses treated patients with care and concern and this was above the regional average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and all comments except one were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We saw no evidence that patients experienced any kind of discrimination.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed staff were careful to protect patients' confidentiality. For example, reception staff were careful to prevent patients overhearing potentially private conversations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas on the national and practice survey. For example, data from the national patient survey showed 78% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were above the regional average. The results from the practice's own satisfaction survey showed that over 90% of patients said they were sufficiently involved in making decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, comments in the practice survey results referred to the supportive nature and individualised care provided by staff to meet patients' needs. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey feedback.

Notices in the patient waiting room, on the TV screen and patient website signposted patients to a number of support groups and organisations, such as dementia and carer support. Staff we spoke with told us that they would refer to this information if they felt patients needed external support services. The practice's computer system alerted staff if a patient was potentially vulnerable. Receptionists we spoke with were aware of how to support patients who were deaf, a carer, had dementia or a learning disability.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice regularly sought the views of a broad spectrum of its patient population and made efforts to ensure the practice survey was circulated to a wide proportion of the patient population including carers, patients in care homes and those aged 17-35. The appointment system was reviewed and changed in response to patient feedback. After the new appointment system was implemented patients were communicated with through various means such as leaflets and on the website to ensure that the system was understood by the patient population. The patients we spoke with had a good understanding of the system as a result. One patient told us of a recent illness they had and the practice had prompted them to come to the practice regularly to monitor their condition.

The practice took steps to ensure patients who were in vulnerable positions were able to access the healthcare they needed. For example, patients with limited hearing were able to access consultations with lip readers or their carers. Staff sought to gain mobile phone numbers for travellers and homeless patients who attend the practice in order to communicate hospital appointments and results. Homeless patients were enabled to register by allowing the practice to be used as an address. The practice worked closely with a local carers support service. There was a successful bid to provide new anti-coagulation service in the practice for patients using a specific medicine which meant these patients would not have to access secondary care services such as hospitals. This was a benefit to patients living in rural areas. There was an online prescription service which reduced the need to travel to the practice for repeat prescriptions.

The practice enabled temporary registrations for those visiting the area to ensure they were able to see a GP or nurses if needed. There was information explaining this service on the website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff told us about the extent of vulnerable sections of the community, such as homeless patients, carers and travellers. Even though the proportion of both these groups was low the practice had considered the needs of these patients and planned the service to ensure these patients could access the practice. The practice provided equality and diversity training to staff.

The practice had access to a telephone translation services and a GP who spoke a foreign language which supported some patients who did not speak English. However, one staff member told us about a patient who required an interpreter but the practice had not used the telephone translation service to ensure that they could keep their appointment that day. Another appointment was arranged but the patient did not attend.

The premises and services had been adapted to meet the needs of people with disabilities, patients with buggies and prams and those with limited mobility. Automatic doors and level access were available. Consultation and treatment rooms were on the ground floor with wide corridors and doorways. 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.

Access to the service

GP Appointments were available from 8.40am to 11.40am and 2.40pm to 5.30pm on weekdays. Comprehensive information was available to patients about appointments on the practice website, including a system of GP triage in order to book an appointment. This also included how to arrange urgent appointments and home visits and how to book appointments through the website. The triage system meant patients needed to request a phone consultation with a GP if their need was not urgent and a GP would ring back within two hours. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. When we spoke with patients they understood the triage system and were generally very satisfied with the ability to book an appointment. They said the call back system worked well and was normally within the two hour time period. However, some patients were not aware of the ability to

Are services responsive to people's needs?

(for example, to feedback?)

book appointments in advance. This meant patients who worked told us that the system meant having to take a morning off work in order to receive a call back as they could not be guaranteed when the GP call back would be. This was reflected in some comments on the practice survey. If patients needed follow up appointments they could be booked at the reception desk before leaving the practice and this proved popular with patients. Comments from the patient survey consistently rated the appointment system highly. Patients valued being able to get an appointment quickly and to access advice through GP phone consultations.

Longer appointments were also available for patients who needed them, those with long-term conditions and those in vulnerable circumstances. This also included appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week, by a named GP and to those patients who needed one.

The practice's extended opening hours on one evening a week at one of its practice sites and patients could attend either. The Princes Risborough practice opened late two weeks out of three from 6.30 to 7.50pm. This was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

The practice valued patient feedback highly. There was a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance. Complaints against a GP would be investigate by that individual and then assessed by another GP in order to review the investigation and response. A partner reviewed all complaints. Written and verbal complaints were accepted by the practice. If verbal feedback was not a complaint but a suggestion this was also reported to and recorded by the practice manager and we saw evidence that such feedback was discussed at governance meetings. We saw an example where a patient had verbally asked if their diagnosis could have been made sooner for a particular problem they had. The situation was complex due to hospital assessments also being involved. The practice investigated the comment thoroughly, responded to the patient and shared the outcome for any learning with staff. We saw that information was available to help patients understand the complaints system displayed on posters displayed, leaflets and on the website.

We looked at several complaints received in the last 12 months and found they were all responded to and investigated. Where any learning was identified the practice ensured this was shared with staff.

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

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had consistently reviewed and planned its service to meet the demands of its patient population. The partners, including a managing partner, told us the practice was focussed on delivering team-based, patient focussed quality care. This was reflected in the planning of care around the needs of an older patient population with high levels of long term conditions, without compromising the care provided to the rest of its patients. The team based approach was reflected in the integrated nature of the nursing team who were fully involved in the practice's governance and planning of care pathways.

We spoke with eight members of staff and they consistently reported the same values integrity, non-hierarchical leadership, involvement and openness. Staff knew what their responsibilities were in relation to these values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All the policies and procedures we looked at were reviewed periodically and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards, with the 2014 QOF achievement nearly 100% compared to the national average of 94%. Audits were used to monitor clinical performance and to ensure that patients were receiving treatment that matched national standards and guidance. We saw audits were discussed at clinical and governance meetings. At the December 2014 governance meeting seven audit outcomes were discussed with staff.

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been carried out for fire safety, control of substances hazardous to health and a business continuity plan identified potential risks to the running of the service. Action plans had been produced and implemented to mitigate risks.

The practice held regular meetings which included governance meetings. We looked at minutes from the last meeting and found that performance, significant events and patient feedback had been discussed.

Leadership, openness and transparency

Staff had the opportunity to attend meetings regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Nursing staff took the first hour of clinical team meetings before GPs joined them to ensure that nurses had the opportunity to cover issues they needed to discuss. Nurses and receptionists felt involved in the running of the practice. They told us the culture in the practice encouraged staff to feedback about how the practice operated and to make suggestions. The practice manager had been made a partner and this was reflected in the culture of the leadership team. The manager was valued as a partner and was able to influence the governance of the practice in a different way to GPs.

We were shown the electronic staff handbook that was available to all staff, which included sections on induction and policies. This was made available to staff.

Seeking and acting on feedback from patients, public and staff

The practice took every opportunity to gather patient feedback. This included through the practice survey, complaints, verbal comments and from external sources such as NHS Choices website. The practice was very responsive to this feedback. For example, changes to the appointment triage system were made to improve the call back time for patients requiring a phone consultation. The patient survey had actively been shared with sections of the patient population traditionally difficult to engage with, such as patients living in care homes and those under the age of 35.

The practice had an active patient participation group (PPG). We spoke with a PPG member who told us the group

Are services well-led?

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

was very influential in what improvements could be made to the service. They were involved in designing and analysis the patient survey. The results and actions agreed from surveys were available on the practice website.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at 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 they had staff away days for training. The nursing team had a system of sharing learning from external events within the team.

The practice was a GP training practice and supported trainees with supervision, training and informal support. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, we saw a significant event had led to action where an external service provider needed to take action as well as the practice and this had been incorporated into the action plan.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not take reasonable steps to ensure that employees were of good character and that information required under schedule 3 was available. Regulation 21 (a)(i)(b)**