Dr J Somers Heslam and Dr C J Griffiths

Quality Report

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

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Overall summary

Dr J Somers Heslam & Dr C J Griffiths (also known as The Old Exchange) provides primary medical services to patients in St Ives, Cambridgeshire.

Patients we spoke with were generally happy with the service they received at the practice. They spoke positively about the staff employed at the practice. We received positive comments from patients who had completed comments cards prior to our inspection.

Patients told us they felt that the practice was safe and that care was given to them in accordance with their wishes. They told us the practice was responsive to their needs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. There were systems in place to safeguard vulnerable patients from the risk of harm. Safeguarding policies and procedures were in place for both children and vulnerable adults. This enabled staff to recognise and act on concerns in relation to abuse.

The practice had a robust process in place for recruiting staff to work. This included checking the registration of nurses and GPs, undertaking enhanced disclosure and barring service (DBS) checks and checking that staff were entitled to work in the UK. There were effective systems in place to minimise the risk of infection. There was appropriate and sufficient emergency medical equipment and medicine available.

Are services effective?

The practice was effective. There were procedures in place to deliver care and treatment to patients in line with the appropriate standards. Systems to improve the management and access for patients to health reviews of their long term conditions were implemented. There were joint working relationships with community services and engagement with health and social care providers to co-ordinate care and meet people's needs.

Are services caring?

The practice was caring. Patients and carers we spoke with described the service provided as good. The patients we spoke with felt they were listened to and respected. Patients told us they were involved in decisions about their care and treatment. Patients told us they were treated with dignity and respect by both the non-clinical and clinical staff.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice worked effectively with other health and social care services to ensure patients received the best outcomes. We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly. The practice sought engagement with patients to gather feedback on the quality of the service provided and responded to the feedback in order to improve the service.

Are services well-led?

The practice was well-led. There was a clear leadership and management structure. The partners and the practice manager we

Summary of findings

spoke with understood how they needed to take forward the practice in the future to improve patients' experiences. There was a commitment to learn from feedback, complaints and incidents. The appointment system had been restructured to improve efficiency and meet patients' expectations and this was reviewed daily. We saw that staff had an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt well supported. There was evidence of a range of team meetings. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice.

Summary of findings

The six population groups and what we found

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

Older people
The Old Exchange surgery had a higher percentage of patients over 65 than the Cambridgeshire and Peterborough CCG and England average. Older patients had a named GP responsible for their care, but could also see another GP if they preferred. Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. Unplanned hospital admissions for this group were regularly reviewed and improvements made.

People with long-term conditions
The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice provided regular health care reviews for patients with a range of long term conditions. There was support and education provided to patients with conditions such as diabetes and asthma. The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives. With consent from the patient, GPs were happy to speak to relatives on the phone or in person so as to provide a holistic approach to patient care. The practice used notes alerts and Special Patient Notes (SPNs) on patients medical records. This information could be accessed by the A&E and 111 services if they needed to access a patients medical records in an emergency when the practice was closed.

Mothers, babies, children and young people
The practice offered lifestyle advice to pregnant patients. The practice worked with local health visitors and midwives to offer a full health surveillance programme for children. Checks were also made to ensure the maximum uptake of childhood immunisations. Health and advice checks were available for 15 year old patients. The practice offered flexible appointments for families, for example, by slotting in extra appointments, offering telephone consultations and booking appointments in advance.

The working-age population and those recently retired
The practice offered flexible appointments, telephone consultations and booking appointments in advance to provide easier access for patients who were at work during the day. Patients were offered a choice when referred to other services. Recently extended hours had promoted access for working patients

Summary of findings

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

The practice was accessible for any vulnerable group. The practice had identified patients with learning disabilities and treated them appropriately. Patients were encouraged to participate in health promotion activities, such as cervical and breast cancer screening, and smoking cessation. The practice offered telephone consultations and contact via email for those patients identified as having verbal communication issues. The practice used a telephone translation line to provide a confidential translation service to people whose first language was not English. The practice used notes alerts and Special Patient Notes (SPNs) on patients' medical records. This information could be accessed by the A&E and 111 services if they needed to access a patients medical records in an emergency when the practice was closed.

People experiencing poor mental health

Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with severe mental illnesses. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. The practice ensured that patients with poor mental health were able to access the practice at a time that was suitable for them. The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. This included representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the

inspection and had displayed our poster in the waiting room. Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected six comment cards, five of which contained detailed positive comments about the caring and compassionate attitude of the staff. Comments cards also included positive comments about the cleanliness of the practice, the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients. One card raised concerns at the length of time waiting at the practice for their appointment time.

The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with said they were happy, very satisfied and they got good treatment. Patients we spoke with told us the GPs and nurses always gave them plenty of time during the consultation to explain things. We were told the clinicians were very good with the patients and there had been effective communication between the GPs at the practice and specialists at the hospitals and other services. Patients told us that the GPs were very supportive and they thought the practice was well run. Patients knew how to complain but told us they mostly had no complaints. We were told us they were aware they could use a private room should they wish to have a personal conversation away from the reception desk.

Patients told us the appointment system was very good and they could get an appointment when it was convenient for them. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs were very approachable and supportive.

We were told they were happy with their supply of repeat prescriptions and reported no delays in obtaining their medicines. Patients told us they would recommend the practice and were satisfied with the practice facilities.

There was health care and practice information on display around the waiting room area.

Areas for improvement

Action the service SHOULD take to improve

The process for recording meetings should be formalised and documented.

The process for annually checking the registrations of clinical staff should be formalised and documented.

Dr J Somers Heslam and Dr C J Griffiths

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector and a practice manager.

Background to Dr J Somers Heslam and Dr C J Griffiths

Dr J Somers Heslam & Dr C J Griffiths (also known as The Old Exchange) provides general medical services Monday to Friday from 8am to 6pm with extended hours from 6.45am to 8am Monday mornings. The practice provides general medical services to approximately 2,785 patients and is situated in central St Ives, Cambridgeshire. The building provides good access with accessible toilets and two car parking facilities for people with disabilities. A local council pay and display car park is situated nearby.

The practice has a team of two GPs meeting patients' needs. Both GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there were three registered nurses, one GP registrar (who is training to be a GP), one healthcare assistant who also saw patients for phlebotomy consultations, a practice manager, an assistant practice manager, a dispenser and two reception/administrative staff.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, health visitors and midwives.

The practice provides services to a diverse population age group, is in a semi-rural location and is a dispensing practice. A dispensing practice is where GPs dispense the medicines they prescribe for patients who live remotely from a community pharmacy. Not all patients at the practice were entitled to this service.

Outside of practice opening hours a service is provided by another health care provider (Urgent Care Cambridgeshire) by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before conducting our announced inspection of The Old Exchange surgery, we reviewed a range of information we

Detailed findings

held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 10 September 2014. During our inspection we spoke with and interviewed a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice.

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

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

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

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate that it had systems in place to report record and analyse significant events. We saw that where meetings had taken place outcomes were shared with staff. Staff were aware of the significant event reporting process and how they could verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following an incident or significant event, the practice manager and GPs undertook a Significant Event Analysis (SEA) to establish the details of the incident and the full circumstances surrounding it.

Learning and improvement from safety incidents

We saw that significant events had been discussed at meetings and when things had gone wrong the practice had put systems in place to improve safety and standards. However we noted that not all the minutes from the monthly meetings were available to us during the inspection. We saw the last clinical meeting minutes were dated April 2014. We were told a meeting took place in June 2014. The practice manager told us that due to staff changes meetings had lapsed and not all the meeting minutes were available for staff. We discussed these concerns with the GPs and the practice manager. The provider confirmed arrangements for regularly recording meeting minutes would be implemented following our inspection.

Reliable safety systems and processes including safeguarding

Staff showed us how they would access the practice safeguarding policies and procedures. We were told staff received changes and updates via emails from the practice manager and attended practice meetings, clinical meetings, and Vulnerable and End of Life Patients meetings where safeguarding concerns were discussed. Clinicians told us the clinical meetings were useful and enabled working in partnership and improved patient care. We were told these meetings were not minuted. However the practice was able to show us agendas for regular multidisciplinary and Vulnerable and End of Life Patients meetings, where safeguarding issues and vulnerable patients, discussion points and actions were logged for discussion. We saw that actions taken from these meetings had been recorded on the medical records of each patient who was discussed.

All staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. There was a safe recruitment process and recruitment checks for staff. All new clinical members of staff had a Disclosure and Baring Service check to ensure their suitability to work with vulnerable adults. Employment files we looked at confirmed that non-clinical staff had been checked and were safe to work with vulnerable adults. Appropriate qualification checks were carried out when new staff were recruited. However the practice manager told us there were no records to confirm the registration of nurses had been checked annually. We discussed this with the practice manager who agreed to undertake these checks annually and record them.

We asked staff about the practice's policy for whistle blowing. This is a process which enables staff to raise concerns identified within the practice; this included concerns of poor practice by colleagues. The staff we spoke with were aware of this process and were aware of their responsibility to raise any concerns they had. Staff we spoke with were able to describe how they supported vulnerable patients who presented as emotionally distressed or angry due to their health conditions. We asked about systems in place to keep staff and patients safe. Staff were able to show us how they would summon assistance if they felt threatened.

There were procedures in place at the practice for the use of clinical staff for chaperoning. Staff were trained and aware of their role and the implications for protecting both the patient and the GP. There were signs around the treatment couches to confirm chaperones were available. Chaperones were routinely offered for cervical smears. We saw there were systems in place for recording if the chaperone had been used or if the patient had declined a chaperone.

Monitoring safety and responding to risk

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis. Staffing

establishments (levels and skill mix) were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being.

Staff confirmed if they had daily concerns they would speak with the GPs, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's in the practice. The practice manager told us the clinical meetings were another opportunity for clinicians to meet and discuss emerging risks.

We saw that staff recognised and responded appropriately to changing risks within the service, including responding to busy periods. Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role and knew what to do in urgent and emergency situations.

There was emergency medicines and equipment available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly and the equipment was available and fit for purpose. We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary was tidy and operated calmly with adequate staffing levels. We looked at controlled drugs stored at the practice. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. There was a clear audit trail of receipt and issue of controlled drugs. The practice had clear procedures in place for the disposal of controlled drugs.

We saw there was a comprehensive range of standard operating procedures for staff to follow and that these were regularly updated. All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. We looked at the storage facilities for refrigerated medicines and immunisations. Staff were able to give examples of how dispensing practices were amended as a result of incidents arising. We were shown how errors were recorded and appropriate actions were taken.

Patients were informed of the reason for any changes in medication prescribed and the dosage. The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patients' medicines were authorised by the prescriber. There were systems in place to make sure any medicines alerts or recalls were actioned by staff. Systems were in place so that checks took place to ensure products were kept within expiry dates. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored daily to ensure that medicines remained effective.

The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how staff who generate prescriptions were trained, how changes to patients' repeat medications were managed and the systems for reviewing patients repeat medication to ensure the medication was necessary and safe. There was a clear audit trail of receipt, storage and issue of blank prescriptions throughout the practice.

Medication levels and expiry dates were monitored by dispensary staff. Dispensing staff working at the practice had received training to undertake dispensing tasks. We saw the competence of staff to dispense medicines had been assessed.

Cleanliness and infection control

During our inspection we visited patient waiting and treatment areas, office and reception areas. We saw that the practice was clean and well maintained. Patients we spoke with said they were happy with the standards of hygiene at the practice.

Are services safe?

Treatment rooms were visibly clean and uncluttered. We found and staff told us that personal protective equipment was readily available and was in date. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. There were hand washing posters above wash hand basins throughout the practice including in the patients' toilet. We saw that there were body fluid spillage kits which enabled staff to clean any contamination or spillages effectively. Staff were able to describe to us how they had recently effectively used one of the kits.

The practice had a lead nurse for infection control, who had undertaken formal training in this area. An infection control audit was undertaken on 27 February 2014. The infection control lead nurse told us that as a result of the audit and the training they had received, the practice had put in place actions for improvement. We saw that whilst some changes had been completed, other changes were part of the building refurbishment plans and were on-going.

There were infection control policies in place. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. The practice employed a cleaning company to oversee daily cleaning at the practice. The practice manager told us they did a daily visual audit of the practice and recorded any concerns in a log book. The practice had undertaken regular audits of the cleaning undertaken at the practice. Areas highlighted for attention and the actions taken were recorded.

We saw there was a system for handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum at the practice.

Staffing and recruitment

We looked at the staff rota and the practice appointments rota. We saw that staffing was monitored and reviewed daily by the practice and assistant practice manager.

However, the practice manager told us there were no formal systems in place for this. We were told by the practice manager, and staff confirmed that administrative and receptionist staff were knowledgeable of each other's roles and were therefore able to stand in for each other in times of absence or busy periods.

Staff we spoke with confirmed if they had daily concerns they would ask any of the GPs, the practice manager, the nurses or the assistant practice manager for support and advice. Staff felt their concerns were listened to and acted on.

Dealing with Emergencies

The practice had a business continuity plan in place. This detailed the responsibilities of the partners and the practice manager in the event of the plan needing to be implemented. We saw the plan had been reviewed and updated when suppliers, contact numbers, doctors or staff changed.

The plan covered incidents such as the loss of the computer system, loss of utilities such as the telephone, electricity, gas, burglar and fire alarms or the incapacity of clinical or reception/administration staff. The plan was clear and told staff what to do in an emergency. The practice manager told us how the plan had recently been put in place following the failure of the telephone system. The outcome of this failure was reviewed and the telephone system had recently been replaced. Staff we spoke with were aware of the plan.

The practice manager told us many of the nurses and non-clinical staff worked part time and would cover each other where possible when they were changes in demand or disruption to staffing.

Equipment

There were policies in place for the safe use and maintenance of equipment. We saw that portable appliance testing had been regularly carried out on electrical equipment throughout the surgery.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with best practice standards. All clinicians we interviewed were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. We were told that revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we interviewed demonstrated evidence based practice. All GPs and nurses demonstrated how they accessed guidelines from NICE and from local commissioners. We saw agendas of practice meetings where new guidelines were itemised for review and discussion. We were told any changes were implemented and the use of them monitored. All the GPs we spoke with were aware of their professional responsibility to maintain their knowledge.

The GPs had access to online prescribing support systems. These systems ensured that the GPs were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments.

We found that patients had their needs assessed and that their care was planned and delivered in line with guidance and best practice. Patients were referred in line with guidance and best practice to secondary and other community care services. We saw that care and treatment decisions were based on people's needs without unlawful discrimination. All the clinicians we spoke with described an effective, mutual respect amongst the partners and team with a culture for asking each other and sharing information. We were told this contributed to the national data which showed the practice had a lower than national average referral rate for all conditions. We saw appropriate use of the Two Week wait referrals, (two week wait referrals are a fast track referral system for managing urgent referrals for patients with suspected cancers.).

We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose the typical range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated.

Management, monitoring and improving outcomes for people

The practice used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that they generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed in comparison to other practices within their CCG area. Staff spoke positively about the culture in the practice around clinical audit and quality improvement.

The practice had a system in place for completing clinical audit cycles (a quality improvement process that seeks to improve patient care through systematic review of care against specific criteria and the implementation of change.) We saw that The Old Exchange surgery had undertaken clinical audits on prescribing, as requested by the prescribing adviser of Cambridgeshire CCG, such as non-steroidal prescribing. The practice had identified historically high prescribing issues and had systems in place to improve and effectively decrease this. The practice had used the local CCG prescribing formulary to ensure effective medicines management.

The practice participated in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess performance. The practice liaised closely with district nurses, the multidisciplinary team coordinator and the out of hours service to try and reduce unplanned admissions. The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep patients in their own homes

Effective Staffing, equipment and facilities

All staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. There were effective induction programmes. The learning needs of staff were identified and training put in place which had a positive impact on patient outcomes. Staff felt well supported in the training programme. Staff told us that training opportunities and their requests for training had never been refused. We saw the staff training record which

Are services effective?

(for example, treatment is effective)

showed that all staff were up to date with the practice's mandatory training including basic life support, infection control, fire safety and safeguarding of vulnerable adults and children.

The practice manager told us that poor performance was identified during observation of staff performance and in the staff appraisal process, and addressed with staff as a training or development requirement.

The practice manager told us that local practice managers had an email link where they could email questions for support and advice. The practice manager attended local practice manager meetings which the local CCG facilitated. We were told these were useful for support and development.

Working with other services

The practice held monthly palliative care meetings. Palliative care and treatment was offered to patients with cancer and other life limiting illnesses, who were identified as approaching the end of their lives. This was confirmed by the GPs who advised that all patients with palliative care needs were reviewed during these meetings. We looked at the meeting agendas and saw these were attended by GPs and representatives of the community care team. The practice shared information with the out-of-hours service, for example special patient notes about patients with complex health needs. The practice working towards the Gold Standard Framework (GSF) for end of life care. The GSF encourages clinicians to talk to patients nearing the end of their life, their families and their carers about how and where they wished to be cared for and to work together to provide a plan to meet their care requirements.

The practice computer system provided an alert on the corner of the screen for each patient who was on end of life care. This system allowed other health care organisations who would be involved with end of life care to see the alert and link in to necessary information or care plan for that patient.

Information about patients who had contacted the out of hours service, had been admitted to hospital, were seen in hospital clinics or had been discharged from hospital were reviewed daily by GPs at the practice.

Results of tests received by the practice, such as blood or urine results were seen by the GPs. There were systems in place to ensure these were seen, actioned and patients were contacted where necessary. We were told patients were often contacted by a clinician to reassure them all was well. This ensured that patients had the opportunity to ask questions about their results.

Health, promotion and prevention

New patients who registered at the practice were offered a consultation for a new patient registration health check with a nurse to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, height, weight, blood pressure and body mass index BMI). Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications.

Information on a range of topics and health promotion literature was available to patients at the practice and on the practice website. This included information on safeguarding vulnerable patients, requesting a chaperone and victim support. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. There was information about services to support them in doing this, such as smoking cessation advice. We saw there was a clear process the practice followed for patients who did not attend for cervical smears.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients, their relatives and carers to organisations. Information on a range of topics for carers and patients was available on the carer's notice board in the waiting room. This included information which signposted patients to organisations which provided support such as Cambridgeshire Crossroads support, and St Ives community car scheme. The car scheme offered lifts to patients registered at the practice for a reduced rate.

Flu vaccinations were offered to all patients over the age of 65, those in the identified at risk groups and pregnant women. A one off Pneumococcal vaccination was offered to patients over 65.

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone and victim support.

Are services effective?

(for example, treatment is effective)

The practice kept a register of patients with a learning disability; we saw that each patient on the register had received an annual health check in the previous 12 months.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The relatively small number of people registered with at the practice clearly encouraged personalised patient centred care approach with easy access. We observed patients and those close to them being treated with respect and dignity by staff in all roles at the practice. Patients who used the service told us they felt supported and well-cared for. We saw that staff responded compassionately to patients in discomfort or emotional distress. Patients we spoke with confirmed that they had not felt rushed during their consultations with the GPs or nurses.

We noted that staff approached people in a person centred way; we saw they respected people's individual preferences, habits, culture, faith and background.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We received six completed cards. A majority of these cards contained detailed positive comments and stated that patients were grateful for the caring attitude of the staff and for the treatment they had received at the practice. However one card raised concerns about the length of time the patient had waited for their appointment time.

Staff were careful to follow the practice confidentiality policy when discussing patients' treatment in order that confidential information was kept private. We saw this was respected at all times when staff were delivering care, in staff discussions with people and those close to them, and in written records. Staff told us that patients were offered a private room should they wish to have a personal conversation.

There were systems in place to support patients and those close to them to receive emotional support from suitably trained staff when required (particularly near the end of a person's life and during bereavement). The practice contacted bereaved families by phone and invited them to visit the practice to talk. Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted.

There was information available at the practice to signpost the patient and those close to them to support groups. Patients we spoke with told us they felt supported by the practice.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour they would raise these with the GPs or the practice manager. Staff were able to give us examples of how incidents and learning outcomes had been discussed with staff, the managers and the partners.

Involvement in decisions and consent

The practice routinely involved patients in their care and treatment and their choices were respected Patients we spoke with told us they felt involved in decisions about their treatment, planning their care, choosing and making decisions about their care and treatment, and were supported to do so where necessary. Patients told us and we saw from comments on the completed comments cards that GPs and nurses gave them time to ask questions during their consultations. Patients told us they were happy with the level of information available to them at the practice. Patients we spoke with told us they were happy with the information they were given and felt they understood the next steps in their treatment. All the GPs we spoke with told us patients were helped and guided to make informed decisions about their care and that patient choice was respected.

Staff told us they always talked to patients and involved them in their care, and those close to them (including carers) were supported to make informed choices and decisions. We were told if a patient had been unable to make a decision about their care, they would be given all the information available and encouraged to make another appointment, to give them time to think about the options available to them.

Patients told us the clinicians always sought their agreement or consent before they examined them. For patients whose first language was not English, the practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

We saw there was a protocol in place which set out how the practice involved patients in their treatment choices so that they can give informed consent. The protocol provided staff with a guide to the Mental Capacity Act (MCA) (2005). This provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. All staff were aware of patients who needed support from nominated carers and clinicians

Are services caring?

ensured that carers' views were listened to as appropriate. There was reference to Gillick competencies, a nationally recognised way of assessing whether children under sixteen are mature enough to make decisions without parental consent. Staff were able to demonstrate a clear understanding of Gillick competencies.

Staff told us that the majority of patients who used the service spoke English. Staff were aware of the availability of interpreter services when required and described the use of relatives, as appropriate; to help patients who did not speak English make informed choices.

We saw that staff communicated with patients in a way that they understood, was appropriate and respectful.

Patients and relatives were able to contact the service when needed and speak to someone about their care. We saw that the practice understood issues relating to confidentiality which did not exclude carers from being given appropriate information.

Staff were able to give us examples of how patients whose first language was not English, those with mental health problems, young patients and patients with dementia or learning disabilities were supported to make informed decisions about their care and treatment. Where patients did not have capacity to consent to their treatment, staff were able to give us good examples of how patient's best interest had been taken into account.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There were a range of services and clinics available to support and meet the needs of different patient groups. We saw that patients were referred to community specialists or clinics where appropriate. The practice worked closely with the community nursing team to support vulnerable patients with long term conditions. We saw the practice liaised with local midwives and health visitors for mothers, babies and young children.

Patients we spoke with told us they felt the practice was responsive to their individual needs. We were told patients had been visited at home when appropriate and felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were made by the GP who was most familiar with the patient where possible. This included vaccinations for the elderly and annual health checks for patients with learning disabilities.

The practice had systems in place to seek and act on feedback from patients. There was a suggestions and comments box available for patients feedback in the waiting room area of the practice. We saw the practice had responded to patient feedback. The practice had an active patient participation group (PPG) to help it to engage with a cross-section of the practice population and obtain patient views. A Patient Participation Group (PPG), is a group of patients who are registered at the practice who have no medical training, but have an interest in the services provided to patients by the practice. There was evidence of quarterly meetings with the PPG throughout the year. The practice had worked with the PPG to implement changes. We spoke with two members of the PPG. We were told the practice was pro-active and responded to issues raised by patients and the PPG.

The practice was aware of patients' access needs and had measures in place to support them. Treatment and consultation rooms were all on the ground floor. There were toilet facilities for disabled patients and baby changing facilities. There was an opening window at one end of the reception desk which provided a lowered desk area and access for wheelchair users. A self-check-in system was available in the reception in several different languages.

The practice had recently been accredited as a GP training practice by Cambridge University, as a suitable teaching centre for trainee GPs. The Old Exchange surgery was also an active research practice. Patients were encouraged to get involved in a number of NHS approved research and clinical trials run by the clinicians at the practice by either taking part in the study or by getting involved in the design or set up of the research. During our inspection we saw information displayed in the waiting area which described the various research programmes the practice was involved in at the time. Examples of these included; 'clothing trials for patients with Eczema' and 'anxiousness in children aged three to eight years'. There were also certificates displayed to show research the practice had been involved in. This included a study of 54 patients in a 'cough complication' study. This research investigated the use of antibiotics in the treatment of lower respiratory tract diseases.

The out of hours service sent a fax to the practice each morning giving details the care it had provided to any patients whilst the practice was closed. This was brought to the immediate attention of the GPs to ensure on-going continuity of care. The practice clinicians attended regular local long term condition monitoring sessions to ensure they were up to date and involved with the latest ideas and projects.

Access to the service

The practice had ensured that patients could access the practice at a time that was convenient and suited them. Patients told us that they could always get an appointment when they needed one. Patients could make appointments on-line, by telephone or in person. Information about the appointment system was found on the practice website and by the reception desk. Patients were happy with the availability of appointments. We were told they liked the on line booking system. Patients were able to request a telephone consultation. The practice offered extended hours appointments on Monday mornings between 6.45am to 8am.

GPs and staff were able to give us examples of how vulnerable people had been able to access the practice's services without fear of prejudice.

Patients could order repeat prescriptions on-line, by post or in person at the surgery. The practice aimed to have the prescription ready for collection within 48 hours.

Are services responsive to people's needs?

(for example, to feedback?)

There were arrangement in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, there was an answerphone message giving advice on telephone numbers to ring dependant on the circumstances. Information on the out-of–hours service was also available on the practice website.

Meeting people's needs

We saw that patient correspondence and laboratory results were reviewed by a GP in a timely way and actioned appropriately. When GPs were on holiday the other GPs covered for each other. Patients' test results were seen each working day and where concerns had been identified, the patient was either telephoned by a GP, contacted by the reception team and invited to make an appointment or a letter was sent asking the patient to contact the practice and make an appointment to see their GP.

Patients requiring further specialist investigation or treatment were referred to other clinics. We saw that systems were in place to ensure there was timely referral for patients to secondary care. The GPs told us they ensured patients understood the choices available to them and that they were happy they had made the right choice. Patients we spoke with told us their referrals had always been discussed with them and they were happy that these had been handled in a timely way. Some of the patients we spoke with and received comments cards from, gave examples of when the doctors had responded promptly and with care to their needs.

We were told the GPs often telephoned patients following their discharge from hospital to review their care and medication.

Concerns and complaints

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

The practice had taken steps to ensure patients were aware of the complaints procedure. Information on how to raise a complaint or concern was clearly displayed within the practice, in the practice leaflet and information was also available on the practice website. The process included timescales in which the practice would respond and information of other regulatory bodies to whom patients could complain. Staff told us that if someone wanted to make a complaint, the receptionist would see if there was anything they could help with. In addition there were small comment sheets patients could fill out, patients could also speak with or see the practice manager or the assistant practice manager.

We saw the practice's log and annual review of complaints it had received. The review recorded the outcome of each complaint and identified where learning from the event had been shared with staff.

Are services well-led?

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

Our findings

Leadership and culture

The GPs, practice managers, nurses, dispenser, staff and GP registrar we spoke with all had a collective vision of high standards of patient-centred family healthcare in a welcoming, safe and caring environment. Staff all told us how proud they were of the team work, patient centred, accessible culture of the practice. We were told patient care was most important and the staffs first priority and how as a small practice they were able to offer continuous care.

Patients we spoke with told us they were able to see the same GP for each consultation. The staff we spoke with told us they felt there was an open door culture and that the GPs and practice manager were approachable. During our inspection we saw that staff were comfortable seeking advice and support from the GPs. The practice had development plans in place to improve the interior layout of the reception area and ground floor offices in order to maximise the space available within the building and improve patient access and facilities.

Governance arrangements

There were systems in place to manage governance of the practice. There were delegated responsibilities to named staff, such as a lead for Quality and Outcomes Framework (QOF), (part of the practice contract which rewards practices for the provision of quality care and helps to fund further improvements in the delivery of clinical care), complaints, infection control, prescribing and safeguarding of vulnerable adults and children. The responsibilities were shared between the GPs, the lead nurse, the practice and assistant practice manager. This provided structure for staff and clear lines of accountability when staff were seeking support and guidance. There was evidence of staff awareness of these roles and staff we spoke with were able to identify lead responsibilities within the practice.

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 fifteen of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the practice risk log which addressed a wide range of potential issues, such as health and safety, infection control and fire risk assessments. We saw that the risk log was regularly updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example following the failures of the old telephone system during practice opening hours a new system had been installed.

Systems to monitor and improve quality and improvement

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly itemised for discussion at staff meetings and action plans were put in place to maintain or improve outcomes.

The practice manager told us they performed daily checks on the running of the service which involved the daily observation and review of the performance of each member of staff. Issues highlighted were discussed with staff at either staff appraisal or if they were of concern, they were addressed with the member of staff immediately. Staff and the practice manager were all very clear of their understanding and responsibility to report concerns or issues. Where necessary they were able to detail how they would report concerns or whistleblow beyond the partners and the practice manager. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Patient experience and involvement

The practice had gathered feedback from patients through patient surveys, suggestions, complaints and the Patient Participation Group (PPG). A Patient Participation Group (PPG), is a group of patients who are registered at the practice who have no medical training, but have an interest in the services provided to patients by the practice. We spoke with representatives of the practice PPG during the inspection. We were told they felt the practice was supportive and had a good working relationship with the PPG. During the 2013 -2014 patient survey, 96% of patients responding to the survey said they would be likely to recommend the practice.

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

Patients were encouraged to feedback their views. Information was provided on the practice website and in

Are services well-led?

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

the practice leaflet inviting patients to put their comments in writing to the practice manager. There was a suggestion box in the waiting area. Following the practice 2013 to 2014 patient survey the practice had put in place a comprehensive action plan to respond to issues raised from the results. We saw details of actions completed. These included 24 hour blood pressure monitoring machines which had been purchased for patients with borderline raised blood pressure. Education events had been put in place to promote issues such as men's health. Information on the self-booking in screen now included information advising patients when they arrived of how long they would have to wait for their appointment. Increased appointments for extended hours on a Monday morning and improvements to availability of telephone consultations. The practice had also made improvements to the layout of the reception area to improve access for mothers with pushchairs and people using wheelchairs. Areas identified on the action plan that had been delayed included the redesign and building improvement to the reception and office area on the ground floor. The practice had received a grant for these improvements and this work had been scheduled for 2015. The patient survey for 2014 to 2015 was currently underway.

Staff were aware of how to raise suggestions and concerns. The practice had a whistle blowing policy which was available to all staff in the staff handbook. Staff told us they felt confident they could raise a concern and felt there comments would be listened to. We were told by staff that they were encouraged to attend and participate in staff meetings.

Management lead through learning & improvement

The practice told us referrals were regularly discussed between clinicians. It was felt that this contributed to the practice referral rate being the lowest in the CCG area. Learning points were itemised for discussion on clinical meeting agendas.

We saw evidence that learning from significant events took place. There were systems in place to audit and review significant events. These audits resulted in action plans and implementation of changes to improve patient safety, care and practice performance.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four 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. The practice was designated a training practice where GP registrars (trainee GPs) were offered placements to develop their skills and clinical competences.

Identification and management of risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. We saw risk assessments had been completed for fire and health and safety risks relating to the building.

We looked at the business continuity plan for the practice. We saw that this included agreement of arrangements with other services for example in response to a disaster situation where the premises were no longer usable. The practice ensured that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care. Risks were itemised for discussion at the monthly practice meeting and any action taken or necessary was documented and cascaded to all staff.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We saw that the practice offered relevant care to older patients, this included blood pressure monitoring, blood tests and general well man and women health monitoring. The practice actively targeted older people to attend surgery for 'flu vaccinations. Patients who attended for flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by a GP to administer their flu vaccine.

All patients over the age of 75 had been provided with a named GP to help achieve continuity of care and reduce risk to patients. Patients in this group had been informed by letter who their named GP was, but were advised they could see any other GP at the practice if they preferred.

The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep them in their own homes.

The practice had links with local care homes and provided regular and on-going care and support to residents as patients. There was support for those patients identified with dementia. There was an awareness amongst the practice staff of the future demands of this patient group and the practice liaised closely with the community care team to manage the care and support of these patients, their families and their carers.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice ran regular clinics for patients with long-term conditions such as cardiovascular disease, diabetes and asthma. We saw the practice followed a call and recall protocol to ensure that as many patients as possible with long term conditions regularly attended for a review.

Patients with multiple long term conditions, where appropriate, were offered one appointment for their multiple annual reviews, incorporating all the tests required in the one session. When required patients were offered the opportunity to see their usual GP during their long term condition review.

The practice actively targeted patients with long term conditions to attend surgery for flu vaccinations where appropriate to their health care. Patients who attended for flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by a GP to administer their flu vaccine.

The practice held regular multi-disciplinary team meetings to manage the care of patients with chronic diseases or nearing the end of their lives. Patients with long term conditions were monitored and kept under review by the multidisciplinary team.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice offered lifestyle advice to pregnant patients. The midwives held a surgery at the practice every week. The GPs offered mothers and babies a postnatal examination and a six week check which could be pre booked. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisation. The practice offered and delivered the full range of childhood immunisations. The practice worked closely with both midwives and the health visitors.

The practice actively targeted pregnant patients, children or young patients with long term conditions to attend surgery for flu vaccinations where appropriate to their health care.

Health and advice checks were available for 15 year old patients. The practice liaised regularly with local health visitors. There was awareness amongst the staff team that young people telephoning or attending the practice would be offered an appointment with a GP.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered pre bookable appointments for patients who may have difficulty attending during the day. The practice offered early morning opening times from 6.45am to 8am on Monday to provide easier access for patients who were at work during the day. Patients could also consult the doctors by telephone or email rather than visiting the surgery.

The practice offered a referral service when patients needed to be referred to other services. Information on other services was also available. Patients could choose to be referred for further treatment or investigation at a hospital closer to their place of work if required.

The practice provided well woman and well man health checks.

The practice offered regular cervical smear appointments with recall periods dependent on identified risks.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care. The practice was accessible for any vulnerable group. The staff culture evidenced that patients could access the practice's services without fear of prejudice.

The practice had identified patients with learning disabilities. These patients had individual care plans and were offered an annual health check. People with learning disabilities were offered appointments that suited their working hours.

Staff were prepared to assist patients with visual impairment, or whose first language was not English in filling in any forms or accessing healthcare if necessary.

The practice recognised that some vulnerable patients may find it difficult to attend the practice for care and support. The practice offered telephone consultations and contact via email, for patients that found it difficult for whatever reason to attend the surgery.

There was a booking-in touch screen in the reception area with a variety of languages available.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Patients experiencing poor mental health received treatment, care and support at the practice and in the community when they needed it. The practice held a register of its patients known to have poor mental health and had effective procedures for undertaking routine mental health assessments. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. Patients with poor mental health were invited to attend an annual health review. The practice ensured that patients with poor mental health were able to access the practice at a time that was good for them. For example, at a quieter time of the day, when there were fewer people in the waiting room or at the same time and with the same GP or nurse they had previously seen. Appointments were often pre booked and allowed for extra time during the consultation.

The practice was responsive in referring patients to other service providers for on-going support. GPs recognised and managed referrals of more complex mental health problems to the appropriate specialist services.

The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.