Bottisham Medical Practice

Quality Report

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

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Overall summary

Bottisham Medical Practice had a proven track record on safety with a prevailing culture of learning from incidents and alerts to ensure patients received care that was safe. For example, the practice followed a process known as significant event analysis (SEA) to ensure lessons learned from such events could be shared by all staff.

There were safe processes and systems in place such as those for responding to a medical emergency and those for ensuring the practice was clean and operated hygienically. All staff were properly trained to recognise and respond to abuse.

Patients at the practice experienced care and treatment that was in line with established guidance. The practice ensured it was effective by completing clinical audits to identify where improvements might be made.

Staff were trained and supported to develop within their role and to maintain their standards of clinical practice. The practice worked well with other service providers, promoted good health and supported patients to prevent ill-health.

Patients received a caring service at Bottisham Medical Practice. Patients were treated with dignity, respect, compassion and were involved in making decisions about their care and treatment. The practice scored highly on satisfaction rates in the national patient survey for its caring approach.

The practice understood the needs of its patient population and provided services to meet their needs. This was particularly the case with two local care homes and the students at a local community college.

The practice was accessible with a range of appointments available. This was also supported by the views of patients canvassed as part of the national patient survey.

The practice was well-led with a culture of learning, clear lines of accountability and effective management structures in place. The practice was supported by an active patient group that both provided feedback on services and helped to create initiatives to improve patient outcomes.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Bottisham Medical Practice was safe. There was an open and transparent culture about keeping people safe and learning from incidents, events, alerts and audits such as prescribing audits. The practice followed established guidance for safeguarding children and vulnerable adults and all staff were appropriately trained.

All staff had been appropriately vetted to ensure they were safe. Staff numbers and the skill mix was also safe and well established.

The practice was equipped to deal with emergency situations such as suspected heart attack, diabetic emergencies and adverse reactions to vaccines. There was appropriate emergency equipment and medicines in place and staff were properly trained in basic life support.

The practice operated safe systems for the reception, handling, storage and management of medicines. This included routine vaccines that were stored at the correct temperature as well as medicines stocked in the dispensary.

There were safe procedures in place for the control and prevention of healthcare associated infections. The practice was clean and hygienic. All equipment in use was properly tested and calibrated so that it functioned safely.

The practice had a clear and robust business continuity plan that allowed it to provide a service to its patients in the event of a major incident.

Are services effective?

The practice was effective. Patients' needs were assessed and care and treatment was planned in line with appropriate guidance. All new guidance was disseminated and discussed by the clinicians to ensure their practice remained effective.

The practice had carried out a review of the diagnosis of bowel disorders as part of a Practice Delivery and Membership agreement (PDMA) with eight local practices in the local commissioning group. The practice GPs peer reviewed referrals made by each other and, in turn, allowed their referrals to be peer reviewed by a small team of colleagues in the locality as part of the PDMA. This ensured consistent and effective referral practice in the area.

Summary of findings

The practice made use of the 'urgent care dashboard' (UCD), a NHS computerised information tool, to help them to identify and support patients who were most at risk of unscheduled hospital admissions. The practice also carried out regular clinical audits to ensure their performance remained effective.

Staff were properly trained and supported to carry out their roles. This included continuing professional development in order to maintain their relevant professional clinical registration and an effective appraisal and development regime.

The practice communicated effectively with other services such as the out-of-hours service, the hospital, the ambulance service and other specialist services. This included multi-disciplinary discussions for particular patients such as those receiving palliative care.

The practice ran a range of clinics for people with long term conditions as well as screening and vaccination programmes. The practice also actively provided up-to-date health promotion and ill-health prevention information to patients through a variety of media.

Are services caring?

The practice was caring. Patients said they were listened to and that their views and wishes were respected. Patients also said that they felt involved in their care and treatment planning. This was supported by data from the national patient survey that indicated a higher than average proportion of patients who felt the practice was caring and compassionate. The data also showed that patients were satisfied that they were involved in their care and treatment planning.

Patients' privacy was respected and a sign was displayed asking patients to respect the privacy of others. Although the practice manager told us that a room could be made available for private conversations if necessary, the layout of the reception area meant that it was not always easy to ensure patients could speak to a receptionist in private. Patients who required an intimate or personal consultation could make use of a chaperone.

There were appropriate arrangements in place to obtain patients consent to care and treatment and this extended to children and those who had limited capacity.

Summary of findings

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice was committed to providing personalised care. The practice also understood the needs of its patient population, particularly those living in two local care homes.

The practice, working with their patient group, was undertaking an initiative to ensure patients that attended a local community college were aware of the availability of chlamydia screening at the practice. They were also in negotiations with the college to use anonymised data from the student questionnaire to try and understand if there were any gaps in health service provision.

The practice was accessible with a range of appointments that could be made in advance, on the day, on the telephone or in person. Telephone consultations were also available. The national patient survey showed that the number of patients satisfied with the appointment system was higher than average.

There was clear information available to patients who might wish to complain about the practice. Complaints were investigated and responded to appropriately.

Are services well-led?

Bottisham Medical Practice was well-led. There was clear visible leadership and all staff believed in and followed the philosophy of care of the partners which put patients first. There was an open door policy and staff could raise concerns at any time.

The practice had planned for the future. It had carried out a review of its services to determine what the staffing and establishment requirement would be over the coming two to five years.

There were effective governance arrangements in place with clear lines of accountability. A designated lead was established for each clinical area. Policies were monitored and reviewed according to a schedule to ensure they were current.

There were effective internal systems and processes to enable the practice to monitor quality and address shortfalls. These systems were in place internally and also as part of the arrangements with local practices on an area-wide basis.

The practice actively sought feedback from patients using a variety of different methods. Foremost was the active patient group. Such groups are made up of practice staff and patients and operate with the aim of ensuring that patients are involved in decisions about the

Summary of findings

range and quality of services provided. The patient group had worked alongside a receptive management team on a number of initiatives to improve outcomes for patients such as a voluntary transport scheme, a 'walking group' and 'heart start' sessions to help patients deal with life threatening situations.

There was a learning culture among the management team and all the staff at 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 practice participated in a scheme,linked with appointment availability, where volunteers drove patients to the practice for their consultations.

Patients at risk or those receiving end-of-life care had their care and treatment proactively managed, including home visits where required.

The practice had specific arrangements with two local care homes to meet the needs of people living there.

All patients over the age of 75 were provided with a named GP to help achieve continuity of care and reduce risk.

People with long-term conditions

The practice proactively managed the needs of people with long term health needs and had a dedicated clinical lead for each of these areas.

Diabetes clinics were run by practice nurses with specialist diabetes training. The needs of patients with type II diabetes were discussed quarterly with the lead GP and practice nurse from Bottisham, and a specialist diabetic nurse and diabetic consultant from the local hospital, to ensure consistent best management and practice.

Patients with respiratory conditions were regularly reviewed including assessments of their lung function.

Prescribing audits for patients with diabetes and respiratory conditions had been carried out to ensure best practice.

Mothers, babies, children and young people

The practice offered pre- and post-natal checks as well as baby immunisations clinics.

The school nurse, health visiting team and community nursing team were based at Bottisham Medical Practice which enabled effective joint working. The practice operated safe procedures for children known to be at risk.

The practice, working with their patient group, had established links with the local community college to provide information to students about chlamydia screening. The practice was also in negotiations with the taking steps with the college to help them to understand where there were gaps in health provision.

Summary of findings

The practice provided an audited contraception service with a dedicated clinical lead that fitted contraceptive implants.	
The working-age population and those recently retired The practice offered a range of different appointments to enable working age people to attend the surgery. Minor surgery and contraceptive fitting clinics were planned according to local need. The practice also carried out adult health checks for patients aged 45 and above as well as cervical smear tests. The practice had made proactive arrangements to help patients to understand and support their health needs, such as a talk on ageing and a session on dealing with life threatening situations.	
People in vulnerable circumstances who may have poor access to primary care The practice accepted patients on a temporary residence basis and any person whose treatment was regarded as immediately necessary. The practice provided annual health checks for people with a learning disability.	
People experiencing poor mental health The practice maintained a register of patients with mental ill-health, patients who were depressed and patients who were living with dementia. There was dedicated lead clinician for mental health who was leading an ongoing review of local mental health services on behalf of the local commissioning group. Patients with dementia were offered an annual health check.	

Summary of findings

What people who use the service say

Bottisham Medical Practice had positive results for the national patient survey of 2013 with 96% of patients stating they would recommend the practice and 97% stating that they felt the practice was good or very good. These were among the highest ratings nationally. Further, 96% of patients reported that the reception staff were helpful with similar high satisfaction rates for patients who thought they were treated with care and concern by the nursing staff and by their doctor.

In other areas, 93% of patients felt the GP was good at giving them enough time, good at listening to them and good at explaining test results to them, whilst 87% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were higher than those for both the local Clinical Commissioning Group (CCG) area and for England in general.

As for the appointments system, 97% of patients said they could get an appointment to see or speak to someone whilst 86% described their experience of making an appointment as good. These, too, were higher than the average ratings for practices in the Clinical Commissioning Group area and for England as a whole.

On the day of our inspection we spoke with five patients and two members of the patient group, often referred to as a patient participation group. We also collected 22 comment cards that patients had left for us in the days leading up to our inspection. The overwhelming majority of comments were positive with patients telling us they were satisfied with the standards of care, the skill, compassion and efficiency of the staff and the comfort and cleanliness of the environment.

The members of the practice's patient group told us that the practice had responded positively to all feedback and to the work they themselves were involved in. This included the voluntary car scheme and the improvements made in the reception area due to the booking-in screen.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that its system to check equipment and medicines used in an emergency is thorough enough to also identify shortfalls in the single use equipment.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice was engaging proactively with the local community college to try and understand the specific health needs of the student population. This was helping them to explore ways of engaging with younger patients and to see what health advice the college were offering to students. For example, this had resulted in the provision of information to students, through the college, about the availability of confidential chlamydia screening and additional information on the practice web-site aimed at teenage patients. The practice was also in negotiations with the college about using anonymised data from the college's student questionnaire. This was in order to help them to understand where there were gaps in health provision for their teenaged patients although this work had yet be completed at the time of our inspection.

The practice's responsiveness to its patient group had empowered the group to implement a number of initiatives that improved outcomes for patients. Such initiatives included improving a voluntary transport scheme that was linked to the appointment booking arrangements to help less mobile patients get to the practice. Other examples included the introduction of a 'Heart Start' session to help patients learn how to deal

with life threatening situations, and the regular 'walking group' that promoted exercise and access to the community, all of which were co-ordinated by the patient group.

Bottisham Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by another CQC inspector, a CQC inspection manager, a GP specialist adviser, a practice manager specialist adviser and a CQC pharmacy inspector.

Background to Bottisham Medical Practice

Bottisham Medical Practice is a rural community general practice that provides primary medical care for around 5,800 patients who live in several villages in a relatively affluent area to the east of Cambridge. The patient population is predominantly white British with a higher than average percentage of patients aged over 65 years (around 24%) as compared with both the Cambridge region and the rest of England. There is a marginally lower percentage of patients aged under 18 (around 18%) as compared with the regional and national average.

The practice operates a medicine dispensing service from its own dedicated on-site dispensary.

Bottisham Medical Practice has seven GPs, four of whom are partners in the practice. Two of the GPs are salaried GPs whilst another doctor is a GP registrar (a senior qualified doctor who is training to be a general practitioner). There are three practice nurses and a healthcare assistant who is also a phlebotomist (a person who takes blood samples from patients for testing). There is a team of non-clinical, administrative, reception staff and dispensary staff, some of whom are employed on flexible working arrangements. The practice management team comprises a practice business manager, an office manager and a dispensary manager.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6pm Monday to Friday. Outside of these hours, primary medical services are provided by another urgent care provider in Cambridge accessed through the practice main telephone number or through the NHS 111 service.

Why we carried out this inspection

We inspected this GP 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

We conduct our inspections of primary medical services, such as Bottisham Medical Practice, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

As part of our inspection we carried out an announced visit on 09 September 2014. During our visit we spoke with the members of the management team, three of the GPs, two members of the nursing team, one of the receptionists and the healthcare assistant. We also spoke with the dispensary manager and the dispensary team.

We spoke with five patients using the service on the day of our visit and two members of the patient consultative forum known as a patient group (PG), often referred to as a patient participation group. We have also sought the views

Detailed findings

of managers from two care homes that the practice provides a service for. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 22 CQC comment cards completed by patients using the service prior to our inspection where they shared their views and experiences.

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

We found that Bottisham Medical Practice had an open and transparent culture amongst its staff about keeping people safe. This was supported by protocols for escalating incidents through the management team for discussion at weekly practice management meetings. For example, we reviewed an incident with one of the GP partners where a particular medicine prescribed to a patient had been incorrectly noted in a patient's records. Although the correct medicine had been prescribed, the GP concerned recognised the recording error, considered that this might have influenced faulty repeat prescribing and so recorded the incident as a 'near miss'. A near miss is an occurrence where the circumstances might have resulted in harm but on that occasion had not.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording, monitoring and learning from significant events, a process known as significant event analysis (SEA). Significant events were recorded, investigated and discussed at the weekly practice meetings. The notes of these meetings were disseminated to all staff to ensure that any learning points were understood. We reviewed a number of examples of the notes of these meetings and found them to be well structured with clear agenda items where the focus was on clinical safety.

Staff understood the importance of reporting significant events and of the value to their work of any learning that arose from them. This was a consistent view of all of the staff that we spoke with on the day of our inspection, both clinical and non-clinical.

We also noted that safety alerts were received by the practice manager and disseminated to all of the clinicians. We reviewed the practice's response to three of these in the last 24 months. We discussed with the GPs the way that patients were identified who might be at risk as a result of these alerts and provided some suggestions about how searches for such patients might be made more effective. We also discussed the way that summary information about significant events might be better handled to ensure greater control over how learning points were implemented or how procedures were affected. During our discussion we found that the GPs were receptive to such feedback and this indicated an openness and willingness to try new approaches which we considered to be positive.

Reliable safety systems and processes including safeguarding

We saw that the practice had comprehensive and clear safeguarding policies and procedures based on national and local authority guidance. The practice had a nominated lead GP for safeguarding to whom any issues or concerns were reported. We saw evidence that the practice had committed to attending multi-agency safeguarding meetings where this was required and to exchange information with relevant partner agencies such as the local authority social work teams and the police. In order to support this process, the practice held monthly meetings when the few children known to be at risk were discussed with the health visiting team, school nurse and community nursing team.

We saw that staff had received safeguarding training appropriate and relevant to their roles and that annual refresher training was also provided. Staff we spoke with could correctly identify the different types of abuse that affected both children and vulnerable adults. They also correctly described the procedure for responding to concerns when asked questions about a hypothetical scenario.

We looked at recruitment arrangements for staff and saw that the practice had robust systems in place to manage the safe recruitment and selection of its staff. Before employment commenced personal and professional references were obtained including criminal records checks in respect of all staff whose role involved contact with patients. In those roles involving no personal contact with patients we saw that the practice undertook risk assessments.

Medical records for all patients were held on open, wooden shelving within the administration offices. The shelving did not have any additional security features, such as lockable shutters but the administration offices were locked and secure when unoccupied. The practice manager told us that there was a rolling programme of transferring patient information into an electronic database but there was no

Are services safe?

planned end-date for the exercise. All staff had received training in information governance and we found they had a rigorous and knowledgeable approach to safeguarding people's personal information.

We saw that the practice had a chaperone policy and all staff were trained to carry out this role when required and staff members we spoke with told us they were confident in doing so. This enabled patients undergoing any sensitive or intimate examination to feel safe during those consultations.

Monitoring safety and responding to risk

The practice maintained appropriate medicines and equipment for use in an emergency. This included oxygen and medicines to manage situations such as suspected heart attack, diabetic emergencies and anaphylactic shock, a severe allergic reaction to treatments such as vaccinations. The practice had an automated external defibrillator (AED) and staff were trained in its use. All staff received annual basic life support training to ensure they could undertake cardio-pulmonary resuscitation if required and those we spoke with told us they were confident they could do so.

However, when we reviewed the emergency equipment contained on the practice's resuscitation trolley, we found that two of the single use syringes were past their use by date. The contents of the trolley were subject to a regular check; however, no auditing of the checks took place. The practice should ensure that its system to check the emergency medicines is thorough enough to also identify shortfalls in the single use equipment.

The practice maintained an emergency contact telephone number for patients to ring in the event of an emergency. In such cases when this number was dialled the telephones throughout the building would ring simultaneously to ensure the caller received an urgent response. The practice manager explained that patients were aware of the need to only use this number in exceptional circumstances and as a result it was not overused.

Medicines management

We looked at all areas where medicines were stored and spent time in the dispensary observing practices, talking with staff and looking at records. Feedback we received from patients about their medicine supplies was good and they reported no delays in obtaining their medicines. We noted the dispensary itself was well organised and staff followed safe dispensing procedures. However, at busier times, we noted that the design of the dispensary hatch did not easily enable patient confidentiality.

We found there were regular checks on all medicines stored at the practice including vaccines, emergency medicines and those stored in the dispensary. We noted there were adequate security measures in place for medicines but we advised on further improvements related to access to the dispensary and the storage of prescription pads. The dispensary manager told us about recent changes to practices and areas of development that were under consideration for the dispensary. The standard operating procedures for safe medicines management had been reviewed by the dispensary manager. However, the newer versions had not been transferred to the hard copy binder used in the dispensary. We were told that dispensary staffing levels were to increase imminently.

Cleanliness and infection control

Suitable arrangements were in place that ensured the practice was cleaned to the specification set out in the Department of Health (DH) guidance for cleanliness in primary medical care. This was through a formal contract with a commercial cleaning company for both the clinical and public areas of the building. There was a separate contract for cleaning within the administration and office areas. We saw each contract had a clear and specific cleaning schedule in place, which was regularly monitored. Cleaning materials and equipment were properly stored in line with the DH guidance and the practice was also clean and hygienic throughout on the day of our inspection.

Staff members were clear about their responsibilities in controlling infection and demonstrated a sound understanding of the need for the highest standards of hygiene. The practice had an identified member of staff with lead responsibility for infection control and we saw that there was a clear policy supported by comprehensive procedures. These provided staff with guidance about the standards of hygiene they were expected to adhere to for tasks such as hand-washing and handling specimens. Staff told us they undertook annual infection control training and we verified this through training records and information held by the practice manager.

We looked at clinical areas and consultation rooms. We saw that protective paper covers for consultation couches

Are services safe?

and personal protective equipment and materials were available in each treatment room. Privacy curtains within consultation rooms were disposable and were date marked with the replacement date.

The practice also had arrangements in place for the safe and secure storage and disposal of waste, including clinical waste and used sharps', such as needles and blades.

We saw an up-to-date Legionella certificate which had been issued after testing had been completed by an authorised external contractor in February 2014. There were no identified shortfalls that had emerged from this test.

Staffing and recruitment

We saw that the practice had reviewed its skill mix in September 2013. There were four partner GPs although not all were full-time. Two salaried GPs and one registrar along with three practice nurses and a part-time healthcare assistant completed the clinical staff. The clinical team was supported by a practice manager, office manager and an administration team. The practice had based its staffing requirements on its experience of how the practice had operated over previous years.

Staffing was monitored and reviewed during the weekly practice meetings between the management team and the bi-monthly administration and dispensary meetings. We saw that consideration had been given to the treatment and care that patients required. For example, staff rotas were planned and published in advance and these were matched to the schedule of clinics and anticipated need for consultation appointments.

We noted that staff regularly rotated their roles so that they could ensure all essential tasks were fulfilled across the practice in times of absence or busy periods.

Dealing with Emergencies

The practice had a documented business continuity plan to ensure they maintained a service in the event of a major incident. This plan made use of an existing relationship that Bottisham Medical Practice had with a 'buddy' practice less than a mile away. There were also contingencies in place for the use of a porta-cabin in the practice grounds or the occupation of a local community hall if this was required. Copies of the plan were kept off site by all staff members that had key roles to make sure it could be located and used at short notice.

We saw that the weekly practice meetings had a template agenda that allowed the management team to discuss and make plans for changes in demand due to public holidays, seasonal health issues, increased demand on the dispensary and drug alerts. In this way, the need to respond to an unforeseen event was reduced because the practice was already proactively looking at risks.

Equipment

The practice was based in a purpose built building that opened in 2001. The presentation and decoration of the practice was as expected for a recently built location, with safe, level access to all treatment and consultation rooms which were sited on the ground floor.

Staff told us they had training in how to operate equipment, and that they were supervised when they first began to use it. This included a blood pressure monitor and a spirometer, a lung capacity testing machine.

Patients were protected from the risks arising from the use of unsafe equipment because equipment was regularly reviewed and tested for electrical safety as well as for operational effectiveness. We saw test and calibration records of, for example, the spirometer and the vaccine fridges that showed they had been checked regularly and were working correctly. There were arrangements to ensure that essential equipment had access to an uninterrupted power supply. For example, the vaccine fridges we saw were not hard wired (connected directly to a main electrical supply) but instead were plugged into a normal electrical socket. The plugs had warning stickers on them, advising that they should not be removed at any time and staff were aware of the importance of this in ensuring a safe temperature was maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

National Institute for Care and Health Excellence (NICE) guidelines and quality standards, as well as guidance from other clinical bodies in the United Kingdom were cascaded to clinicians and other relevant team members by a staff member who received such alerts through the email system. Thereafter, we saw that the senior partner and the other clinicians discussed newly issued guidance at weekly practice meetings. This provided the clinical team with up to date knowledge to effectively assess people's needs and to plan and deliver their care in line with evidence-based guidance, standards and best practice.

Moreover, the practice contributed to the development of good practice locally. For example, Bottisham Medical Practice, along with eight other local practices belonged to a local commissioning group who shared a practice delivery and membership agreement (PDMA). One of the features of the PDMA was for members to promote good practice by considering, among other things, new guidance or developments in general practice. As part of the PDMA, Bottisham Medical Practice had reviewed the NICE guidance on gastroenterology referrals. They had shared their findings and good practice with the group by way of a 'referral pathways' document they had prepared and which they had begun to use in the assessment and treatment of their own patients. One of the diagnostic options used by the practice within this approach was the early adoption of a particular test to distinguish between irritable bowel syndrome and inflammatory bowel disorders such as Crohn's disease or ulcerative colitis. The practice used this test to prevent patients with irritable bowel syndrome from having to undergo unnecessary invasive hospital investigations.

We saw that every referral for specialist consultation made by GPs was subject of a daily peer review by other GPs at the practice, with some being reviewed by an external group as part of the PDMA. This level of scrutiny promoted learning, the adherence to evidence based guidelines and the surety of referrals according to patients' needs.

The practice had an effective end-of-life care programme in place with a designated lead doctor. Patients approaching the end of their lives were identified on a palliative care register. The evolving care needs of each of these patients were discussed at monthly multi-disciplinary team (MDT) meetings involving the district nursing team and the Macmillan service. Each patient's care plan was constructed using a model known as 'preferred priorities of care'. The template set out, for example patients' preference at the time of their death and decisions made about resuscitation in a medical emergency.

Management, monitoring and improving outcomes for people

We saw that the practice made use of a NHS information tool called the 'urgent care dashboard' (UCD), a NHS computerised information tool, to help them to identify and support patients who were most at risk of unscheduled hospital admissions. The UCD collates data on contacts with this group of patients by the hospital, the minor injuries unit, the out-of-hours service and the 111 service. Many of the patients in this group were in two local care homes and the practice had provided a commitment to those homes which included a dedicated telephone line that bypassed the usual telephone queueing system. In this way the practice were able to prioritise early treatment of significant conditions in this group of patients. For example, the practice had agreements in place to expedite the dispensing of anti-infection or pain management medicines that might be required urgently.

The practice had a proactive approach to monitoring performance through clinical audits and the analysis of data on a regular basis. Clinical audits are performance assessment processes that identify the need for improvement then measure performance once improvements or changes have been made to see whether they were effective. In addition to the audits on prescribing practices for antibiotics and of the use of a particular medicine for patients with diabetes that we discussed in 'safe', above, we also looked at a number of others. For example, we reviewed completed clinical audit cycles on the effectiveness of minor surgery and on the use of long acting reversible contraception. These demonstrated the practice's diligent approach to using research and information to improve outcomes for patients for a diverse range of treatments.

Effective Staffing, equipment and facilities

The practice employed staff who were appropriately skilled and qualified for their role and supported them with an effective training regime. This included an induction

Are services effective?

(for example, treatment is effective)

process for new staff members who were mentored through a probationary period. We found evidence that showed this was comprehensive and effective for the staff members concerned.

We also found that there were effective record-keeping arrangements in place that helped the practice to be assured that all clinical staff maintained their registration with their relevant professional bodies. We noted that all such staff were up to date with their continuing professional development. For example, the practice nurses described to us how they had been supported to receive additional specialised training in key aspects of their role which the practice had funded.

We also saw that non-clinical staff received appropriate support; this included appropriate levels of training in safeguarding, basic life support and infection control. The practice was supportive of staff who wished to attend training and continue their personal and professional learning and development.

Staff received annual appraisals that were relevant and meaningful and which were undertaken by the management team. For example, the nurses we spoke with told us that they received an annual appraisal with one of the GPs which helped to support their clinical practice. The appraisal process was set out in a written framework and was designed to identify achievements throughout the year and any future learning and development opportunities.

The practice did not have any regular, structured supervision in place for staff between appraisals. However, the positive, open working relationship between the staff and the management team meant that any issues, questions or concerns were dealt with straight away. Staff told us they felt supported by this arrangement.

The practice had a comprehensive 'capability' policy and supporting procedures for managing poor performance. We reviewed documentation relating to an instance when these procedures had been used effectively. The practice also had a whistle blowing policy and procedure which was available to staff should they be concerned about matters at the practice although there was no evidence of this process having been used.

Working with other services

We found that the practice engaged regularly and effectively with other health care providers and services in the area such as the health visiting service, the community matron, the emergency department of the local hospital, the out-of-hours GP service and the school nurse. The district nursing service that covered this and a neighbouring practice were based at Bottisham and it was evident that this enabled clear, effective and timely communication about patients who used that service.

All records of contact that patients had with other providers, such as the out-of-hours service or the hospital were received and scanned into the records system for clinical review. The records of all such contacts with other providers, such as information about attendances at the accident and emergency department, hospital discharge letters and test results were reviewed by a GP each day. This ensured that the practice retained clinical oversight of their patients' encounters with other health services and could coordinate any further or follow-up actions that were indicated.

We also saw that the practice shared key information with the out-of-hours service and the ambulance service about patients nearing the end of their lives, particularly information in relation to decisions that had been made about resuscitation in a medical emergency. This ensured that patients' preferences about their death could be fulfilled. Furthermore, we noted that the monthly MDT meetings that were set up to monitor patients' end-of-life needs also discussed the death of each patient once they had passed away. This was in order to review whether the circumstances of their death had been in accordance with their plan and their preferences about their death.

We also noted that the practice was proactive in their engagement with two local care homes to which they provided regular, scheduled visits as well as visits when required. The arrangements with the care homes included dedicated meetings with the management of the homes to discuss the needs of individual patients and of the people living at the homes in general.

Health, promotion and ill-health prevention

We saw that the practice identified patients who required extra or a particular kind of support. For example, we have already noted the arrangements for people receiving end-of-life care. We also saw that there was a system for identifying patients who were caring for others and for ensuring they received support according to their own needs. There was a dedicated section of the notice board

Are services effective?

(for example, treatment is effective)

providing information about additional support for carers and the practice operated a 'carer's prescription scheme'. This scheme facilitated access for carers to other services that could provide additional support.

As part of their core services, the practice ran a range of clinics and programmes for people with long term health needs, either as discrete clinics or as part of range of regular health reviews. For example, there were separate clinics for diabetes and respiratory conditions as well as a fortnightly ante-natal service. This was supported by designated lead members of the nursing team for respiratory conditions and diabetes.

Other programmes included childhood immunisations, flu and shingles vaccinations, cervical screening and the adult health check programme for patients aged 45 to 74.

Patients had access to a range of information in the reception area about various health issues such as diabetes, respiratory conditions and heart disease. We also noted that there was a highly prominent 'seasonal' information section which focused patients' attention on a particular and different health promotion topic which was changed periodically. At the time of our inspection the seasonal section carried a range of detailed information about flu; its causes, preventative measures, treatment and the vaccination programme. We learned from patients and staff we spoke with that the seasonal section had recently also focussed patients attention on other key issues such as heart disease and diabetes.

The practice web-site was detailed and informative and signposted patients to information about healthy living and the promotion of 'self-care'. There were also prominent web-site sections that linked to other national organisations and information sources such as those specifically intended for carers, people living with dementia and people with different types of long term condition. Of note were the sections intended for families and in particular, the dedicated section for teenage health which was linked to the NHS 'live well' resource.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The people we spoke with during our inspection, including two members of the patient group, told us that the GPs and staff were caring and compassionate. Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. They said they were listened to and that their views and wishes were respected.

We also heard that the recent introduction of the electronic booking in screen had led to improved privacy. However, we received some comments about the layout of the reception making it difficult to engage in a private conversation with the receptionists. This was the case for both the main reception and the smaller waiting area for the dispensary. We observed that patients sometimes stood next to each other at the reception whilst waiting to be seen by a receptionist. On two occasions we could see conversations taking place with patients about their health which could be overheard by other patients standing next to them. This was despite the efforts of the staff members who clearly made every effort to speak quietly and discreetly and a prominent sign asking people to respect privacy of other patients. The practice manager told us that a room could be made available for patients wishing to speak in private.

We received 22 comment cards that were completed by patients visiting the practice in the days leading up to our inspection. Without exception, the comment cards reported positive experiences of patients in relation to their treatment. Some of the cards referred to GPs and staff by name, singling out individual examples of kindness, care and compassion. Several of the comment cards referred to the care that patients received as being 'exceptional'.

We looked at data from the 2013 National Patient Survey. We noted that 96% of patients stated they would recommend the practice with 97% stating that they felt the practice was good or very good; these were among the highest ratings nationally. 96% of patients reported that the reception staff were helpful. The survey also showed similar high satisfaction rates for patients who thought they were treated with care and concern by the nursing staff and by their doctor. This data was reflected in our observations on the day of our inspection. We observed a number of interactions between staff and patients where people were consistently treated with respect, compassion and dignity, both in person and on the telephone.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a doctor.

We noted that patients' relatives were also supported once they were bereaved by way of a consultation with a GP to determine whether they needed any additional emotional or practical support.

Involvement in decisions and consent

We found that patients were involved in decisions about their treatment. The National Patient Survey showed that, on average, 93% of patients felt the GP was good giving them enough time, good at listening to them and good at explaining test results to them. 87% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were higher than those for both the local Clinical Commissioning Group (CCG) area and for England in general.

Patients we spoke with on the day of our inspection told us that their diagnoses were explained well by their GP and that this enabled them to make informed decisions. We also saw that the provisions of the Mental Capacity Act 2005 were used appropriately and that assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. For example, we spoke with the managers of the care homes that the practice served and asked them how the GPs carried out assessments of people's capacity to make decisions about resuscitation in the event of a medical emergency. It was evident that the GPs involved relatives and care staff who were caring for people in all discussions about patients' capacity to consent, and in any subsequent decisions made in their best interests about resuscitation.

Are services caring?

We also saw that the practice applied well established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without agreement from a person with parental responsibility.

Where there was doubt about whether a patient could understand information about their care and treatment, the practice took steps to ensure the patient was involved. For example, we learned that a specialist service was engaged to aid communication with a particular patient with a learning disability.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

During our interviews with the staff at the practice, it was evident that they worked hard to understand the needs of their patients. Both the clinical and non-clinical staff we spoke with demonstrated a clear understanding of the concept of providing individual, personalised care for the patients according to their needs. For example, the practice had identified the small proportion of their patient population who were considered most vulnerable and at risk of unscheduled hospital admissions and had drawn up personalised care plans for them.

The practice recognised the particular nature of its patient population group and had sought to address specific needs and develop services to meet those needs. Two examples illustrate the practices' approach to this. Firstly, we have already described the proactive arrangements the practice have taken to understand and provide a service for the people living in the two care homes nearby, including dedicated, scheduled visits and meetings with the management of the homes.

Secondly, we learned of a meeting the patient group had held with the local college at the request of the practice. The purpose of this was to try and understand the specific health needs of the student population, to explore ways of engaging with younger patients and to see what health advice the college was offering to students. The outcome of this was the provision of information to students, through the college, about the availability of confidential chlamydia screening and the provision of additional information on the practice web-site aimed at teenaged patients. The practice was also in the process of using anonymised data from the college's student questionnaire in order to help them to understand where there were gaps in health provision although this piece of work had not yet been completed at the time of our inspection.

Due to the practice's rural location, they had accommodated specific local, independent services who ran occasional sessions within the practice such as a podiatrist, a physiotherapist, a counsellor and hearing aid provider. In addition, the practice nurses told us how they linked up with specialist teams, such as the community respiratory team and the community diabetes team for regular case discussions about patients' needs and their care and treatment plans.

Access to the service

We found that the practice was accessible, with appointments that could be made in person or on the telephone. Appointments were available between 8.30am and 6pm each working day. Patients who needed to see a GP that day could do so at the end of the normal appointment list or could book a telephone consultation. Patients wishing to see a GP outside of these hours would access another out-of-hours provider whose details were shown on the practice web-site.

Repeat prescriptions could be ordered online or in person and were available for collection within 48 hours. The staff we spoke with told us that if patients could not attend specialist clinics at the published clinic hours that arrangements would be made to see patients at other times.

The 2013 National Patient Survey showed that 97% of patients said they could get an appointment to see or speak to someone whilst 86% described their experience of making an appointment as good. These were higher than the average ratings for practices in the Clinical Commissioning Group area and for England as a whole.

This was borne out in our interviews with patients on the day of our inspection. Patients told us that if they wanted to see a particular GP they could generally do so if they were prepared to wait a couple of days but that they would always be seen on the day in the case of an emergency or urgent need. None of the comment cards we received raised any issues about appointment availability.

The practice was a modern, purpose-built, medical centre and there was appropriate access for people with limited mobility, with level flooring to the outside and wider doors.

Meeting people's needs

We saw that the practice web-site had an automatic translation facility which meant that patients whose first language was not English could gain 'one-click' access to information about the practice and about NHS primary medical care. The practice also utilised interpreting services for pre-booked face-to-face appointments with patients who required this help. We spoke with a member of the reception staff who showed us how they would

Are services responsive to people's needs?

(for example, to feedback?)

access information in other languages on the internet should any new patient arrive at the practice who could not speak English. However, we were informed that these instances were very rare.

We saw that the practice knew many of its patients well and had developed ways of responding to patients' individual needs. For example, we heard of an arrangement the practice had made with the ambulance service to meet the particular needs of one patient with a mental illness.

Staff we spoke with demonstrated that they were aware of the importance of understanding patients' individual needs and putting patients first when co-ordinating referral pathways with other providers. We heard of a number of examples that illustrated this way of thinking. We asked patients about their experience of being referred onwards to other services. Without exception, all of the patients we spoke with reported that they had received a good service from the practice with any necessary follow-up action being carried out straight away. This included the immediate notification of test results. Several of the 22 comment cards also reported positive experiences of being referred onwards to other services and of the practice's role in keeping them informed.

Concerns and complaints

The practice had a system in place for responding to complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England with a designated person responsible for handling all complaints in the practice. All staff we spoke with understood the complaints policy and there was clear information both on the web-site and in the practice in leaflet form. The practice leaflet did not contain any information about independent support or advocacy for people who wished to complain, although this information was available on the practice web-site.

Patients we spoke with on the day of our inspection told us they had never had cause to complain but that they would complain to the practice manager if they needed to. All the patients we spoke with felt that the practice would respond positively to any complaints.

Staff told us that they had a culture of learning at the practice and this also applied to complaints. They said that complaints were discussed at staff meetings although there had been no such complaints to discuss recently. We saw examples of occasions when complaints had been made where the practice had taken action and made changes to the way they operated as a result. Information provided to patients about the length of time they would have to wait for repeat prescriptions to be processed had been modified as a result of one such complaint for instance.

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

It was clear from our interviews with the management team, the GPs and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. This was reflected in the practice statement of purpose that was posted on the practice web-site that staff were able to draw our attention to. We also saw that there was a policy statement on the web-site that set out what patients had a right to expect from the practice and it was evident during our inspection that staff believed in and adhered to this.

Staff members we spoke with told us they felt their contribution to providing good quality care was valued. They told us that they welcomed the opportunity to raise issues with the GPs and the management team as part of the 'open door' policy. This was also reflected in the arrangements for training staff and an appraisal system that was supportive, meaningful and driven by individual objectives.

The practice had a clear picture of its future make-up in terms of its personnel, its environment and its service provision. For example, the practice had undertaken a strategic review of its business using an analysis of its strengths, weaknesses, opportunities and threats (SWOT analysis) in 2013. The SWOT analysis had identified the need to plan for the retirement of two of the GPs in the following two to five years. We also saw that this review had resulted in plans to re-occupy another building on the site of the practice**.** This has enabled the practice to consider how it might put additional services in place, such as community services or outreach secondary care services, although these plans would not come to fruition until 2016.

Governance arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business, such as the designated lead nurses for diabetes and infection control. All of the GPs had lead roles for different clinical aspects according to their own areas of interest. We saw that the practice also had a designated 'Caldicott Guardian', the person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.

As well as having robust strategic governance in place, the practice also had clear systems and processes that enabled it to operate effectively. We saw, for instance, that key policies were monitored by a member of the management team and were delegated to key members of staff with particular expertise when they were due for review. This ensured that policies and protocols were relevant and reflected current guidance.

There was also a system for managing variable performance of staff that was robust as well as being fair and proportionate. We found evidence of this process being applied effectively.

Systems to monitor and improve quality and improvement

The practice held weekly governance meetings involving the GPs and the practice management team during which decisions were made about clinical issues. Other issues relevant to the running and development of the practice were also discussed such as significant events, safety alerts, complaints and clinical audits. As we have commented in the section on 'safe' and 'effective' above, this demonstrated the practice's diligent approach to using information to improve outcomes for patients.

The weekly practice management meetings were supported by quarterly extended meetings. During these meetings the management team reviewed those areas of its business that were affected by the practice delivery and membership agreement (PDMA) they shared with other local GPs. This included, budgets, prescribing and referral patterns. In this way the practice had oversight, not only of their own service provision, but also of the service provision across the local area.

Patient experience and involvement

The practice was proactive in seeking feedback from patients about its services and it did this in a co-ordinated way. The practice used a well-established annual survey tool known as the General Practice Assessment Questionnaire (GPAQ) to gather patients' views. This survey

Are services well-led?

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

was carried out by the practice in 2011 to 2012, 2012 to 2013 and 2013 to 2014. Information from the survey was used by the practice to improve its services in addition to information obtained through the national patient survey.

The practice also engaged with a patient group. Such groups, often referred to as patient participation groups, are made up of practice staff and patients that are representative of the practice population. They operate with the aim of ensuring that patients are involved in decisions about the range and quality of services provided. Bottisham Medical Practice was actively engaged with its patient group and there was clear information both in the reception and on the web-site about the make-up of the group and about how patients could become involved. The patient group also helped to raise the profile of the practice by contributing a monthly article about it to the local village magazine. The group had contributed some of the questions to the 2013 to 2014 GPAQ to elicit the views of patients about its role and what it had to offer.

One of the patient group's main roles was to help the practice management team to devise an action plan arising from the GPAQ results and from their own canvassing of patients' views during visits to the reception. We saw that the practice and the patient group had agreed a joint action plan for the previous two years that was posted on the web-site. The action plan had been successful in ensuring patients' views were taken into account when planning services. For example, we saw that the action plan arising from 2012 to 2013 showed that improvements had been made to the way information was conveyed to patients waiting in the reception area by means of a TV screen. We also saw that suggested improvements to reception staffing levels at peak times had also been achieved.

The patient group had also been responsible for a number of initiatives in the practice that improved outcomes for patients. Such initiatives included improving a voluntary transport scheme that was linked to the appointment booking arrangements to help less mobile patients get to the practice. Other examples included the introduction of a 'Heart Start' session to help patients learn how to deal with life threatening situations, and the regular 'walking group' that promoted exercise and access to the community. We considered that the activity generated by the patient group and the responsiveness of the practice to the work of this active group was an example of outstanding practice.

Management lead through learning and improvement

The practice was effective in ensuring its staff performed well and operated within a learning culture. We have reported above that staff received annual appraisals that were relevant, meaningful and driven by objectives. The emphasis in this process was on development, promoting opportunities to learn and improve and on maintaining good clinical practice. This was mirrored in the practice's approach to monitoring quality and performance through the use of clinical audits and the review of significant events.

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

The practice participated in a scheme organised by their patient group where volunteers drove patients to the practice for their consultations. The scheme was linked with appointment availability.

The practice registered all patients over 75 years old as part of their multi-disciplinary team caseload. This was in addition to those patients who were receiving palliative care or were approaching the end of their lives. Patients receiving end-of-life care had care plans in place that outlined their preferences and these were shared with the out-of-hours and ambulance services.

Patients who were unable to get to the practice were visited by GPs in their homes. The practice also had specific arrangements with two local care homes. This included holding regular meetings with the management of the homes to consider the needs of patients living there and a dedicated telephone line that bypassed the main telephone queueing system. GPs carried out three 'ward rounds' each week at the larger of the two care homes and one ward round at the other so that patients' needs were considered regularly.

The practice actively targeted older people to attend flu and shingles vaccination clinics. All patients over the age of 75 were being provided with a named GP to help achieve continuity of care and reduce risk to them.

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 maintained registers on the computer system of people with long term health needs such as diabetes and chronic respiratory conditions. These registers were used to manage the recall of patients for review. The practice had a dedicated clinical lead for each of these areas.

Frequent diabetes clinics were run by two of the practice nurses who had received specialist diabetes training. The needs of patients with type II diabetes were discussed quarterly with the lead GP and practice nurse from Bottisham, and a specialist diabetic nurse and diabetic consultant from the local hospital, to ensure consistent best management and practice.

Patients with respiratory conditions had access to regular spirometry at the practice, a process which helps to assess their lung function. The practice also carried out reviews for patients with asthma.

The practice recently carried out prescribing audits for patients with diabetes and respiratory conditions and the outcomes were discussed between the GPs in order to ensure best practice was followed.

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

Weekly pre-natal checks and baby immunisations clinics were carried out at the practice. Six-week post natal checks were also carried out.

The school nurse, health visiting team and community nursing team were based at Bottisham Medical Practice which enabled effective joint working. All of the children registered at the practice who were known to be at risk were monitored and discussed at monthly internal meetings to which the community teams were invited. This helped to inform the practice's contributions to multi-agency meetings set up under local authority safeguarding procedures. The practice utilised a clear and robust child safeguarding protocol.

The practice had worked with its patient group to establish links with the local community college to help to provide information to students about the availability of confidential chlamydia screening. The practice was also in negotiations with the college about using anonymised data from the college's student questionnaire in order to help them to understand where there were gaps in health provision.

There was also a dedicated area of the practice web-site that provided a range of health advice for teenaged patients linked to the NHS 'Live Well' resource. The practice followed established guidance for assessing the competence of a young person under 16 to provide consent to care and treatment in their own right.

The practice provided a contraception service with a dedicated clinical lead that fitted contraceptive implants. This contraceptive service was also subject of a clinical audit to ensure best practice was followed.

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 a range of different appointments to enable working age people to attend the surgery. These included GP, nurse and blood-taking appointments that were pre-bookable up to four weeks in advance, appointments that were released 'on the day' and minor illness or injury appointments.

Minor surgery and contraceptive fitting clinics were planned according to the number of patients who required these services.

The practice also carried out adult health checks for patients aged 45 and above who did not have a pre-existing medical condition. The practice also provided cervical smear tests.

The practice were proactive in enabling patients to understand and support their health needs. With the patient group, they had held an educational talk on ageing, a 'Heart Start' session to help patients learn how to deal with life threatening situations, and a regular 'walking group' that promoted exercise and access to the community.

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 accepted patients on a temporary residence basis if this was required and any person whose treatment was regarded as immediately necessary.

The practice held a register and provided annual health checks for people with a learning disability.

The practice had a vulnerable adult safeguarding protocol in place. The practice also followed guidance set out under the Mental Capacity Act 2005 to assess the capacity of certain patients to consent to care and treatment where that capacity was in doubt.

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

The practice maintained a register of patients with mental ill-health, patients who were depressed and patients who were living with dementia. There was dedicated lead clinician for mental health who was leading an on-going review of local mental health services on behalf of the local commissioning group.

Patients with dementia were offered an annual health check. This included patients living with dementia at the local care homes.

The practice operated a system for recalling and reviewing such patients and followed appropriate guidance set out under the Mental Capacity Act 2005 where this was necessary.