Comberton Surgery

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.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

There was an effective system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. Safeguarding procedures were good and risks to patients were assessed and well managed. Patients received care in an hygienic and clean environment and medicines were managed well.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all members of staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they felt that they were treated well by all members of staff, and that they were involved in decisions about their care and treatment. The practice proactively identified and supported patients with extra needs

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice offered a wide range of services, and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. The practice sought feedback from its staff which it acted on.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice provided effective and consistent support to residents living in two local care homes.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. GPs worked with relevant health and care professionals to deliver a multidisciplinary care package to patients with the most complex needs. Nursing staff were experienced and well trained in chronic disease management, and patients at risk of hospital admission were identified as a priority. There was an efficient and effective recall system in place.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered a wide range of family planning advice and treatment to all age groups.

Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances might make them vulnerable. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing,

Summary of findings

documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with significant mental health problems had annual mental health and medicines reviews, and many had their own care plan in place. The practice participated in the proactive identification scheme for patients with dementia, and its performance for dementia and depression related performance indicators was above local and national averages. However, performance for some mental health indicators was lower than these averages.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 2 July 2015, The results showed the practice was performing above local and national averages in most areas. 255 survey forms were distributed and 126 were returned.

- 88% found it easy to get through to this surgery by phone compared to a CCG average of 76 % and a national average of 73%.
- 91 % found the receptionists at this surgery helpful (CCG average 88%, national average 87%).
- 88 % said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 86 % described their experience of making an appointment as good (CCG average 77%, national average 73%).
- 68 % usually waited 15 minutes or less after their appointment time to be seen (CCG average 65%, national average 65%).

We also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 completed comment cards and respondents commented that getting appointments was easy, that staff understood their health concerns and the practice was clean.

We spoke with 11 patients during the inspection. All 11 patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. However we received mixed feedback about the practice's newly installed automated telephone appointment booking service, with some patients welcoming it, and others disliking the fact they were not able to speak to an actual receptionist.

We received particular positive feedback from the managers of two care homes about the skill and competence of the regular GP who visited their homes.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Improve the ways patients are able to contribute to the development of the practice
- Improve checks on emergency equipment to ensure that defibrillator pads are within the date for their safe use.

Comberton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor and two additional CQC inspectors.

Background to Comberton Surgery

Comberton Surgery is a well-established GP practice that has operated in the area for many years. It serves approximately 9,300 registered patients and has a general medical services contract with NHS Cambridgeshire and Peterborough CCG. It is located in an affluent area of South Cambridgeshire . The service is delivered from two sites, one in the village of Comberton and the other close by in Eversden. A dispensary is attached to each site.

According to information taken from Public Health England, the patient population has a higher than average number of patients aged 45-74 years, and a lower than average number of patients 15-39 years compared to the practice average across England.

The practice consists of five GP partners, two salaried GPs, four nurses and a health care assistant. A number of dispensing and administrative staff support them. It is a teaching practice involved with the training of GPs and medical students.

The branch at Comberton is open between 8am to 6pm Monday to Friday; the branch at Eversden is also open during these hours but closes on a Thursday afternoon from 12.30 pm. In addition to this, the dispensary at Comberton is open from 8:30 to 10:30 am on a Saturday for the collection of pre-ordered medication.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 December 2015. During our visit we spoke with a range of staff including GPs, nurses, dispensers and administrative staff. We reviewed a range of the practice's policies and procedures and a small sample of anonymised patient treatment records. We also reviewed comment cards where patients and members of the public shared their views and experiences of the service. We visited both branches of the practice.

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

- Is it safe?

Detailed findings

- 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
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff told us they would inform the practice or dispensary manager of any incidents, and there was also a recording form available on the practice's computer system.

We reviewed the reports of seven significant events that had occurred in the practice's dispensary. The records contained good information about each incident and what had been learnt from them. We noted that both the dispensary manager and the senior partner reviewed each report before signing it off. Staff we spoke with were aware of recent significant events that had occurred and told us of one which had led to a change in the way patients' letters were addressed.

Significant events were a standing item at the weekly partners' meetings, and minutes we viewed showed they were regularly discussed there, as well as the practice wide meetings so that learning from them could be shared. One GP told us that they particularly valued significant events discussions as they highlighted areas where they hadn't performed well. In addition to this, the practice manager told us he undertook quarterly reviews of all significant events and complaints that occurred in order to identify themes and patterns, although a record of this was not kept.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency, and we viewed emails from the dispensary manager to GPs informing them of recent safety alerts in relation to medications. We found good evidence of patient searches that had been undertaken in response to these alerts to ensure that any changes required were implemented.

Overview of safety systems and processes

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The lead GP for safeguarding told us she had recently attended training in female genital mutilation, which had helped increase her understanding of the issue.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. We noted that the practice's safeguarding procedures were discussed at a practice wide meeting in July 2015 to ensure staff knew who the leads were in the practice, and where they could find guidance about protecting patients.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice held quarterly meetings with the local health visitor and school nurses to review any children and young people on the practice's safeguarding list . We viewed notes from the safeguarding meeting of 21 September 2015 where a list of patients with safeguarding concerns was discussed. Although actual minutes of the meeting were not kept, we saw that patients' notes had been updated with relevant information from this meeting.

The practice had a chaperone policy and notices in the waiting and treatment rooms advised patients that chaperones were available if required. Chaperoning was provided by the nurses, health care assistant or experienced reception and dispensing staff. They had received training and had been checked with the disclosure and barring service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Infection Control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice had a named lead for infection control and also conducted its own comprehensive infection control audits, evidence of which we viewed. Infection rates following minor surgery were monitored closely and the most recent audit showed there had been no infections.

Good

Are services safe?

We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, corridors, meeting rooms and treatment rooms. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. There were posters providing prompts above each sink reminding staff of the correct way to wash their hands. We saw that sharps boxes had been assembled and labelled correctly. There were foot operated bins and personal protective equipment available in each room to reduce the risk of cross infection. Some treatment rooms had carpets on the floor, however we were told that these were to be replaced with more suitable flooring as part of refurbishment.

Medicines management

The practices dispensaries were both well managed and patients we spoke with told us they received an efficient dispensing service run by pleasant and helpful staff. They reported that it was easy to order repeat prescriptions and the quality of advice given by dispensing staff was good. Patients could access medicines urgently if needed, and the dispensary at Comberton opened on a Saturday morning for patients to collect their medicines. However, the dispensary hatch at this site where patients collected their medicines was not particularly confidential, and conversations between dispensing staff and patients could be easily overheard.

Both dispensaries where medicines were stored were well organised, secure and clean. We found that medicines were stored safely. The practice had detailed written procedures in place for a wide range of dispensing activities which reflected current practice. These were updated each year by the dispensary manager. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were to be managed. We checked a small sample of controlled drugs (CDs) at each dispensary and found appropriate records were kept, and the amount in stock tallied with the amount recorded as being in stock.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Records we viewed demonstrated that all members of staff involved in the dispensing process were very well qualified and their competence to undertake a range of dispensing tasks had been assessed. A wide range of audits were undertaken to ensure that patients received their medicines safely and in line with national guidance.

We saw a positive culture in the dispensary for reporting and learning from medicines incidents, errors and near misses. Minutes of meetings showed that incidents were reviewed and that appropriate actions were taken to minimise the chance of similar errors occurring again.

There was good GP oversight and accountability for medicines and all prescriptions were reviewed and signed by a GP before they were given to the patient. There was a robust system in place for the management of high-risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included the regular monitoring of patients' bloods in accordance with national guidance.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. One staff member was pleased by the purchase of new ECG monitoring equipment, where the results were automatically uploaded onto the computer. All equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this.

Staffing and Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed four personnel files and found that appropriate recruitment checks had been undertaken prior to staff's employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

We spoke with a recently recruited nurse to the practice who described her recruitment as 'thorough'. She reported that her induction training had been excellent and she had received good support from a mentor. She was new to practice nursing but was very impressed at the level of

support and training she had received for her role. This was also echoed by the GP trainee who told us that her induction training was especially good in comparison to colleagues in other practices.

Staff told us there were enough of them to maintain the smooth running of the practice and that there were always enough staff on duty to keep patients safe. The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and these were reviewed regularly. The practice had specific rules in place for both GPs and non-clinical staff to ensure minimum staffing numbers during holiday periods. There were clear GP buddy arrangements in place to cover clinical work.

Monitoring risks to patients

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Regular checks of the buildings and their environment were completed to ensure both staff and patients were safe. We viewed evidence in relation to health and safety including fire safety, hazardous waste, water temperature recording, portable appliance testing and electrical wiring, which showed that the practice maintained a safe environment for staff and patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and there was an on-call GP on duty throughout the day. Records showed that all staff had received training in basic life support. Emergency equipment including oxygen and automated external defibrillators (used in cardiac emergencies) were available in the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly by nursing staff. However despite these regular checks we found that the pads for one of the automated external defibrillators were beyond their expiry date for safe use.

Emergency medicines were easily accessible to staff and all staff knew of their location. Processes were also in place to check that emergency medicines were within their expiry date. All the medicines we checked were in date and fit for use. The GPs did not routinely carry emergency medicines for use in acute situations when on home visits, however they informed us they were in the process of reviewing this.

During our inspection a patient emergency occurred which resulted in an ambulance being called: we noted staff dealt with this quickly and professionally.

There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice such as the loss of premises, electrical power, or the telephone system. This plan had been reviewed regularly and copies of it were kept off site by senior staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of, and worked to, guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment.

We viewed minutes of the GPs' and nurses' meetings for the previous six months which showed that a range of issues was discussed including latest NICE guidance, clinical protocols, local health services and treatment referral pathways. For example, at the meeting of 12 October 2015 one of the GPs went over the new guidelines in relation to diabetic patients and changes were made to the computer template as a result of these. At the meeting of 28 September 2015, it was decided to review the practice's asthma pathway against the latest NICE guidance. The practice had created a number of clinical templates to use, which automatically triggered relevant guidance and advice in relation to treatment options. One of the nurses reported that she was part of a national practice nurse forum and received regular NICE and Green Book (information on vaccines and vaccination procedures) alerts by email, all of which helped keep her practice up to date.

The pharmacy manager sent regular updates to clinicians informing them of any medicines alerts or changes in the British National Formulary.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed that the practice had achieved 97.9% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed;

- Performance for diabetes related indicators was at 95.3%. This was 5.8 percentage points above the CCG average, and 6.1 percentage points above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100%. This was 1.9 percentage points above the CCG average, and 2.2 percentage points above the national average.
- Performance for mental health related indicators was 88%. This was 3.9 percentage points below the CCG average and 4.3 percentage points below the national average.
- Performance for dementiarelated indicators was 100%. This was 5 percentage points above the CCG average and 5.5 percentage points above the national average.

The practice had identified its patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. Personalised care plans had been developed for these patients to improve the quality and co-ordination of their care. GPs rang these patients following their discharge from hospital to check that their needs were being met, and to understand the reason for their admission. Emergency hospital admission rates for the practice were slightly lower at 10% compared to the national average of 14% .

The practice took part in a CCG referral support scheme which, one GPs told us, had led to an improvement in the quality and appropriateness of the referrals it made.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice undertook both clinical and non-clinical audits that it used to monitor quality and systems to identify where action should be taken. For example, we saw that full cycle audits had been completed to evaluate chronic obstructive pulmonary disease treatments, gout, and antibiotic prescribing, which had led to improvement in patient outcomes. The practice had undertaken an audit to assess the impact on hospital admission of having a regular weekly GP visit to two local care homes. The audit showed that the number of hospital admissions by residents had greatly reduced as a result. In August 2014, the practice had employed a specialist company to run searches to ensure the accuracy of its coding and data quality. The practice manager told us these same searches were now run regularly to ensure standards were

maintained. More recently, another company had been commissioned to complete an osteoporosis audit to check that the practice was prescribing appropriate and cost effective treatment to patients. A second cycle had been completed which showed improved results, with more patients receiving the correct treatment.

The practice was an accredited research practice and participated in applicable local audits and research. For example, it was participating in the Very Brief Interventions study (VBI) run by Cambridge University to assess the efficacy and cost effectiveness of brief interventions to increase physical activity among adults attending NHS Health Checks. It had also participated in a study about the use of the drug theophylline in the treatment of chronic obstructive pulmonary disease.

In addition to formal audits, the practice ran regular searches of patients to check, for example, the uptake of flu vaccinations; that patients had been informed of their named GP, that paperwork had been completed correctly for temporary residents.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The GP to patient ratio was above national average at one GP for every 1,550 patients, (national average is one GP for every 1800 patients).

We found staff to be knowledgeable, well qualified and experienced for their roles. For example, the dispensary manager was a clinical chemist; five dispensers had achieved an NVQ Level three in pharmacy service skills, and the practice's health care assistant was a former nurse. Staff told us they had good access to training and were well supported to undertake further development in relation to their role. A newly recruited nurse stated that she had received more training in the first few months of her job at the practice than she had received in nine years with her previous employer. Reception staff had undertaken training in information governance, customer services skills, mental health and complaints handling which they told us they had found useful.

Each month the practice held education meetings where outside speakers were invited to attend. In September 2015 a speaker from a local exercise referral scheme attended, as did representatives from the local mental health trust to keep the GPs up to date with local services and care pathways. A trainee GP told us that training and learning from each other was given a high profile within the practice, and she had recently delivered a presentation on military veterans' health at the GPs' meeting. The practice's senior partner regularly provided educational sessions for staff.

There was a structured system for providing staff in all roles with annual appraisals of their work and for planning their training needs. Staff we spoke with told us they found their appraisal useful. However, there was no regular peer review process in place for the GPs, other than opportunistically via the duty doctor system. One GP told us they would greatly welcome the opportunity to sit in on the senior partner's consultations to learn how he did them so well and efficiently.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and the practice had been chosen as a first test environment because of the IT skills of its staff.

The practice held multidisciplinary team meetings to discuss patients with complex needs, such as those with multiple long term conditions and those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and the community matron, and decisions about care planning were documented in the patients' records. A district nurse told us that the meetings were well attended and assured a community wide response to patients' needs.

Care plans were in place for patients with complex needs and shared with other health and social care workers as

Good

Are services effective?

(for example, treatment is effective)

needed. The practice had implemented Summary Care Record for patients. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency.

District nurses told us they had regular contact with the surgery and that staff were always quick to email and update them with patient information . The practice manager told us he worked well with the GP liaison worker at Addenbrookes hospital to discuss patients' needs.

The practice provided GP care to older people living in two local care homes. Representatives from these care home confirmed that the practice worked with them in a supportive and helpful way.

Consent to care and treatment

Patients we spoke with told us that they were provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

Training records we viewed showed that all staff (both clinical and non-clinical) had received training in understanding mental capacity. All the clinical staff we spoke with understood the key parts of Mental Capacity Act (MCA) legislation and were able to describe how they implemented it in their work. One GP was able to describe a situation where a terminally ill patient's wish to decline medical intervention was respected as they had the mental capacity to make this decision for themselves.

Care home representatives told us that the practice's GPs were good at involving families in important resuscitation decisions for their residents who could not make those decisions for themselves. One commented that the GPs had a particularly good knowledge of deprivation of liberty safeguards and the need for a coroner's inquest for residents subject to these safeguards.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Written patient consent forms were used for minor surgery.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice had an informative website which provided information about a wide range of health and care topics and there were leaflets in the waiting rooms, giving patients information on a range of medical conditions. Smoking cessation clinics were held regularly at the practice.

The practice had two blood pressure monitoring machines which patients were encouraged to use, as well as completing a health questionnaire, whilst they waited to be seen. Respiratory checks were offered to all smokers.

Patients had access to appropriate health assessments and checks. These included health checks for people aged 40–74 years who were sent a letter inviting them in for the check. Figures given to us by the practice showed that 131 patients in this age group had received an annual health check in 2014/2015.

The practice also offered health checks for patients with a learning disability. The practice had 19 people with a learning disability on its register, and had already completed 10 checks in 2014/2015. The practice manager had identified this as an area of improvement for the practice.

Figures given to us by the practice showed that 93% of patients with diabetes, and 99% of those with chronic obstructive pulmonary disease had received an annual health review.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%.Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 100 % and five year olds from 95 % to 99%. Flu vaccination rates for the over 65s were 78%, and at risk groups 58%. These were above national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Reception staff we spoke with had a good understanding of the importance of patients' confidentiality and spoke knowledgably about the practical ways they maintained it. The practice's patient dignity policy offered detailed and very practical guidance on how promote patients' privacy and dignity in the reception areas, and also during a consultation.

Patients' privacy and confidentiality at the reception areas at both sites was compromised as conversations between reception staff and patients could be easily overheard. However, we noted a poster advising patients to let receptionists know if they wanted to speak confidentially to them, and a rope barrier had been placed to encourage patients to stand back from the area. We spent time in the waiting area and observed a number of interactions between the reception staff and people coming into the practice. Overall, the quality of interaction was good, with staff showing empathy and respect for patients. Clinicians called through patients into consulting rooms in person, and in a friendly and professional manner.

We noted that consultation and treatment room doors were closed during consultations, and that conversations taking place in these rooms could not be overheard. Consultation rooms had window blinds and curtains round treatment couches to maintain patients' privacy during intimate examinations.

The GPs ran personal patient lists, allowing them to get to know their patients and providing continuity of care. This was something that patients we spoke with greatly valued. The practice's routine appointment times were 12 minutes, longer than national averages, allowing clinicians more time to listen to and assess their patients. Staff told us they regularly rang patients living with dementia to remind them of their appointment time.

We received consistently good feedback both from the patients we spoke with, and the comment cards we received, about the helpfulness of the practice's staff. Results from the national GP patient survey showed patients felt they were treated well by the practice's staff. The practice was above the average for its satisfaction scores on consultations with doctors and nurses. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 94% said the GP gave them enough time (CCG average 88%, national average 87%).
- 98% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 90% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 93% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 90%).
- 91% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)

Care planning and involvement in decisions about care and treatment

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

We spoke with the managers of two local care homes who knew the practice. They told us that the GP who visited involved residents in decisions about their care and were also good at listening to, and consulting with, their staff about the best way to manage residents' health needs. They reported that the GP consulted residents' relatives where appropriate to determine their wishes concerning resuscitation. We viewed a small sample of patients' notes and viewed that those on the practice's palliative care register had their preferred place of care recorded so that their wishes could be respected if possible.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 93 % said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.

Good

Are services caring?

- 93% said the last GP they saw was good at involving them in decisions about their care (CCG average 82% , national average 81%)

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

Patient and carer support to cope emotionally with care and treatment

The practice had implemented a 'TLC' board which alerted staff to any patients suffering from a recent bereavement, cancer diagnosis or other personal crisis to ensure that they could respond effectively and empathetically to them. All staff were aware of this board and it was updated every day to ensure it remained accurate. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer them their condolences and signpost to useful services. Care home managers reported that the GPs always ensured their residents had medication packs in place to ensure good pain control at the end of their lives.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a range of services to patients in addition to chronic disease management. including phlebotomy, anticoagulation monitoring, smoking cessation advice, minor surgery and dermatoscopy. It also provided travel advice and immunisations, and a range of contraception services. It delivered medicines to older patients in certain villages and also provided flu clinics in the community for patients who found it hard to attend the practice. The practice offered a weekly 'ward round' to two local care homes, providing regular contact and continuity of care for residents living there

The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting areas were large with plenty of space for wheelchairs and prams. However, the practice's front doors at both sites were not automatic and there was no call bell in place to alert staff that a wheelchair user might be trying to access the building. There were no portable hearing loops to assist patients with a hearing impairment.

Translation services were available if needed and the practice self-check in service was available in a number of languages.

Access to the service

Information was available to patients about appointments on the practice's website and in its patient information leaflet. Appointments could be booked in person, by telephone or on-line. The practice had recently introduced an automated appointment telephone booking service allowing patients to ring and book without having to wait for reception staff to answer their call.

Opening and closing times for the practice's Comberton branch varied throughout the week but it was generally open from 8am to 6pm Monday to Friday. In addition to these times, the dispensary was also open from 8:30am to 10:30 am every Saturday for the collection of pre-ordered medication. The practice's Eversden branch was open Monday to Friday 8am to 6pm, however it closed on a Thursday afternoon from 12.30 pm.

Appointments could be made up to a month in advance and the practice operated a GP telephone triage service each day for urgent same day requests for appointments. Our inspection took place on the 4 December 2015, the next available routine appointment was on the 14 December 2015: a period of five working days.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages, despite the practice not offering extended hours in the evening or over week-ends.

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 88% patients said they could get through easily to the surgery by phone (CCG average 76%, national average 73%).
- 86% patients described their experience of making an appointment as good (CCG average 77%, national average 74%.
- 67% patients said they usually waited 15 minutes or less after their appointment time (CCG average 65%, national average 65%).

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns and its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We saw that information was available to help patients understand the complaints system on the practice's website and in its information booklet. Reception staff showed a good knowledge of the practice's complaints procedure and spoke knowledgably about the various ways patients could raise their concerns. Leaflets informing patients about how to raise their concerns were available on reception desks.

We viewed documentation in relation to five recent complaints and found they had been fully investigated and responded to in a timely and empathetic way. A genuine apology had been given where appropriate. The practice also kept a record of informal complaints and comments from patients that reception staff received. We viewed 11 minor complaints that had been recorded since April 2014 and noted that each had been reviewed by the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

manager and action taken to address any shortfalls. For example, in response to patients' complaints about long waits for routine appointments, the practice manager had a recruited a locum GP to better meet patient demand.

One care home manager told us they had complained to the practice about the process for issuing residents' prescriptions. In response to this a GP and a pharmacist had visited the home to discuss the issue. As a result, the practice's GPs now faxed prescriptions directly to the pharmacy so that residents received their medicines sooner. The care home manager felt that the practice responded well to her concerns and was very pleased with the outcome.

Complaints were discussed with practice staff so that learning form them could be shared. We viewed the minutes of two recent practice wide meetings held in July and September 2015, and noted that complaints were a standing agenda item for both meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver 'high quality, evidence based medical care and health promotion to the local population'. Staff were aware of mission statement and told us it had been discussed in a previous staff meeting.

Practice staff were well aware of future challenges they faced including possible federation with other local practices, and the need to upskill its nursing staff to undertake a wider range of clinical tasks. One of the practice's GPs was chair of the local medical committee and several others were members. The practice manager was on the steering group of the local federation and was also a member of the primary care work force sub group. He engaged widely with a range of stakeholders.

Governance arrangements

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and the practice staff. There were clearly identified roles within the practice for both clinical and administrative areas. For example there was a lead nurse for infection control and partners took lead roles for safeguarding, training, Caldicott and QOF. Staff we spoke with were all clear about their own roles and responsibilities. Staff worked across both sites to ensure consistency in service delivery.

The practice had a number of policies and procedures in place to govern its activity and these were available to staff on the practice's computer systems. We looked at six policies and procedures and found that they were up to date and had been reviewed regularly. The dispensing manager ensured that all standard operating procedures were updated every year.

Communication across the practice was structured around key scheduled meetings. There were weekly practice meetings involving the GPs and the practice manager, monthly nurses' meetings, and regular administrative staff meetings. Practice wide meetings involving all staff were also held. Minutes of these meetings were kept and shared.

All staff received regular appraisal of their performance. One member of staff told us she had been appraised by the senior nurse and was pleased that the practice manager also viewed her appraisal so that he was aware of any issues affecting staff.

Leadership, openness and transparency

We found that the partners and practice manager had the experience, capacity and capability to run the practice and ensure high quality care. Staff clearly enjoyed their work citing good team work, support and the professionalism of colleagues as the reason. Two members of staff described the managers as 'inspirational' .

The partners held social events involving the whole practice team and their families, including summer BBQs and Christmas parties.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Minutes of all the meetings we reviewed showed that information about the practice and any challenges it faced were shared openly with staff, and that staff were actively consulted about changes. We noted that new requirements under the duty of candour had been discussed with staff at their meeting in September 2015 to ensure they were aware of the responsibility to let patients know when something had gone wrong.

Feedback from NHS Choices', Friends and Family test and complaints was regularly discussed at practice wide meetings, evidence of which we viewed.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through dispensary surveys, complaints received and its patient participation group (PPG). However, the PPG had only recently been formed and was still in its infancy. There were 43 members in total who mostly communicated by email. The practice manager acknowledged that more needed to be done to develop this group so it became an effective and critical friend of the practice.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results of these were shared at staff meetings. Since January 2015, 149 patients had responded, 147 of whom would be likely to recommend the practice.

Are services well-led?

Good

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

The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were given many examples from staff where the GP partners had listened to them, and implemented their suggestions to improve the service to patients and their working environment. For example, a driver had been employed to deliver medicines to local village post offices; new flooring had been laid in the waiting room, shelving had been purchased to make one treatment room less cluttered and staff rang patients to inform them of hospital generated medication changes.