Huntingdon Road 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	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Huntingdon Road Surgery on 5 April 2016. Overall the practice is rated as outstanding.

Our key findings across all the areas we inspected were as follows:

- Patient feedback scores from the NHS GP Survey, the Friends and Family Test (FFT) and from our own comments cards was extremely positive about the practice. Patients expressed high satisfaction levels with the service citing attentive and caring staff, continuity of GP, the quality of treatment and speedy referrals as the reasons. 174 of 176 patients who completed the FFT would recommend the practice. 88% of respondents would recommend this surgery to someone new to the area.
- GPs held individual patient lists, encouraging good continuity of care and enabling strong relations to be built up between them and their patients.
- There was an open and transparent approach to safety and effective systems in place to report and record significant events which enabled learning to be shared.
- Safeguarding was given a high priority, and the practice had comprehensive, robust and effective procedures in place to protect patients.
- Risks to patients were assessed and well managed. There was a robust programme of infection prevention and control in place which was facilitated by the infection control lead GP.
- The practice worked closely with other health and social care teams and local community organisations such as university college nurses and the Alzheimer's Society to deliver co-ordinated and effective care for patients.
- The practice used a wide range of both clinical and non-clinical audits to monitor and improve outcomes for patients.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had a high level of training for their roles and were well supported in their work.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by practice staff with evidence of good team working across all roles.

We saw one area of outstanding practice:

- The practice had a committed and very active safeguarding lead who worked hard to ensure patients were protected. For example, in January 2016 and in addition to regular meetings with the health visitor, she had checked and updated the practice's paediatric and domestic violence folder;hadcreated a document in relation to Gillick and Fraser guidelines and completed all pending items on the practice's section 11 safeguarding audit. The practice's child safeguarding learning reports had been used as a model example by other local safeguarding agencies.

The areas where the provider should make improvement are:

- Implement a protocol for the non-collection of prescriptions and medicines by patients.
- Read code children who do not attend hospital appointments on the practice's clinical IT system and develop an appropriate follow up contact protocol.
- Actively flag informal carers on the practice's clinical IT system to make them easily known to staff.
- Undertake regular fire evacuation simulations at the Girton branch.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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?

Outstanding 

The practice is rated as outstanding for providing safe services. The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Safeguarding had a high priority within the practice and procedures were robust and effective in protecting patients. Staff had received a wide range of training in safeguarding and the practice had a very active lead who met frequently with health and social care professionals to protect patients. Infection control also had a high priority, and a range of audits was undertaken to ensure staff and patients were protected. Medicines were managed well.

Are services effective?

Good 

The practice is rated as good for providing effective services. Systems were in place to ensure all clinicians were up to date with the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw examples of full cycle clinical audits that were relevant to the needs of the practice population and ongoing audit activity that had led to improvements in patient care and treatment. Effective multi-disciplinary working took place and feedback from external stakeholders was very positive.

Staff had the skills, knowledge and experience to deliver effective care and treatment. Arrangements were in place to ensure staff were supported with an induction, appropriate training, professional development and appraisals.

Are services caring?

Good 

The practice is rated as good for providing caring services. Data from the National GP Patient Survey showed patients rated the practice higher than others for almost all aspects of care. For example, 92% of patients said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.Feedback from patients about their care and treatment was consistently and strongly positive. We received 38 completed comments cards which were overwhelmingly positive about the caring attitude of staff.

Summary of findings

We observed a strong patient-centred culture with patients at the heart of everything the practice did. Patient and information confidentiality was also maintained. Information about the services available including support organisations was accessible to patients and easy to understand.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. Patients could access appointments and services in a way and at a time that suited them. This was reflected in patient feedback received and the national GP patient survey results. For example, 92% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%. The practice offered a wide range of services and was well equipped to treat patients and meet their needs. Each year staff attended student fresher's week, and also held specific patient registration events at the university colleges. One of the GPs gave talks to a local Bengali women's group to improve their understanding of gynaecological matters. One GP visited patients with learning disabilities at their own home to ensure take up of health checks for this group was high.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example it had reviewed its telephone access to patients and also changed the way it offered child immunisations appointments to better meet patients' needs. Members of the PPG were involved in reviewing the practice's complaints.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. The practice shared their values with patients through the PPG and through its website.

The practice had strong and visible clinical and managerial leadership and governance arrangements. Staff were supported and well managed at all times, and there were clear lines of responsibility and accountability within the practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction.

The practice sought feedback from staff and patients, which it acted on. The patient participation group was active and met regularly making suggestions for improvements. There was a strong focus on continuous learning and improvement at all levels.

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

Outstanding 

The practice is rated as outstanding 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 had an urgent triage system for visits requested by them. Nurses were able to offer complex leg ulcer dressings which prevent the need for patients to attend community leg ulcer clinics. It worked closely with a number of local organisations and participated in initiatives to increase access to health care for older people and reduce the number of hospital admissions. The practice provided effective and consistent support to residents living in two local care homes. All new patients with a diagnosis of dementia were referred to the local Alzheimer's Society for additional support.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the care of patients with long-term conditions. GPs worked with relevant health and care professionals to deliver multidisciplinary care packages 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 patient recall system in place.

GPs meet twice weekly to discuss the care of patients who had complex needs or were being considered for referral to hospital to ensure their needs were being met in the best way.

Families, children and young people

Outstanding 

The practice is rated as outstanding for the care of families, children and young people.

Patients told us that the doctors and nurses provided particularly good care for their young children. The practice met regularly with health visitors and school nurses to discuss families with particular needs. Nursery nurses were based at the practice and the community midwife visited weekly. Immunisation rates were relatively high for all standard childhood immunisations.

Patients could access sexual health advice and services including family planning, fitting of intrauterine devices (IUD) such as coils and contraceptive implants.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered early morning appointments two days a week before the start of school and lectures.

Working age people (including those recently retired and students)

Outstanding ☆

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. The practice had good working relationships with local colleges and ran registration days at each college to enable students to register easily. It participated in the chlamydia screening programme and provided test kits for students

The practice offered extended opening hours two mornings a week for patients unable to attend during normal working hours.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding 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, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. There was an active safeguarding lead in the practice who provided staff with guidance and expertise in all safeguarding matters.

The practice informed vulnerable patients about how to access various support groups and voluntary organisations and worked with multi-disciplinary teams in the case management of vulnerable people. Specific information was available to support carers and the practice participated in a local carers' prescription service which provided respite care. It supported a local village charity to provide a medication delivery service to older and vulnerable patients.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding 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. Systems were in place to help patients with mental health problems be seen quickly for their appointment to avoid them having to wait.

Summary of findings

The practice performed well in indicators for depression, dementia and mental health. All new patients diagnosed with dementia were referred to the Alzheimer's Society for support.

The practice worked closely with college nurses and staff to support students with eating disorders, anxiety and depression. The head of the university's counselling service and a manager of a local mental health service had recently attended a PPG meeting to discuss their services.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing above local and national averages in most areas. 355 survey forms were distributed and 131 were returned, giving a response rate of 40%.

- 86% found it easy to get through to this surgery by phone compared to a CCG average of 75% and a national average of 73%.
- 94 % found the receptionists at this surgery helpful (CCG average 88%, national average 87%).
- 96 % said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 87 % described their experience of making an appointment as good (CCG average 77%, national average 73%).
- 88% would recommend the surgery to someone new to the area (CCG average 80%, national average 78%).

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 38 completed comment cards, all but two of which were extremely positive about the quality of services received. Patients told us that that staff were attentive, listened well and that they never felt rushed during their appointment. They stated that GPs were thorough in following up their symptoms and liaising with hospitals. A number of patients commented that staff were particularly good with their children, and took time to explain things to them in a way that they understood. One patient described the practice's environment as calm, clean and well managed. Reception staff were described as friendly, helpful and cheerful.

We spoke with three district nurses that knew the practice. They told us the GPs were very supportive and actively communicated with them. Two care home managers described strong and effective relationships in place with the GPs who responded quickly and effectively to requests for visits from their residents.

Areas for improvement

Action the service SHOULD take to improve

- Implement a protocol for the non-collection of prescriptions and medicines by patients.
- Read code children who have do not attend hospital appointments on the practice's clinical IT system and develop an appropriate follow up contact protocol.
- Actively flag informal carers on the practice's clinical IT system to make them easily known to staff.
- Undertake regular fire evacuation simulations at the Girton branch.

Outstanding practice

- The practice had a committed and very active safeguarding lead who worked hard to ensure patients were protected. For example, in January 2016 and in addition to regular meetings with the health visitor, she had checked and updated the practice's paediatric and domestic violence folder; had created a document in relation to Gillick and Fraser guidelines and completed all pending items on the practice's section 11 safeguarding audit. The practice's child safeguarding learning reports had been used as a model example by other local safeguarding agencies.

Huntingdon Road 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 an additional CQC inspector.

Background to Huntingdon Road Surgery

Huntingdon Road Surgery is a well-established GP practice that has operated in the area for many years. It serves approximately 15700 registered patients and has a general medical services contract with NHS Cambridgeshire and Peterborough CCG. It is located in an affluent area of Cambridgeshire . The service is delivered from two sites, one on Huntingdon Road in Cambridge city, and the other in the village of Girton. A small dispensary is attached to the Girton site.

According to information taken from Public Health England, the patient population has a higher than average number of patients aged 15 to 34 years, a lower than average number of patients 25-69 years, and under 15 years compared to the practice average across England. The practice covers six Cambridge University colleges and therefore patient turnover is high at around 18% per year. The practice's population is also growing at rate of 4% per year.

The practice team consists of eight GPs, seven nurses, three health care assistants, and a pharmacist. A number of dispensing and administrative staff support them. It is a teaching practice involved with the training of GPs and district nurse students

The opening times for main surgery are Monday to Fridays from 8.15am to 1pm, and from 1.45pm to 6pm. It also opens from 7am to 8am for pre-booked appointments on Thursdays and Fridays.

The Girton branch is open Monday to Fridays from 8.15 to 1pm. On a Monday it also opens in the afternoon from 3pm to 6pm. The dispensary is open between 8.45 and 1pm each day, and from 3.45 to 5.15 pm on Monday.

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 5 April 2016. During our visit we spoke with a range of staff including GPs, nurses, a pharmacist, dispensers and administrative staff. We reviewed a range of the practice's policies and procedures and a small sample of patients' 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.

Detailed findings

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

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

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

- Older people
- People with long-term conditions
- 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.

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

The practice had a specific protocol in place for managing and learning from significant events and a lead GP had been appointed to oversee the management of significant events. Staff we spoke with were aware of the reporting policy and told us they felt confident in reporting any issues.

We viewed the practice's significant event log which listed 38 events that had occurred since 2012 and the action taken as a result. We also viewed a small sample of significant event report forms which were detailed and clearly outlined the incident, what had been learnt and any changes required at the practice as a result. Specific meetings were held to review significant events to identify any common themes or patterns, the last of which was held in October 2015.

We found good evidence in the minutes of the practice's meetings that significant events were discussed widely. For example, at a meeting held on 21 March 2016 a recent event concerning a breach of confidentiality had been discussed. A decision to update practice's protocol in light of the event was agreed, and a meeting was planned to share the event with the whole reception team so that learning could be shared. We also saw that, where appropriate, patients' complaints were treated as significant events.

Overview of safety systems and processes

Safeguarding patients was given a high profile within the practice and there were robust systems in place to protect and support vulnerable adults and children:

- The practice's safeguarding lead had developed a wide ranging and comprehensive library of information and guidance relevant to safeguarding patients that was available to all staff on the practice's intranet system. This included newsletters from the local safeguarding teams, case conference reports, the latest guidance on female genital mutilation, findings from serious case reviews and safeguarding templates amongst other things.
- The practice's safeguarding policies and protocols were detailed and specific to the practice. They included, amongst other things, information about staff's responsibilities, definitions of abuse ,sources of support, links to relevant guidance, training requirements for staff, record keeping requirements and responding to requests for safeguarding information.
- A detailed audit had been undertaken by the practice's lead GP for safeguarding of the quality of coding of safeguarding children related information in patients' notes. Some shortfalls had been identified and as a result amendments were made to 22 of fifty patients' notes, and to 19 of fifty parents' notes to ensure they met good recording standards.
- One of the practice's child safeguarding learning reports had been used as a model example by other local safeguarding agencies.
- The local health visitor met with the lead safeguarding GP every fortnight, and then again with the all the GPs every month to discuss children of concern. The lead GP also held quarterly meetings with school nurses.
- The lead GP kept a detailed log of the meetings she had attended and the work she had undertaken in relation to her safeguarding responsibilities. Since January 2016 in addition to regular meetings with the health visitor, she had attended a children's safeguarding leads annual conference; had checked and updated the practice's paediatric and domestic violence folder; had created a document in relation to Gillick and Fraser guidelines and completed all pending items on the practice's section 11 safeguarding audit. She had also followed up children who were on the practice's child protection register but had not attended immunisation appointments.
- Records we viewed showed that all staff had received safeguarding training relevant for their role. In addition to this, we viewed minutes of a safeguarding training provided to 22 staff held in February 2016. The training had included feedback from recent serious case reviews in Cambridge, and presentations from representatives of the multi-agency safeguarding hub, Cambridgeshire sexualised behaviours service and Cambridge constabulary. The lead GP had also given a tour of the safeguarding children's folder in the practice's guidance and contacts file. On the day of our inspection, the local designated doctor for safeguarding was in attendance to provide safeguarding training to the whole practice team.

Are services safe?

- We noted good information about protecting patients around the practice; there was a child protection poster available in the waiting area and Information about key contacts on a laminated poster in each treatment room. Information on the practice's web site, giving people contact numbers
- A safety alert issued on 30 March 2016 in relation to the risk of death from failure to prioritise home visits had been shared with staff at the practice meeting of 4 April 2016

Notices in the practice's waiting room and on its website advised patients that chaperones were available if required. Chaperoning was provided by the nurses who 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 might 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. We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, corridors, meeting rooms and treatment rooms. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. There were foot operated bins and personal protective equipment available in each room to reduce the risk of cross infection. We checked a sample of medical consumable items in treatment room cupboards and drawers and found they were packaged appropriately and in date for safe use. Sharps boxes were labelled correctly and not over-filled.

The practice had a named lead GP for infection prevention and control (IPC) who demonstrated a good knowledge in this area. There were robust procedures in place to maintain cleanliness and hygiene which included:

- Detailed information about all aspects of infection control were available on the practice's intranet, making it easily available to staff.
- The practice had a specific committee which included the lead GP, a practice nurse and a member of the administrative team which met regularly to discuss all IPC matters.
- All staff received regular training in infection control. The lead GP had developed specific training in hand washing techniques which was delivered to all staff in the practice. This had been upheld as an area of good practice by the local CCG.
- The lead GP undertook regular IPC audits of the practice, evidence of which we viewed.
- We viewed daily cleaning schedules covering all areas of the practice, and also certificates of quarterly deep cleaning undertaken by an external cleaning contractor.
- In response to concerns from reception staff about handling sharps, the GP lead had undertaken a comprehensive audit in relation to the management of sharps. This had led to safer sharps management within the practice and an improvement in the systems for checking and replacing sharps bins.
- We viewed a summary of the practice's GP lead activities in 2014-2015. IPC meetings had been held regularly throughout the year, all staff had received IPC and hand washing training, and policies in relation to waste management, managing Ebola and needle stick injury had been updated to reflect recent guidance.

Medicines management

The dispensary where medicines were stored was well organised and clean. Windows into the dispensary had bars on them for additional security, access was restricted and keys held securely. However, the main door into the dispensary did not meet national guidelines for security.

We found that medicines were stored safely. 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 and found appropriate records were kept, and the amount in stock tallied with the amount recorded as being in stock. Processes were in place to check that all medicines were within their expiry date and suitable for use, and we viewed

completed stock checks that took place every three months. Records showed refrigerator temperature checks were carried out which ensured medicines requiring refrigeration were stored at appropriate temperatures.

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 appropriately qualified and their competence to undertake a range of dispensing tasks had been checked. The practice had appropriate written procedures in place for a range of dispensing activities which reflected current practice. However, we noted that there was no written procedure for following up uncollected medicines or prescriptions.

There was a robust system in place for the management of high-risk medicines. Audits of patients who took these drugs were undertaken every three months to ensure they were being monitored. We checked records for patients prescribed methotrexate and lithium and found that they were receiving regular blood tests and medication reviews in line with guidance.

We viewed a recent methotrexate audit undertaken to ensure that appropriate advice and information was given to patients about the medicine when they called to collect it. The audit had identified a number of shortfalls and in response the practice now highlighted all methotrexate prescriptions, and had instructed staff to refer these prescriptions to the pharmacist so he could advise patients accordingly.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency and the local CCG medicines management team. We found evidence of patient searches that had been undertaken in response to these alerts to ensure that any changes required were implemented. We checked a sample of patient records which showed that the practice had taken appropriate action in response to MHRA alerts relating to the medicines simvastatin and clopidogrel.

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

The practice's prescribing rates for 2014 to 2015 were better than national figures. For example, the number of antibacterial items prescribed per patient unit was 0.19, compared to a national average of 0.27. 66% of non-steroidal anti-inflammatory drugs items prescribed were lower risk ibuprofen or naproxen, compared to a national average of 77%. We viewed prescribing data which showed that the practice was the fourth best performing surgery within local CCG out of 27 practices for both quality and against prescribing budget.

However one care home manager reported that prescriptions for residents could take a long time in getting from the surgery to the local chemist. She had met with the GP concerned and practice manager to discuss the issue, and although there had been some initial improvement, there continued to be minor problems.

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 employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, Hepatitis status and the appropriate checks through the Disclosure and Barring Service.

Succession planning was good and a salaried doctor had already been recruited and was working in the practice to replace one GP who was about to retire. A new pharmacist had just been appointed to replace the current one who was about to leave.

We spoke with one new member of the practice's administrative team who told us their recruitment had been thorough and that she had felt, 'well looked after' during her induction period.

Monitoring risks to patients

We looked at a sample of risk assessments which described how the practice aimed to provide safe care for patients and staff. These covered a wide range of areas including those for Legionella, lone working, use of couches, cryosurgery, use of oxygen cylinders, COSSH, waste storage and fire safety. Risks had been clearly identified and control measures put in place to reduce them. It was clear that risk was taken seriously by staff: we noted from minutes of the practice nurses' meetings that a risk assessment had been completed following two incidents where patients had

Are services safe?

caught their trouser leg on one of the treatment couches. The updated risk assessment for use of electro surgery equipment had been discussed at a practice meeting on 8 February 2016 to ensure all staff were aware of it.

There was a comprehensive control of substances hazardous to health folder in place containing chemical safety data sheets for products used within the practice. All equipment was tested and serviced regularly to ensure its safety and we viewed a range of maintenance logs and other records that confirmed this. Regular checks of the buildings and their environment were completed to ensure both staff and patients were safe. However staff at Girton told us they did not regularly practice evacuating the building to ensure they knew what to do in the event a fire.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment 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. 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. One patient told us that they had witnessed a patient collapse in the reception area and that staff had responded 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 pandemics, staff illness and the loss of utilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We reviewed a sample of patients' care records and care plans and found they were of a good standard. The GPs frequently used computer generated templates to ensure that the treatment provided was comprehensive, standardised and took into account best practice guidance. A clinical decision making tool for patients provided by the CCG was to be installed to enable faster access to the latest clinical information whilst in a patient's record.

The GPs led in specialist clinical areas such as mental health, cardio vascular disease, minor injury and dispensing and were able to offer colleagues expertise in these areas. The practice had a comprehensive 'Guidelines and contacts' folder in its intranet system which provided information on each area. Each GP lead was responsible for keeping the guidelines up to date and disseminating it to other clinicians. GPs told us it was an invaluable resource and used daily.

Latest guidance was regularly discussed at weekly meetings and we viewed examples where the practice had updated its policy and procedures in light of NICE guidance for asthma reviews and the management of cholesterol.

The practice held two clinical meetings a week attended by all GPs where patients' referrals were discussed and any clinical queries were raised.

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 91% of the total number of points available, this was slightly below the CCG average of 91% and national average of 95%, with 5.7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). However more recent figures given to us by the practice showed an increase for 2015-2016 to 97%.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 87 %.This was 0.9 percentage points below the CCG average, and 0.6 percentage points above the national average. Exception reporting was comparable to the CCG average at 13.2%.
- The percentage of patients with hypertension having regular blood pressure tests was 97.5%. This was 0.6 percentage points above the CCG average, and 0.3 percentage points below the national average. Exception reporting was comparable to the CCG average at 5.5%.
- Performance for mental health related indicators was 98%. This was 6 percentage points be above the CCG average and 5 percentage points above the national average. Exception reporting was lower than the CCG average at 3.8%.
- Performance for dementia related indicators was 100%. This was 5 percentage points above the CCG average and 5 percentage points above the national average. Exception reporting was lower than the CCG average at 7.6%.

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 action plans had been developed for these patients to improve the quality and co-ordination of their care. The reason for each unplanned admission was regularly reviewed. Emergency hospital admission rates for the practice were lower at 8.67 per 1000 population compared to the national average of 14.6 .

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. We were shown a number of completed and first cycle audits that had been

Good

Are services effective?

(for example, treatment is effective)

undertaken in 2015-2016. These were wide ranging and comprehensive and included audits of drugs prescribed for urinary frequency, lipid management, the dispensing of methotrexate, sharps' management and the quality of coding for children with safeguarding concerns. Findings were shared at the practice's twice weekly referral and clinical meetings.

Effective staffing

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 had specific rules in place for both GPs and non-clinical staff to ensure minimum staffing numbers and there were clear protocols and GP buddy arrangements in place to cover the clinical work of absent doctors.

We found staff to be knowledgeable, well qualified and experienced for their roles. Staff told us they had good access to training and were well supported to undertake further development in relation to their role. A number of the GPs held further qualifications in gynaecology, geriatrics, child health, family health and genito-urinary medication. At least one nurse has extended skills for each long term medical condition. One of the nurse's had undertaken training in dermatology enabling them to provide complex leg ulcer dressings and removing need for patients to attend leg ulcer clinics. One nurse told us she was given18 hours of study each year and had attended recent study days in asthma, smoking cessation, diabetes and family planning. A dispensary assistant showed us her training file which demonstrated that she had undertaken a range of courses including blood pressure medicines, cholesterol, warfarin, diabetes and allergies. Administrative staff had undertaken training in information governance, infection control, health and safety, and equality and diversity. Training for registrars was good and to date 100% of them had passed their placement at the practice.

There was a structured system for providing staff in all roles with annual appraisals of their work and for planning their training and development needs. Staff we spoke with told us they found their appraisal useful.

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. Electronic task management was good.

The practice worked collaboratively with other health and social care professionals to assess and plan the ongoing care and treatment of patients; and to ensure efficient ways of delivering integrated care for patients. We spoke with three district nurses during our inspection who were overwhelmingly positive about the working relationship with practice staff and felt suitable arrangements were in place to facilitate effective communication and coordinated care for patients.

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.

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. The managers of two care homes that the practice supported told us that GPs responded quickly to requests for referrals for Mental Capacity Assessments and also to complete resuscitation paperwork for their residents to ensure their wishes were respected. They told us the GPs always consulted family members where appropriate. Clinicians 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. The practice's safeguarding lead had recently added guidance about Gillick and Fraser competence to the practice's safeguarding resources file, making it easily available to staff.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice had an informative website which

Good

Are services effective?

(for example, treatment is effective)

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.

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 228 (28%) of patients in this age group had received an annual health check in 2014/2015. This exceeded the Cambridgeshire and Peterborough CCG's target rate of 12%. The practice had introduced a new recall system to try and improve this uptake even more by specifically targeting hard to reach groups such as working aged men.

The practice participated in the learning disability enhanced service and 81% of people with a learning disability had received an annual health check in 2014-2015.

The practice's uptake for the cervical screening programme in 2014-2015 was 66%, which was considerably lower than the national average of 74%. The practice identified there had been problem with its recall system, and patients had not been receiving their third reminder letters to attend. In response to this, the recall system was now monitored closely each month. A new letter had been drafted to patients including more information about screening and references to web sites to encourage attendance. GPs were given a list of patients who had not had a cervical screen to invite them to book an appointment if they attended for other reason. Year to date figures given to us by the practice already showed an improvement to 72%.

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 75% to 97%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The GPs ran personal lists, allowing them to get to know their patients well and providing good continuity of care. This was something that patients we spoke with greatly valued. The practice scored well in the national GP patients survey in this regard, with 79% of patients getting to see their preferred GP, as opposed the CCG average of 61% and the national average of 59%. A number of patients told us they had been with the same GP for many years and had built up strong relations with them as a result. One patient reported that his wife had been with the same GP since she had been born. Another, that her GP knew her children's nick names, and provided her daughter with suggestions of what she might ask the consultant when she attended hospital.

We noted that clinicians called through patients into consulting rooms in person, in a friendly and professional manner; something which PPG members told us patients particularly liked. The practice had implemented measures to reduce stress for patients with mental health problems by arranging to see them as soon as they arrived for their appointment, rather than them having to wait.

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. Additional rooms were available if patients wanted to talk privately, including one so that mothers could breast feed in private. There was a screen between the waiting area and reception desk to offer more privacy, and receptionists answered calls in a separate room behind the reception desk to ensure confidentiality for patients ringing into the practice. Computer screens had a filter on them to minimise visibility as patients passed them. 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.

We received consistently good feedback both from the patients we spoke with, and the comment cards we received, about the helpfulness and empathy 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 comparable to the average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 89% said the GP gave them enough time (CCG average 87%, national average 87%).
- 96% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 82% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).
- 89% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 91%).

Care planning and involvement in decisions about care and treatment

Patients 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 didn't feel rushed during consultations.

A range of health information was available on the practice's web site and clinicians told us they regularly downloaded and printed off information for patients from a trusted medical information web site, ensuring it was of an appropriate level for their understanding.

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.

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 comparable to local and national averages. For example:

- 86% 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?

- 84% said the last GP they saw was good at involving them in decisions about their care (CCG average 82% , national average 82%)

However scores for the nurses were slightly below average

- 85% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 73% said the last nurse they saw was good at involving them in decisions about their care (CCG average 85% , national average 85%)

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of local support groups and organisations, and we noted a Samaritans leaflet displayed in the toilet allowing patients to access the information unobserved.

The practice had a specific protocol in place for identifying and managing patients with caring responsibilities and had identified 217 (1.4%) patients of the practice list as carers. However, carers were not flagged on the practice's computer system so that staff could easily identify them. There was a specific carers' information board in the waiting area and a link to carers' organisations on the practice's web site. The practice took part in the Carers' Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a prescription for them which could be 'cashed in' by the carer to access a specialist worker at Carers' Trust Cambridgeshire for support, information and respite care. The PPG had held a specific a carers evening in the practice and had invited all registered carers.

Care home managers told us that end of life care provided by the GPs for their residents was good. They stated that the GPs always took time to speak to families and ensured residents' resuscitation wishes were recorded. GPs attended monthly palliative care meetings and had a specific bereavement protocol in place. GPs told us they always made contact with relatives following a family member's death.

Outstanding ☆

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, smoking cessation, chlamydia screening, minor surgery and dermatology. It also provided travel advice and immunisations, and a range of contraception services.

The practice looked after around 3000 students from six nearby Cambridge University colleges. Practice staff attended four of the colleges during freshers' week, where they worked with the college nurses to inform students about the services available at the practice. They also ran registration days at each college to enable students to register at the practice easily. The practice was part of a chlamydia screening programme and provided test kits for students.

There were longer appointments available for patients with a learning disability and one GP visited these patients at home to ensure they received their annual health check. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. There was a branch surgery at Girton for patients in outlying villages who found it difficult to attend the main surgery. The practice offered early morning appointments from 7am two days a week to facilitate access for working people.

The practice's web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice. The website also included fact sheets about UK health services that could be downloaded in a number of different languages

The practice offered a weekly 'ward round' to a local care home, providing regular contact and continuity of care for residents living there.

One of the GP's told us she had provided talks on women's health to a local Bengali women's group.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. It had taken part in a pilot local enhanced service to triage visit requests for older patients, and had found it valuable and had continued to operate it. One GP was the locality group Chair and a member of the CATCH (Cambridgeshire Association to Commission Healthcare Ltd) executive committee. He had been involved in reviewing diabetes services locally and pressing for additional diabetes specialist nurses locally.

Access to the service

The practice's opening times for its main surgery were Monday to Fridays from 8.15 to 1pm, and from 1.45am to 6pm.It also opened from 7am to 8am for pre-booked appointments on Thursdays and Fridays. The Girton branch opened Monday to Fridays from 8.15 to 1pm. On a Monday it also opened in the afternoon from 3pm to 6pm. The dispensary was open between 8.45am and 1pm each day and from 3.45 to 5.15 pm on a Monday. Information was available to patients about appointments on the practice's website and in its patient information leaflet. On-line booking was available for appointments and ordering medicines. An SMS text service was used to remind patients of their appointments and patients were able to email the practice with non-urgent general enquiries.

Consultation rooms were situated on the ground floor and reasonable adjustments had been made to the premises to meet the needs of people with disabilities. The waiting areas in the main branch were large with plenty of space for wheelchairs and prams. A portable hearing loop was available.

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.

- 92% of patients were able to get an appointment to see or speak to someone the last time they tried, compared to a CCG average of 87% and a national average of 85%
- 96% of patients said the last appointment they got was convenient (CCG average 93%, 92%).
- 86% patients said they could get through easily to the surgery by phone (CCG average 75%, national average 73%).
- 87% patients described their experience of making an appointment as good (CCG average 77%, national average 73%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 63% of patients feel they don't normally have to wait too long to be seen (CCG average 59%, national average 58%)

Listening and learning from concerns and complaints

Information about how to complain was available in the downstairs waiting area, on the practice's website and also in the patients' information booklet. However, the information was limited and did not include details about timescales for investigating complaints or other organisations that could be contacted if the patient was not satisfied with the practice's handling of it. No information about complaints was available in the upstairs waiting area. Reception staff reported that they told patients they had to write in or email with their complaint, thereby making it difficult for patients to raise concerns.

The practice did not keep a log of any informal complaints received or issues that had been resolved quickly in order to monitor any trends or patterns. However, following our inspection, the practice told us that they had put up large complaints' posters in several areas, had created a comments and suggestions form which was available on the reception desk, and had begun to log all minor issues.

We viewed the practice's complaints' log which showed 12 complaints had been received between 2015-2016. These had been responded to in a timely way and all had been resolved. We noted that two complaints had been treated as significant events, and specific meetings held with relevant staff to discuss them. Complaints were reviewed each year and the practice involved PPG members in this.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients, and its core values were available on its web site for patients to view. Each year the practice drew up a plan with active input from staff and the patient participation group (PPG). We viewed the plan for 2016/2017 which clearly outlined both the key priorities and challenges the practice faced, including the development of North West Cambridge, federated working, nurses' revalidation and the recruitment of new staff. A meeting to share this plan with the PPG and staff was organised for the 15 April 2016.

Governance arrangements

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager, nurses and the practice staff. The practice had a clear set of policies and procedures to support its work and meet the requirements of legislation. We viewed many of these which were comprehensive, dated, and monitored as part of the practice's quality assurance process. Staff understood and had access to the polices.

We found the governance and performance management arrangements were kept under constant review and the practice actively sought out and used data from a wide range of sources including audits and performance data to improve patient outcomes. The practice took effective action to address any shortfalls, such as low cervical screening rates, or to improve the take up of NHS heath checks.

Communication across the practice was structured around key scheduled meetings. There were weekly management meetings involving all the GP partners and senior dispensing, nursing and administrative staff. Each of these staff then held regular meetings with their respective teams. No formal meetings were held with dispensing staff, however they told us that as the team was so small, communication was easy and meetings were not needed. In addition to this there was a twice weekly clinical and referrals review meeting. Minutes of all these meetings were of good quality. Whole practice governance days were held every three months, facilitated by the local CCG.

All staff received regular appraisal of their performance and the practice kept a staff training matrix to help monitor training and ensure it was kept up to date.

Comprehensive information governance policies were in place to guide staff and there was a named GP Caldicott guardian. The practice regularly completed an information governance tool to ensure it managed patients' information in line with legal requirements. It was rated at level three and met all requirements.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. Staff told us they received good leadership and enjoyed their work citing training, team work, good communication and support as the key reasons. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

The practice's team approach was clearly evident on the day our inspection. For example, a different GP had taken responsibility for providing written evidence to answer each of our key questions and for presenting it to us at the beginning of the day. The GPs had undertaken a 'dry run' of their presentation at a practice meeting beforehand so that they could get feedback from all staff. This demonstrated to us a very open, transparent and inclusive culture within the practice.

In 2015 the practice had entered a team comprising of staff from its pharmacy, GP and patients to participate in the annual Chariots of Fire charity race.

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

The practice had an active patient participation group (PPG) of about 80 members and its committee met every six weeks with one of the GP partners, and every quarter with the practice manager. It regularly invited speakers to attend and a video shown at one meeting by a local hearing charity had also been shown to receptionists at the practice to raise their awareness of patients with hearing impairments. The PPG was responsible for collating the practice's newsletter and had been instrumental in ensuring the practice's dispensary at Girton remained open.

Are services well-led?

Outstanding ☆

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

Members of the PPG were involved in reviewing complaints received by the practice and had been invited to attend the practice's forthcoming action plan meeting. The practice had listened to the PPG's suggestions and had responded to suggestions about reading materials for the waiting area and also for staff to have photographs of themselves in the waiting area.

The practice regularly consulted its patients. We were shown the results of a recent survey that the practice had undertaken about telephone access which had identified that some patients had difficulty getting through. In response to this the practice had increased the number of appointments available that could be booked on-line; reviewed its appointment system, and was in the process of reviewing its telephone provider. It had listened to concerns from patients and staff, and changed the appointment structure for childhood immunisation service, meaning that parents could attend at any time rather than on a set afternoon clinic in each week.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. From April 2015 to March 2016, 176 patients had responded, 174 of whom would recommend the practice.

The practice regularly monitored comments left by patients on the NHS Choices web site and provided responses to comments left by patients. At the time of our inspection the practice had scored 4 out of five stars based on 23 reviews.

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 examples from staff where the GP partners had listened to them, and implemented their suggestions to improve the service to patients. For example, one nurse's suggestion to provide a specific information leaflet to patients about malaria had been implemented. Reception staff's request to change the practice's protocol and allow two, instead of one member, of their staff to be on annual leave contemporaneously had been agreed.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area such as tele-dermatology and increasing access to healthcare for older patients. The practice had been nominated as a Beacon Site for SystemOne, and had supported other practices in the transition to on-line services.

The practice had a programme of lunchtime and evening meetings for doctors and nurses when speakers were invited to discuss areas identified as learning needs by the team. Recent examples had focused on children's health and included sessions on self-harm, allergies and the assessment of sick children.