

Milton Surgery

Quality Report

Coles Road, Milton, Cambridge, CB24 6BL

Tel: 01223 420511

Website: www.miltonsurgery.co.uk

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Milton Surgery on 27 April 2016. Overall the practice is rated as good.

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

- Patients expressed high levels of satisfaction with the practice, citing caring and attentive staff, ease of access and being involved in decisions about their treatment as the reasons. Figures from the national GP survey stated that 92% of patients would recommend the surgery to someone new in the area.
- 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.
- The practice worked closely with other health and social care teams, and local community organisations such as the Alzheimer's Society and community wardens to deliver co-ordinated and effective care for patients.
- 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. Patients' long-term conditions were managed well, and they received regular health checks and medicines reviews.
- The practice had an active patient participation group that it worked closely with to improve its services.
- Staff were well supported and received good training for their role.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

The areas where the provider must make improvement are:

- Ensure that any changes to patients' medicines following their discharge from hospital or out patients' appointments are checked by a clinician.

The areas where the provider should make improvement are:

- Ensure that more secure arrangements are in place for prescription forms and medicines held in the dispensary so that they are only accessible by authorised dispensers and GPs.

- Keep a record of near-miss dispensing errors to monitor trends and ensure appropriate actions are taken to minimise the chance of similar errors occurring again.
- Review and update protocols for the management of controlled drugs within the practice
- Ensure that a record of staff recruitment interviews is made.

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?

- There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed.
- Patients received their care in a clean and hygienic environment, and equipment was well maintained.
- There was appropriate and sufficient emergency medical equipment and medicine available.
- However, patients were not fully protected against the risks associated with the management of medicines because there were not appropriate arrangements in place for the safe dispensing of medicines.

Requires improvement



Are services effective?

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed 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 staff.
- There were joint working relationships with community services and engagement with health and social care providers to co-ordinate care and meet patients' needs.

Good



Are services caring?

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example 95% said the last GP they saw was good at listening to them.
- Patients said they were treated in a respectful and empathetic way by the practice's staff.
- Staff understood the importance of confidentiality and patient information was managed well.

Good



Summary of findings

- Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Good



- The practice offered a range of services and was well equipped to treat patients and meet their needs.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and the patient participation group.

Are services well-led?

Good



- Staff were supported and well managed at all times, and there were clear lines of responsibility and accountability within the practice .
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- Staff had received inductions, regular performance reviews and attended staff meetings and events.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- 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.

Summary of findings

The six population groups and what we found

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

Older people

The practice 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.

The practice was part of a pilot scheme with Cam Health and the Alzheimer's Society and had a specialist nurse attached to the practice to support to patients there. It worked closely with the Parish village warden to support older patients in the community. The practice's PPG held a local drop in café where they encouraged older patients to attend for friendship, advice and support.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. There was an effective patient recall system in place to ensure that patients' health needs were reviewed. Longer appointments and home visits were available when needed and patients at risk of hospital admission were identified as a priority. GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care to patients with the most complex needs.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked with local health visitors, midwives and school nurses to offer a full health surveillance programme for children. Immunisation rates were relatively high for all standard childhood immunisations. The practice's web site contained links to support groups and advice specifically for young people.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of these patients been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments were available with the GPs and

Good



Summary of findings

nurses from 8am each morning. 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 and uptake was high compared to local and national averages.

People whose circumstances may make them vulnerable

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, documentation of safeguarding concerns and how to contact relevant agencies. The practice regularly worked with other health care professionals in the case management of vulnerable patients

The uptake of health check for patients with a learning disability was high and specific information packs were available to support carers.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice performed well in indicators for depression, dementia and mental health. Patients with significant mental health problems had annual mental health and medicines reviews. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Good



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 comparable local and national averages in most areas. 231 survey forms were distributed and 110 were returned, giving a response rate of 48%.

- 94% described their overall experience of the surgery as good or very good, (CCG average 86%, national average 85%).
- 86 % found the receptionists at this surgery helpful (CCG average 88%, national average 87%).
- 92 % said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 75% with a preferred GP usually get to see or speak to that GP (CCG average 61%, national average 59%).
- 95% said the last GP they saw or spoke to was good at involving them in decision about their care (CCG average 82 %, national average 82%).

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. Despite asking that they be distributed widely to patients, we only received one completed card. However this was very positive with the respondent describing the service as outstanding.

We spoke with five patients during our inspection and three members of the PPG. Patients told us they particularly appreciated the small size of the practice, which allowed the GPs to get to know them well and provide continuity of care. They told us that they never felt rushed during their appointment and the GPs and nurses took time to listen, and to explain treatment if needed. However one patient commented that the practice was slow in providing medical reports for insurance purposes.

We spoke with a manager of a local learning disability care home who told us that the GPs were responsive, caring and communicated well with their residents.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that any changes to patients' medicines following their discharge from hospital or out patients' appointments are checked by a clinician.

Action the service **SHOULD** take to improve

- Ensure that more secure arrangements are in place for prescription forms and medicines held in the dispensary so that they are only accessible by authorised dispensers and GPs.

- Keep a record of near-miss dispensing errors to monitor trends and ensure appropriate actions are taken to minimise the chance of similar errors occurring again.
- Review and update protocols for the management of controlled drugs within the practice

Ensure that a record of staff recruitment interviews is made

Milton 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 and a pharmacist advisor.

Background to Milton Surgery

Milton Surgery is a well-established GP practice that has operated in the area for many years. It serves approximately 4950 registered patients and has a general medical services contract with NHS Cambridgeshire and Peterborough CCG. It is located in an affluent area of Cambridgeshire.

According to information taken from Public Health England, the patient population has a slightly higher than average number of patients aged 30-54 years, and a lower than average number of patients 10-29 years, compared to the practice average across England.

The practice team consists of two partnered GPs, a salaried GP, two nurses, a health care assistant and a phlebotomist. They are supported by a number of dispensing and administrative staff

The opening times for the surgery are Monday to Fridays from 8am to 6pm. The dispensary is open from 8am to 12 noon Monday to Friday.

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 27 April 2016.

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 patients' records.

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)

Detailed findings

- 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.

Are services safe?

Our findings

Safe track record and learning

Staff we spoke with were aware of the practice's incident reporting policy and told us they felt confident in reporting any issues. They told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. Staff told us openly about specific events they were involved in showing us a transparent approach to errors made.

We viewed the practice's significant event log which listed 37 events that had occurred in the last year and the action taken as a result. Significant events were a standing agenda item at each practice meeting and we found good evidence that they had been discussed widely. For example, at a meeting in December 2015 an incident involving the misdiagnosis of a pregnancy was discussed, and at a meeting held in March 2016 the resuscitation of a patient who had collapsed was reviewed. It was clear that staff learned from events and changed their procedures accordingly. For example, the start and end dates for medicines were now written on prescriptions following an incident where a medicine only meant to be taken for two weeks, had been taken continually for a couple of months. Only the practice's staff now had access to the vaccine fridge following an incident where a community healthcare professional accidentally left the fridge door open, leading to destruction of £5,000 worth of vaccines.

Overview of safety systems and processes

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies involved in protecting people. Staff we spoke with gave us specific examples of where they had made safeguarding referrals and we viewed a list of local safeguarding contacts in every consultation room. Quarterly meetings were held with the health visitors, school nurses and GPs to discuss all children with safeguarding concerns

Safeguarding matters were regularly discussed at practice meetings. For example, at a meeting in December 2015

details of a new domestic violence unit were shared with staff and also the protocol to be followed if a child missed three GP appointments. In March 2016, EMIS child protection codes were discussed to ensure all clinicians were aware of them, along with the most recent child protection update.

The practice had a policy of reviewing the child's and family's notes to check if there were any concerns following the discharge summary received from A&E in relation to children with an injury. The notes of any child who did not attend a hospital appointment were reviewed by the duty GP to check if there were any immediate concerns, then passed to the GP who made the initial referrals. There was a standard letter sent to parents following this.

Notices in treatment rooms advised patients that chaperones were available if required. Chaperoning was provided by staff 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

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area, corridors, and treatment rooms. We checked two consultation 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. Hand gel was available on reception and in the entrance way to the practice. Some consultation rooms were carpeted but staff told us there were plans in place to refurbish these in line with best infection control practices. We noted that the carpet in the nurse's room was very stained.

The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date

Are services safe?

training. Infection control audits were undertaken every six months and we saw evidence that action was taken to address any shortfalls identified as a result. The lead nurse provided hand washing training to all staff.

Medicines management

The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure dispensing processes were suitable and the quality of the service was maintained. Dispensary staffing levels were in line with DSQS guidance. The practice had conducted quality assurance of their dispensing service showing high levels of patient satisfaction. Dispensing staff were appropriately qualified and had their competency annually reviewed.

The practice had written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed, however its protocols for how it managed controlled drugs were not easily available and also out of date.

There were a variety of ways available to patients to order their repeat prescriptions, however this included the receipt of requests via telephone which presented a greater risk of error. Prescriptions were reviewed and signed by GPs before they were given to the patient, however, following discharge from hospital and outpatient appointments dispensers made changes to patients' medicines which were not checked by GPs to ensure safety.

Blank prescription forms were recorded and tracked through the practice. However, we noted that improvements were needed to ensure more robust secure arrangements were in place for prescription forms and medicines held in the dispensary to ensure they are accessible only by authorised dispensers and GPs. Records showed medicine refrigerator temperature checks were carried out which ensured medicines requiring refrigeration were stored at appropriate temperatures. Processes were in place to check medicines stored within the dispensary area and emergency medicines were within their expiry date. All the medicines we checked were within their expiry dates.

We saw a positive culture in the practice for reporting and learning from medicine incidents and errors. Dispensed errors were logged and then reviewed. However, we noted

that the practice did not keep records of near-miss dispensing errors to monitor trends and ensure appropriate actions were taken to minimise the chance of similar errors occurring again.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency. We found evidence of patient searches that had been undertaken in response to these alerts to ensure that any changes required were implemented. There was a system in place for the management of high-risk medicines. We checked records for patients prescribed lithium and found that they were receiving regular blood tests and medication reviews in line with guidance.

One of the practice's GPs was the prescribing lead and regularly attended quarterly meetings with the clinical commissioning group (CCG) to discuss medicines' management. A clinical pharmacist from the local CCG visited regularly to review prescribing habits and to offer advice.

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 comparable to local national figures. For example, the number of antibacterial items prescribed per patient unit was 0.27, compared to a local average of 0.29, and national average of 0.27. 69% of non-steroidal anti-inflammatory drugs items prescribed were lower risk ibuprofen or naproxen, compared to a local average of 72%, and national average of 77%.

Staffing and Recruitment

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However we found that a record had not been made of recent employment interviews.

A number of staff had recently left the practice, but all posts had been filled quickly. All new staff received a thorough induction to their role, and administrative staff's induction lasted up to 18 months. They received close supervision

Are services safe?

and mentorship throughout this time. We spoke with two new members of the practice's administrative team who told their recruitment had been thorough and they were receiving good support.

The practice regularly used locums to cover GPs' annual leave and sabbaticals. These locums came from a locally approved pool of GPs, and full employment checks were undertaken prior to their employment to ensure they were suitable to work.

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 every area of the practice and the risks had been clearly identified and control measures put in place to reduce them. The practice had a variety of other risk assessments in place to monitor safety of the premises such as fire, the control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). These assessment were reviewed each year by the practice manager to ensure they remained relevant and up to date.

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.

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 and regularly practiced responding to situations such as anaphylaxis. Staff had responded quickly and effectively to a patient who had recently collapsed from a heart attack in the car park.

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.

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. It contained contact details of staff and also useful telephone numbers for utility companies and local support agencies. Senior staff kept a copy of the plan off site. We viewed the minutes of a business continuity meeting held in March 2016 where incidents of potential flood, electrical failure and a gas leak were discussed in depth so that those present knew how to respond to each.

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. Clinicians we spoke with were good at recognising and knowing where to look for new guidelines both nationally from NICE and more locally. They were aware of email systems for NICE updates and also on-line clinical knowledge systems. NICE guidance was also shared in the regular clinical meetings held and one GP told us that recent guidance in relation to the management of menopause had been discussed there. If any of the GPs attended an update course they shared their findings at the next clinical meeting, and a recent update on diabetes management had been discussed at this meeting. The practice had undertaken a clinical audit on the referral of patients with chronic obstructive pulmonary disease for rehabilitation in response to new NICE guidelines.

Management, monitoring and improving outcomes for people

There was an effective recall system in place managed by the practice's administrative team to ensure that patients received regular check-ups of their health and medication reviews.

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 98% of the total number of points available, this was comparable to the CCG average of 98% and above the national average of 95%, with 12 % 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).

- Performance for diabetes related indicators was at 96 %. This was 6.9 percentage points above the CCG average, and 7.2 percentage points above the national average. Exception reporting was lower at 8%, than the CCG average of 13% and national average of 11%.

- Performance for mental health related indicators was 98%. This was 5 percentage points above the CCG average and 5 percentage points above the national average. Exception reporting was lower at 9% than the CCG average of 13% and national average of 11%.
- Performance for COPD related indicators was 98%. This was 2 percentage points above the CCG average and 2 percentage points above the national average. Exception reporting was lower at 5%, than the CCG average of 14% and national average of 13%.

The practice took part in the Avoiding Unplanned Admission Enhanced Service, which requires that patients who are part of the service have a care plan in place. We found that 81 of 83 patients had a care plan to ensure the care delivered met their needs and was planned for. (the other two were in the process of being completed). Emergency hospital admission rates for the practice were lower at 7% per 1000 population compared to the CCG average of 13% national average of 15%

All patient deaths were reviewed at the practice's meetings to ensure their care had been appropriate, evidence of which we viewed.

The practice undertook both clinical and non-clinical audits that it used to monitor quality and systems to identify where action should be taken. These were usually undertaken in response to clinical events or patients' needs. We viewed eight audits in total including those for the use of anticoagulants for the treatment of atrial fibrillation; asthma management and the outcome of Larcs insertions (long acting reversible contraception). Some audits had resulted in better outcomes for patients, for example a high risk smoker audit had led to an increase in the number of patients (from 4%- 25%) referred to a smoking cessation clinic, and an audit of coeliac patients had led to an increase in the number who received an annual health check-up. However some audits showed no significant clinical impact or re-audit done.

Effective staffing

Staff told us there were enough of them to maintain the smooth running of the practice and that there were always enough of them on duty to keep patients safe. The practice had a stable and long established GP team, however both nurses and four members of the administrative team were new. At the time of our inspection the GPs were

Are services effective?

(for example, treatment is effective)

undertaking all long-term condition management checks with the help of a locum diabetic nurse, until such time as the practice's own new nurses had received appropriate training for their role.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. The GPs were allocated five study days a year, and one nurse told us the practice were supporting her to undertake a Diploma in Asthma. Training records we viewed showed that staff had undertaken wide range of training including safeguarding patients, equality and diversity, infection control, information governance and dealing with aggressive patients. Most of this training had been provided by external trainers, as the practice manager felt this more effective for staff than doing it on-line. The practice manager had a nationally recognised qualification in health management and the practice's secretaries had done medical terminology courses. All dispensers had received Buttercup training (NVQ equivalent pharmacy training).

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 as a forum for discussing problems and for having their hard work recognised and appreciated.

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. Correspondence management was good and a log of all patient referrals was kept so they could be tracked.

The practice worked collaboratively with other health and social care professionals such as the local parish community warden, district nurses and Arthur Rank hospice to assess and plan the ongoing care and treatment

of patients. Multi-disciplinary meetings were held monthly and patients' notes and care plans were updated following these meetings. Patients' hospital admission and discharges were also reviewed at this meeting.

The practice provided GP care to patients with learning disabilities living in a care home. A representative from there told us 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. One GP was able to give two examples of best interest meetings that had been held to discuss patients who lacked capacity. 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.

Written consent forms were used for minor surgery and notes we viewed for patients who had undergone recent surgery demonstrated that their consent had been obtained and recorded appropriately.

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. Staff were about to attend a health and well-being fair that was being organised in the local community by the practice's PPG.

Patients had access to appropriate health assessments and checks. New patients who registered with the practice were offered a consultation with a nurse to discuss any health needs. Health checks for patients aged 40–74 years were also offered. Figures given to us by the practice showed that 15% of patients in this age group had received an annual health check in 2015/2016. This exceeded the Cambridgeshire and Peterborough CCG's target rate of 12%.

Are services effective?

(for example, treatment is effective)

The practice participated in the learning disability enhanced service and 39 of 41 patients of people with a learning disability had received an annual health check in 2015-2016, with two refusing.

The practice's uptake for the cervical screening programme in 2014-2015 was 77%, which was higher than the CCG average of 73% and national average of 74 %. Breast cancer screening was also higher at 77%, than the CCG average of 73 and national average of 73%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 95 %, and five year olds from 80% to 83%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us they valued being able to see the same GP, allowing them to build good relationships with them. The practice scored well in the national GP patients survey in this regard, with 75% of patients getting to see their preferred GP, as opposed the CCG average of 61% and the national average of 59%.

We spent time in the patient 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. We observed one receptionist take time to ensure a patient whose first language was not English, fully understood their prescription. The receptionist was very patient and skilled, and used a blank prescription form as a visual aid to help the patient understand. Another staff member told us she regularly rang a particular patient with dementia to remind them of their appointment.

Staff gave us practical examples of how they maintained patients' confidentiality such as never referring to patients' names in public, just their NHS numbers; offering patients a pen and paper to write sensitive information down and providing them with a private room. We noted that computer screens were not overlooked, and there was a glass partition at the reception desk that staff could close for privacy if needed. Administrative staff showed a good understanding of how to manage patient information confidentially. We observed one nurse remove her smart card from the computer before leaving to room to talk to a colleague.

We noted that consultation and treatment room doors were closed during consultations, and that conversations taking place in all but one of these rooms could not be overheard (there was a large poster outside this room, informing patients that their conversation could be heard). Consultation rooms had curtains round treatment couches to maintain patients' privacy during intimate examinations.

Results from the national GP patient survey showed patients felt they were treated well by the practice's staff. The practice was higher to 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 89% and national average of 89%.
- 94% said the GP gave them enough time (CCG average 87%, national average 87%).
- 100 % said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 93% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).
- 92% 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.

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:

- 92% 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%.
- 94% said the last GP they saw was good at involving them in decisions about their care (CCG average 82% , national average 82%)
- 91% 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%.
- 83% 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

Are services caring?

Notices and leaflets in the patient waiting room told patients how to access a number of local support groups and organisations.

The practice had identified 71 (1.4%) patients as carers and one member of staff had been appointed to distribute specific carers' information packs to them. The practice's PPG had recently run a local event at Milton Fayre dedicated to carers and 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. Staff told us they had referred about five patients to this scheme. A representative from the local carers support agency had attended a practice meeting to discuss their service with all staff present.

GPs told us they always contacted, and usually visited, bereaved family members.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. For example, it was part of a pilot scheme with CamHealth (LCG) and the Alzheimer's Society to provide a dementia nurse specialist support to patients at the practice. The practice offered a number of services to patients in addition to chronic disease management, including phlebotomy, smoking cessation support, minor injuries, well person clinics, minor surgery and a range of contraception services.

Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. 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 was large with plenty of space for wheelchairs and prams. A portable hearing loop was available. Large coloured dots had been placed on each consultation room door as a visual aid to help patients identify which room they needed to go to.

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. Leaflets describing the range of local NHS services were available in a number of languages in the waiting room.

Access to the service

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 and the practice was about to introduce an electronic prescription service which would allow patients to collect the medicines directly from a chemist of their choice. Patients could register to receive information by text message regarding their appointments and health care.

The opening times for the practice were Monday to Fridays from 8am to 6pm. The dispensary was open from 8am to 12noon Monday to Friday. Patients were able to book a month in advance, or from 4pm the day before for an

appointment the next day, or from 8am for a same day appointment. Emergency appointments were available at the end of each morning and afternoon session. When busy, the practice employed a triage system to determine the urgency for medical attention.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 93% 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%
- 92% of patients said the last appointment they got was convenient (CCG average 93%, 92%).
- 77% patients said they could get through easily to the surgery by phone (CCG average 75%, national average 73%).
- 79% patients described their experience of making an appointment as good (CCG average 77%, national average 73%).
- 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 waiting area and in the patients' information booklet. Staff we spoke with had a good knowledge of the practice's complaints' procedure and we were shown a copy of the form and information that was given to patients by reception staff.

Complaints were regularly discussed with all staff at the practice meetings evidence of which we viewed, and the PPG told us the practice regularly shared and reviewed complaints with them.

We viewed paperwork in relation to three recent complaints and found these had been responded to in a timely way and all had been resolved. One patient's complaint about the lack of confidentiality had led to staff placing a large notice on a consultation room door to inform patients that their conversations could be overheard in the room.

Between 2014 and 2015, three complaints had been received by the practice, none of which had been upheld.

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

Although staff could not outline a specific vision for the practice, it was clear they were committed to providing a good quality service to patients. Each year the practice held a business planning meeting and staff were clear about the forthcoming priorities for the practice which included possible federation with other practices, succession planning for the replacement of a long-serving partner and investing in staff training.

Governance arrangements

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager, nurses and administrative staff. Practice specific policies were implemented and were available to all staff.

Communication across the practice was structured around key scheduled meetings. There were yearly business continuity meetings involving representatives of all staff; monthly clinical meetings involving all GPs, nurses, the health care assistant and phlebotomist; and monthly practice meeting involving all staff. There was a rotating chair for the clinical meetings, so that one month it might be chaired by a partner, the next by a health care assistant. Minutes of these meetings were kept and of a good quality. The manager maintained an 'action log' so that all actions arising from these meetings were logged and tracked to ensure their completion.

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.

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

On the day of inspection the partners in the practice demonstrated they 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 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.

There was a clear leadership structure in place and staff felt supported by management. Team away days were held, and the next was planned for November 2016 to focus on how the practice team could better meet the needs of its patients with disabilities.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had worked closely with the practice to change appointment systems and times, and conducted a survey to see if the changes had been successful. The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing and there was a comments box available to patients in the waiting area.

The practice also 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, the office manager's request for a dishwasher had been met, as had a nurse's request for a different type of speculum to be used.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12- Safe Care and Treatment which states that care and treatment must be provided in a safe way for service users, including the proper and safe management of medicines. We found that patients were not fully protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the safe dispensing of medicines. • Following discharge from hospital and outpatient appointments dispensers made changes to patient's medicines which were not checked by GPs to ensure safety Regulation 12(2)(g).