Parkhall Surgery

Quality Report

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Date of inspection visit: 18 May 2016
Date of publication: 20/06/2016

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Parkhall Surgery on 18 May 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, availability of appointments 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.
- We received exceptionally good feedback about the GPs from the managers of two care homes the practice supported. They told us that the practice's GPs provided and effective and responsive service to their residents, and were always available for advice and guidance when needed.
- The practice performed well in relation to many local and national performance indicators including those for screening rates, the NHS GP survey and antibiotic prescribing.
- Staff clearly enjoyed their work citing good support, training and teamwork as the reason.
- There was an open and transparent approach to safety and effective systems were 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 services 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.

Summary of findings

The areas where the provider must make improvement are:

- Introduce an audit trail for prescription pads and computer forms so that they can monitor their use in line with national guidance.

The areas where the provider should make improvement are:

- Implement a formal system to disseminate NICE guidance and ensure all clinicians are aware of any updates.
- Ensure that dispensary staff are supported to keep up to date, and that they are regularly assessed as competent to carry out their role.
- Establish an effective process for monitoring the quality of the dispensing process including reviewing errors and near misses for learning.

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?

Requires improvement

- 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 management of medicines.

Are services effective?

Good

- 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.

Are services caring?

Good

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example 94% said the last GP they saw was good at listening to them; 94% said the last nurse they saw was good at treating them with care and concern.
- Patients told us they were treated in a respectful and empathetic way by the practice's staff.
- We found many examples where staff had gone out their way to support patients, both practically and emotionally.

Summary of findings

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 there was continuity of care, with urgent appointments available the same day.
- 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.

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 its 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 to make 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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in end of life care, dementia and avoiding unplanned hospital admissions.

People with long term conditions

Good

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. A specialist diabetic nurse visited the practice each month and there were regular virtual consultations with a consultant. 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.

The practice was part of a scheme to ensure patients had access to 'just in case' medicines in the evening and at week-ends.

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Families, children and young people

Good

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 well 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. Information was available specifically for young people questioning their sexuality or gender identity.

Working age people (including those recently retired and students)

Good

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 nurses from 8.30am each morning and the practice opened till 8pm every Monday evening. The dispensary was open until 6pm each evening.

A full range of health promotion and screening that reflected the needs for this age group was available.

People whose circumstances may make them vulnerable

Good

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice performed well in indicators for dementia and mental health. Patients with significant mental health problems had annual mental health and medicines reviews.

The practice provided rooms for a range of mental health professionals to use to see patients, including those from the Gainsborough Foundation (alcohol support), and the IAPT team (independent access to psychological therapy).

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 better than local and national averages in most areas. 236 survey forms were distributed and 117 were returned, giving a response rate of 50 %.

- 96% described their overall experience of the surgery as good or very good, (CCG average 86%, national average 85%).
- 89% found the receptionists at the surgery helpful (CCG average 88%, national average 87%).
- 97% said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 44% with a preferred GP usually get to see or speak to that GP (CCG average 38%, national average 36 %).
- 90% 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. We received 10 responses, all of which were very positive about the service received.

We spoke with five patients during our inspection. 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 appointments were easy to get and they rarely waited a long time to be seen once arrived

We also spoke with the managers of two care home who told spoke very highly of the practice. They told us that the GPs always visited residents on request, and made referrals quickly if needed. One manager described the practice as a 'really supportive service, the doctors are never too busy to advise, never refuse to come out and are absolutely fantastic with our residents'. We also spoke with a range of health and social care professionals including the multi-disciplinary co-ordinator, a midwife and a health visitor, all of whom regarded the practice and its staff highly. All told us they would be happy to be a patient there.

Areas for improvement

Action the service MUST take to improve

Introduce an audit trail for prescription pads and computer forms so that they can monitor their use in line with national guidance.

Action the service SHOULD take to improve

- Implement a formal system to disseminate NICE guidance and ensure all clinicians are aware of any updates.
- Ensure that dispensary staff are supported to keep up to date, and that they are regularly assessed as competent to carry out their role.
- Establish an effective process for monitoring the quality of the dispensing process including reviewing errors and near misses for learning.

Parkhall 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 member of the CQC medicines' team.

Background to Parkhall Surgery

Parkhall Surgery is a well-established GP practice that has operated in the area for twenty five years. It serves approximately 4800 registered patients and has a general medical services contract with NHS Cambridgeshire and Peterborough CCG. It serves Somersham and the surrounding villages of Colne, Earith, Bluntisham, Needingworth and Pidley.

According to information taken from Public Health England, the patient population has a slightly higher than average number of patients aged 40-54 years, and a lower than average number of patients aged 19-39 years, compared to the practice's across England. The area in which it is situated has low levels of social and economic deprivation.

The practice team consists of two partnered GPs, two salaried GPs, two nurses and a health care assistant. 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, with extended opening hours on a Monday evening until 8pm. Out of hours' services are provided by Urgent Care Cambridge between these times.

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 was 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 18 May 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:

Detailed findings

- 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.

Requires improvement

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.

Significant events were a standing agenda item at the practice's meetings and we found evidence they had been discussed widely at both clinical and non-clinical meetings. We viewed the practice's significant event log which listed events dating back to 2008. We found that a detailed record had been kept of the incident type, the learning from it, and the date it had been discussed at the relevant staff meeting.

Overview of safety systems and processes

The practice had systems to manage and review risks to vulnerable children, young people and adults. It had appropriate policies and procedures in place which were easily available to staff. A recent audit of its safeguarding procedures had led to the practice updating its policy to include domestic violence, and reviewing its patient registration form to include a section relating to children. We were shown the practice's recently implemented protocol on reporting suspected cases of female genital mutilation.

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. We viewed a list of local safeguarding contacts in every consultation room, making them easily accessible to staff. Quarterly meetings were held with the health visitors to discuss all children with safeguarding concerns and minutes we viewed showed appropriate case review and action had taken place. We found that children on the child protection register were appropriately flagged on the practice's computer system.

Notices in treatment rooms advised patients that chaperones were available if required. Chaperoning was provided by the health care assistant or nursing staff all of whom had received relevant 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, 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 drawers and the first aid box 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.

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 training, and also specific training in hand washing techniques. Infection control audits were undertaken every six months and we saw evidence that action had been taken to address any shortfalls identified as a result. For example, chairs had been re-upholstered with easily cleanable material; soap dispensers had been attached to walls, disposable curtains had been purchased and bodily fluid spillage kits were now available. Following a suggestion raised by a member of the patient participation group (PPG), the practice had provided anti-bacterial hand gel on the reception desk.

Reception staff were able to describe to us the correct way to handle any specimens brought in by patients.

Medicines management

Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG medicines' management team to ensure prescribing was in line with best practice guidelines

for safe prescribing. Blank prescription forms and pads were securely stored but there was no system in place to track their use through the practice in line with national guidance so we could not be sure that if any were lost or stolen this would be promptly identified and investigated. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines against a patient specific prescription or direction from a prescriber.

There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines were appropriately qualified and had received general training such as health and safety. However there were no records to show they had undertaking any role specific learning and development in the last 18 months. The practice had signed up to the Dispensary Services Quality Scheme to ensure the quality of the service, but we noted that the practice did not carry out a regular competency assessment on dispensing staff.

Records showed that dispensing errors were recorded in the practice significant event log and reviewed at practice meetings, however the log in the dispensary did not reflect this. There was no record of 'near misses' and no evidence that trends were identified and monitored for learning. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).

The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. At the time of our visit the correct requisition form was not in use for all controlled drugs orders but the practice has since told us they have the form available. There were also arrangements in place for the destruction of controlled drugs.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency. We found evidence of audits that had been undertaken in response to alerts about diclofenac, domperidone and amlodipine to ensure that any changes required in patients' medicines had been implemented. There was also a system in place for the management of high-risk medicines. We checked a small sample of records for patients prescribed these medicines 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. The practice had signed up to a locality prescribing agreement to promote medicines optimisation. It also used an electronic prescribing decision support toll to ensure patients received the most appropriate and cost effective medicines.

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 0.34, compared to a local average of 0.29, and national average of 0.27. We looked at recent prescribing figures and the practice was one of five practices within the locality group of 17 to underspend on its prescribing budget.

Staffing and Recruitment

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to staff's employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice regularly used locums to cover GPs' annual leave and full employment checks were undertaken prior to their employment to ensure they were suitable to work. All new staff received an induction to their role.

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 assessments were reviewed each year by the practice manager to ensure they remained relevant and up to date.

Requires improvement

Are services safe?

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. Staff told us that they practised full fire evacuation drills every three months.

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 in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely

There was an instant messaging system on the computers in all the consultation and treatment rooms which 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 epidemics, utilities failure and fire. It contained contact details of staff and also useful telephone numbers for utility companies and supplier agencies. Senior staff kept a copy of the plan off site.

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. Clinicians we spoke with knew 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. We saw evidence that the latest guidance was discussed at clinical meetings. For example at a meeting in January 2016 nurses were given COPD and asthma revised guidelines. The practice had undertaken an audit on broad spectrum antibiotic use in response to NICE guidelines and used a two week cancer referrals template based on NICE guidelines. We were told that a clinical decision making tool for patients was to be installed by the CCG to enable faster access to the latest clinical information whilst in a patient's record. However, there was no formal system in place to disseminate guidance such as NICE and ensure all clinicians were aware of any updates .

Management, monitoring and improving outcomes for people

There was an effective recall system in place managed by one of 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 93% and the national average of 95%.

- Performance for diabetes related indicators was at 81%.This was 4 percentage points below the CCG average, and 4 percentage points below the national average. Exception reporting was lower at 7%, than the CCG average of 13% and national average of 11%.
- Performance for mental health related indicators was 100%. This was 8 percentage points above the CCG average and 7 percentage points above the national average. Exception reporting was comparable at 12% to the CCG average of 13% and national average of 11%.
- Performance for COPD related indicators was 100%. This was 4percentage points above the CCG average and 4 percentage points above the national average. Exception reporting was lower at 9%, than the CCG average of 14% and national average of 12%.
- Performance for asthma related indicators was 100%. This was 4 percentage points above the CCG average and 3 percentage points above the national average. Exception reporting was lower at 0.2%, than the CCG average of 7% and national average of 7%.

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 or A&E visit was regularly reviewed at the monthly clinical meetings, evidence of which we viewed. Emergency hospital admission rates for the practice were slightly lower at 11% per 1000 population, compared to the CCG average of 13% and national average of 15%.

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. These were usually undertaken in response to clinical events or patients' needs. We viewed a number of two cycle audits in total including those for minor surgery, COPD, steroid prescribing in polymyalgia, and the use of broad spectrum antibiotic prescribing, all of which had led to improved care for patients.

Effective staffing

The practice had a stable and long established GP team and staff told us there were always enough of them to maintain the smooth running of the practice. Three GPs

Good

Are services effective?

(for example, treatment is effective)

always worked on a Monday morning to cope with higher demand at this time. The nurse told us she had protected time each day for administrative work and her additional responsibilities which she greatly valued.

Turnover of staff was low allowing them to get to know patients well, and two staff had worked at the practice since it had open some 25 years ago. Locums were used to cover GPs' annual leave and sickness, but they regularly worked at the practice so knew it well.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. For example, one administrative staff member told us her request for cervical smear data input training had been granted. Training records we viewed showed that staff had undertaken a wide range of training including safeguarding patients, health and safety, equality and diversity, information governance and infection control. The GPs had undertaken additional training in dermoscopy, travel health, minor surgery and emergency medicine. Two of the nurses had undertaken recent training in diabetes medicines and the medical secretary undertaken medical terminology training. However, there were no recent records of role-specific training and updating for dispensary staff. The practice closed four afternoons a year to participate in either in-house or locality led 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 way of their identifying goals and developing training plans.

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. Staff used an electronic patient record to coordinate, document and manage patients' care. The practice had moved to a new computerised clinical system in the last two years and was undertaking further training in its use in the coming months. Correspondence and task 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 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. Health visitors were based in the practice and told us that practice staff worked well with them. A community diabetic nurse visited the practice every month to see patients with complex needs and a virtual clinic was held every year with a diabetes consultant to review these patients.

Consent to care and treatment

Records we viewed showed that staff had received recent training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards to ensure they understood their responsibilities when dealing with patients who were not able to make decisions for themselves.

Clinical staff we spoke with understood the key parts of MCA legislation and were able to describe how they implemented it in their work. Care home managers we spoke with told us that the GPs consulted and involved relatives about end of life care for their residents if appropriate. Clinicians with duties involving children and young people under 16 were aware of the need to consider Gillick competence and Fraser guidelines. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent.

Written consent forms were used for a range of surgical procedures, evidence of which we viewed.

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. One staff member was responsible for keeping patients' noticeboards up to date and changed the displays regularly. The practice's patient participation group held regular information evenings on topics such as nutrition and first aid.

Good

Are services effective?

(for example, treatment is effective)

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 of 170 patients who had been invited for a check in 2015/2016, 34 had taken up the offer. The practice was working to increase this uptake by changing the appointment times to make them more accessible for patients who worked.

The practice participated in the learning disability enhanced service and three of four patients of people with a learning disability had received an annual health check in the last 12 months. The one patient who hadn't received a check had only recently joined the practice.

The practice's uptake for the cervical screening programme in 2014-2015 was 83%, which was comparable to the CCG average of 82 %, and national average of 82%. Breast cancer screening was also higher at 79%, 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 86% to 94 %, and five year olds from 90% to 97%.

In order to encourage the uptake of flu vaccinations, the practice advertised in local shops and held flu clinics on a Saturday.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We were provided with many examples which highlighted the caring and empathetic nature of the practice's staff. For example, one nurse had spent considerable time with a patient who was very anxious about their smear test. This nurse had met with the patient beforehand to discuss the procedure and also let the patient handle the speculum, brush and gel used in the procedure. This nurse also told us of an occasion when a patient had experienced an anaphylaxis attack in the middle of a field. The nurse had stayed on the phone to the patient until they had managed to drive themselves to the nearest surgery. The practice's dispensers regularly delivered medicines to patients on their way home from work and the practice sent congratulations cards to new parents and birthday cards to 100 year olds. An additional appointment time had been created in the afternoon to accommodate the needs of a very autistic patient who found it difficult to wait.

One care home manager told us that the GPs always made a point of meeting a new resident within a week of their admission. We viewed a range of very positive comments made by patients who had completed the Friends and Family test (FFT): patients had described the practice's staff as caring, helpful and compassionate.

The practice's reception desk was completely separate from the patients' waiting area, and behind two sets of doors, allowing for good privacy and confidentiality. We noted that consultation and treatment room doors were closed during consultations, and that conversations taking could not be overheard. Consultation rooms had curtains round treatment couches to maintain patients' privacy during examinations.

Results from the national GP patient survey showed patients felt they were treated well by the practice's staff. The practice permored higher than local and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 93% said the GP gave them enough time (CCG average 87%, national average 87%).
- 98 % 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%).
- 99% said the nurse gave them enough time (CCG average 93%, national average 92%).

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 higher to local and national averages. For example:

- 91% 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%.
- 91% said the last GP they saw was good at involving them in decisions about their care (CCG average 82%, national average 82%)
- 96% said the last nurse they saw was good at explaining tests and treatments (CCG average of 90% and national average of 90%)
- 91% 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

We noted good information about support services in reception and the waiting room, including a flyer for young people who might be exploring their sexuality or gender identity.

The practice's computer system alerted GPs if a patient was also a carer and the practice had identified 68 (1.4%) of patients as carers. The nurse told us that she always asked patients if they had caring responsibilities when they came for their health check. The practice took part in the Carers'

Good

Are services caring?

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 practice's PPG held specific carers' support events four times a year and recent events had included presentations by an occupational therapist, The Carers' Trust and representatives from a local skills exchange project. The PPG had recently been awarded a £250 grant from the carers' peer support bursary fund and hoped to use it to hire venues for more talks.

GPs occasionally made their own mobile phone numbers available to patients at the end of their lives. One patient told us her husband, who was at the end of his life, was able to call his GP at any time, something which both she and her husband greatly valued. The practice usually rang family members after a bereavement to offer support and signpost to appropriate services. A midwife described to us some outstanding care that a patient and their family had received from the practice, following their sudden and aggressive diagnosis of cancer.

Good

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 locality 'just in case' medicines scheme to ensure that patients who might need medicines quickly at night or during week-ends had them easily available. Due to the distance to the nearest local hospital, the practice offered a minor injuries service to both registered and non-registered patients. The practice undertook fortnightly visits to two care homes to provide support and continuity of care to residents living there. It was also an approved yellow fever immunisation centre and offered a full range of immunisations for travel abroad.

The practice offered a number of services to patients in addition to chronic disease management. including well person clinics, minor surgery, hearing tests, ankle Dopplers and a range of contraception services. Weekly ante-natal clinics were held with the midwife at the practice and a dietician visited monthly to offer nutritional advice. A mental health worker attended every week to support patients.

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.

Care home managers told us the practice was very responsive to the needs of their residents and always visited on request. One manager told us that if they rang at 8.30am the resident always got a visit by lunchtime. Referrals were made quickly too, one care home manager commented that they had recently reported that a resident's mobility was deteriorating quickly and the GP had organised a physiotherapist to visit and assess the resident that same week.

The practice had access to a telephone interpretation service for people whose first language was not English.

There were both male and female GPs in the practice; allowing patients to see a doctor of their preferred gender.

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'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. About 40% of appointments each day were pre-bookable and about 60% were available to book on the day. Patients were able to ring at 8am, and again at 1pm for urgent appointments.

The opening times for the practice were on Mondays from 8am to 8pm, and Tuesdays to Fridays from 8am to 6pm. The practice remained opened during lunch time.

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.

- 84% of patients were satisfied with the surgery's opening hours, compared to a CCG average of 75 % and a national average of 75 %
- 97 % of patients said the last appointment they got was convenient (CCG average 93%, 92%).
- 97 % patients said they could get through easily to the surgery by phone (CCG average 75%, national average 73%).
- 65% 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

The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Information about how to complain was available in the reception area, in the patients' information booklet and on the website. There was a designated responsible person who handled all complaints in the practice and staff we spoke with had a good knowledge of the procedure.

The practice kept a log of both written and verbal complaints received, along with the action taken in response, and the date of the practice meeting where they had been discussed with staff. Complaints were a standing agenda item at the practice's meeting agenda and we

Good

Are services responsive to people's needs?

(for example, to feedback?)

viewed minutes where complaints had been discussed openly with those attending. It was clear that complaints were used to improve the service. For example, following a complaint about the lack of appointments, special appointments cards were given to the GPs so they could then hand them to the patients to indicate to reception staff that they required a priority appointment.

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 satisfactorily. Between 2014 and 2015,four complaints had been received by NHS England about 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

The practice's ethos was to provide, 'traditional, patient centred general practice informed by moderns evidence based medicine'. 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.

Staff we spoke with were clear about the forthcoming priorities for the practice which included possible federation with other practices, training student nurses, extending the role of the health care assistant and succession planning for the replacement of a partner.

Governance arrangements

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

Communication across the practice was structured around key scheduled meetings. There were monthly partners meetings, monthly clinical meetings, monthly MDT/ palliative care meetings, quarterly child protection meetings and whole practice meetings every six months. Detailed minutes were kept of all meetings and staff told us they were a good forum to discuss issues.

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 graded as satisfactory for the year 2015-2016..

Leadership and culture

On the day of inspection the GPs 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 we spoke with clearly enjoyed their job and were enthusiastic about their work. They described an inclusive, open and supportive environment in which their suggestions and views were valued by senior staff. There was a clear leadership structure in place and staff felt supported by management.

Staff told us that the practice supported them to maintain their clinical professional development through training; attendance at local network meetings and study days.

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. There was an active patient participation group (PPG) which met monthly with representatives from the practice and had supported them with providing patient feedback. The chair of the PPG told us she had a good working relationship with practice staff, and felt their concerns were listened to and respected.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing . To date, a total of 143 responses had been received from patients, 141 of whom would recommend the service, indicating high levels of satisfaction. There was a notice board devoted to FFT comments received on display in waiting area.

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 five out of five stars.

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. For example, one administrative assistant told us her suggestion to have a ten minute 'hot topic' slot provided by a GP at the start of their meetings had been agreed. This was to ensure that non-clinical staff were kept up to date with contemporary issues affecting health services. The acting practice manager told us that the practice had introduced electronic scanning to better manage its correspondence following her suggestion.

This section is primarily information for the provider

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
	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 in line with current legislation and guidance. We found that patients were not fully protected against the risks associated with the management of medicines because the provider did not have an audit trail for prescription pads and computer forms so that they could monitor their use in line with national guidance. Regulation 12(2)(g).