Milton Surgery

Quality Report

Coles Road,
Milton,
Cambridge,
Cambridgeshire,
CB24 6BL.
Tel: 01223420511
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.

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Overall summary

Patients we spoke with were generally happy with the service they received at Milton surgery. They spoke positively about the staff employed at the practice. Patients told us they felt that the practice was safe and that care was given to them in accordance with their wishes. They told us the practice was responsive to their needs. For example urgent appointments could be obtained on the day the patient contacts the practice. This reflected the information provided on the practice website. Patients told us about their experiences of the practice. The responses were positive from the patients we spoke with on the day, the comments cards completed and the practice's own survey completed in 2013, (150 questionnaires were sent out and 100% patient response received) .

There was evidence of investigation and learning from incidents, with changes implemented to improve patient care. The practice was effective in the way it provided care to patients. Clinical audits of patient care and prescribing were undertaken. There was evidence of response to staff training requirements. There were clear management structures at the practice. Staff told us they felt supported and spoke highly of the GPs and management team. We saw there were systems in place which regularly monitored the safety and effectiveness of the care provided.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS local area team about the practice. Neither of these organisations had any significant concerns about it.

We also examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of those patients in these groups.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to safeguard vulnerable patients from the risk of harm. Safeguarding policies and procedures were in place for both children and vulnerable adults. This enabled staff to recognise and act on concerns in relation to abuse. The practice had a robust process in place for recruiting staff to work at the practice. This included checking the registration of nurses and GPs, undertaking enhanced disclosure and barring service (DBS) checks and checking that staff were entitled to work in the UK.

There were effective systems in place to minimise the risk of infection.

There was appropriate and sufficient emergency medical equipment and medicine available.

Are services effective?

The practice was effective. There were procedures in place to deliver care and treatment to patients in line with the appropriate standards. Systems to improve the management and access for patients to health reviews of their long term conditions were implemented. There were joint working relationships with community services and engagement with health and social care providers to co-ordinate care and meet people's needs.

Are services caring?

The practice was caring. Patients and carers we spoke with described the service provided as good. The patients we spoke with felt they were listened to and respected. Patients told us they were involved in decisions about their care and treatment. Patients told us they were treated with dignity and respect by both the non-clinical and clinical staff.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice worked effectively with other health and social care services to ensure patients received the best outcomes. We found that the practice understood the individual needs of patients and made reasonable adjustments accordingly. The practice sought engagement with patients to gather feedback on the quality of the service provided and responded to the feedback in order to improve the service.

Are services well-led?

The practice was well-led. There was a clear leadership and management structure. The partners and the practice manager we

Summary of findings

spoke with understood how they needed to take forward the practice in the future to improve patients' experiences. There was a commitment to learn from feedback, complaints and incidents. The appointment system and nursing team had been restructured to improve efficiency and meet patients' expectations and this was reviewed daily. We saw that staff had an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt well supported.

There was evidence of a range of team meetings, which included department meetings and whole practice meetings.

There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice.

Summary of findings

The six population groups and what we found

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

Older people
Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. There was an awareness amongst the staff team that the local elderly population were striving to maintain independent living, either alone or with elderly partners. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care.

People with long-term conditions
The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice provided regular health care reviews for patients with a range of long term conditions. There was support and education provided to patients with conditions such as diabetes. The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives.

Mothers, babies, children and young people
The practice offered lifestyle advice to pregnant patients. The practice worked with local health visitors, midwives and school nurses to offer a full health surveillance programme for children. Checks were also made to ensure the maximum uptake of childhood immunisations. Health and advice checks were available for 15 year old patients.

The working-age population and those recently retired
The practice offered early morning opening times from 8am Monday to Friday to provide easier access for patients who were at work during the day. Patients were offered a choice when referred to other services.

People in vulnerable circumstances who may have poor access to primary care
The practice was accessible for any vulnerable group. The practice had identified patients with learning disabilities and treated them appropriately. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. The practice offered telephone consultations and contact via email. There was a booking in touch screen in the

reception area with a variety of languages available for people whose first language was not English. The practice used a telephone translation line to provide a confidential translation service to people whose first language was not English.	
People experiencing poor mental health Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with severe mental illnesses. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. The practice ensured that patients with poor mental health were able to access the practice at a time that was suitable for them. The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.	

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. This included representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room. Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected two comment cards, both of which contained detailed positive comments about the caring and compassionate attitude of the staff. Comments cards also included positive comments about the cleanliness of the practice, the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients.

The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with said they were happy, very satisfied and they got good treatment. Patients told us that the GPs were very good and they thought the practice was well run. Patients knew how to complain but told us they mostly had no complaints.

Patients told us there had been issues with the appointment system, but improvements had been made which were effective. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity. However over half of the patients we spoke with told us conversations at the reception desk could be overheard by patients sitting in the waiting room area. They were not aware of alternate arrangements in place at the practice where they could request a quiet area to have a private discussion.

We were told they were happy with the supply of repeat prescriptions and reported no delays in obtaining their medicines. Patients were satisfied with the facilities at the practice. However patients using wheelchairs told us they experienced problems opening the heavy front doors at the practice. Patients were not aware of any arrangements in place for asking reception staff for assistance to open these doors.

There was health care and practice information on display around the waiting room area. However people told us this was often repetitive and there was too much on display which made it difficult to locate specific information.

Of the two comment cards we received both commented on the building being clean and tidy.

Areas for improvement

Action the service MUST take to improve

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. We saw that repeat prescriptions were handed to patients without proper authority and that the medicines were supplied to patients before prescriptions were signed by the doctors. This is unsafe and unlawful practice. The practice must ensure that dispensing standard operating procedures are regularly reviewed with dispensing staff and that these are followed.

We saw evidence that dispensary staff had annual appraisals of their performance and practice manager told to us that the competence of staff to dispense medicines had been assessed. However there was no documentary evidence to support this. We could therefore not be assured that patients were dispensed their medicines by staff who had their competence regularly checked and deemed as satisfactory.

Action the service SHOULD take to improve

The practice should ensure controlled drugs that have expired and been put aside for disposal, are destroyed regularly.

Summary of findings

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice liaised with the parish council community warden and the local community multidisciplinary teams to ensure all those patients who required support, maintained independent living.

Milton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector, a practice manager and an Expert by Experience.

Background to Milton Surgery

Milton Surgery provides primary medical services to people living in the village of Milton, Cambridgeshire and the surrounding areas.

Milton Medical Practice is located in the town of Milton, Cambridgeshire. The practice provides primary medical services to approximately 4,755 patients and is situated in purpose built premises. The building provides good access with accessible toilets and car parking facilities. The practice has a team of three GPs meeting patients' needs. All the GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition to the team of three GP partners there are two registered nurses, one health care assistant and a phlebotomist a practice manager, an assistant practice manager, six reception/ administrative staff and one dispenser.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, health visitors and midwives.

The practice provides services to a diverse population age group, is in a semi-rural location and is a dispensing practice. A dispensing practice is where GPs dispense the medicines they prescribe for patients who live remotely from a community pharmacy. Not all patients at the practice were entitled to this service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Milton Surgery is open between Monday and Friday: 8am to 6pm.There are pre-bookable appointments designed to be used by patients going to work.

Outside of these hours a service is provided by another health care provider (Urgent Care Cambridgeshire) by patients dialling the national 111 service.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before conducting our announced inspection of Milton Surgery, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 27 August 2014. During our inspection we spoke with and interviewed a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients

Detailed findings

shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We held a listening event where patients and members of the public shared their views and experiences of the service.

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

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Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that they had maintained a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen, for example with a prescribing error or a safeguarding concern, they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

Learning and improvement from safety incidents

The practice had system in place for reporting, recording and monitoring significant events. We found the learning from safeguarding reviews was communicated internally at practice meetings and externally at multi-disciplinary team (MDT) Vulnerable and End of Life patients meeting. Staff told us that at the Vulnerable and End of Life patients meeting they would talk about individual patients and what they could have done differently. We saw the practice had learnt when things had gone wrong and put systems in place to improve safety and standards.

Reliable safety systems and processes including safeguarding

Staff told us they would access the practice safeguarding policies and procedures on line or by paper copies via the office. We were told staff received changes and updates via emails from line managers and team members and attended regular practice meetings, clinical meetings, and Vulnerable and End of Life Patients meetings where safeguarding concerns were discussed. The Vulnerable and End of Life Patients meetings had been changed to different days each month, this was to enable more clinicians to attend the meetings. Clinicians told us these meetings were useful and enabled working in partnership and improved patient care.

There were appropriate checks carried out when new staff were recruited, including locums. However we noted that in some cases evidence of two written references had not always been recorded in staff records. We discussed this with the practice manager who agreed to improve arrangements for recording references following our inspection.

We asked staff about the practice's policy for whistle blowing. This is a process which enables staff to raise concerns identified within the practice; this included concerns of poor practice by colleagues. The staff we spoke with were aware of this process and were aware of their responsibility to raise any concerns they had. We spoke with one member of staff and asked how they would support vulnerable patients who may present as emotionally distressed or angry due to their health conditions. We asked about systems in place to keep staff and patients safe. Staff were not all able to locate the panic button on the computer system or recall the chosen alert word when using the telephone. Staff were unsure how to summon assistance if they felt threatened. The practice immediately agreed to appraise all staff on the practice systems to keep staff and patients safe.

There were procedures in place at the practice for the use and training of chaperones. The practice held a register of staff who were trained to act as chaperones. These included nurses, health care assistants, phlebotomists and experienced receptionists. There were signs around the waiting room and treatment couches to confirm chaperones were available. One GP showed us the procedure used for recording when a chaperone had been offered. The systems in place recorded if the chaperone had been used or if the patient had declined a chaperone.

Monitoring safety and responding to risk

Staffing establishments (levels and skill mix) were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being.

Staff confirmed if they had daily concerns they would speak with the GP's and the practice manager for support and advice. The GPs discussed risks at patient level at the daily early morning clinician's meeting. GPs held informal Monday morning meetings to discuss prescribing issues. We saw that clinical meetings were another opportunity for clinicians to meet and discuss emerging risks.

We saw that staff recognised and responded appropriately to changing risks within the service. This included responding to busy periods. Staff told us they felt the practice manager listened to their concerns and acted on these. We saw that staff were supported in their role and knew what to do in urgent and emergency situations.

There were emergency medicines and equipment available to use in the event of an emergency, for example a

defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly and the equipment was available and fit for purpose. The practice manager told us that all staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

The patient leaflet and practice website gave patients information regarding urgent medical treatment both during and outside of surgery hours.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary was tidy and operated calmly with adequate staffing levels. We saw that refrigerated medicines were stored correctly.

We looked at controlled drugs stored at the practice. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We found that some controlled drugs that had expired in early 2013 had been put aside for disposal, but had still not been disposed of.

Staff were able to give examples of how dispensing practices were amended as a result of incidents arising. We were assured that if an error arose, it was recorded and appropriate actions were taken.

We saw there was a comprehensive range of standard operating procedures for staff to follow and that these were regularly updated. However we found that staff did not always follow these procedures.

We saw that repeat prescriptions were handed to patients without proper authority or consultation with the GP and that the medicines were supplied to patients before the prescription had been signed by the GP.

Dispensing staff working at the practice had received training to undertake dispensing tasks. The practice manager told us that the competence of staff to dispense medicines had been assessed, but there was no documentary evidence to support this. Staff we spoke with told us they had not received competency assessments. Therefore we could not be assured that patients were dispensed their medicines by staff who had their competence regularly checked. We discussed these concerns with the GPs and the practice manager. The provider confirmed arrangements for medicines management would be improved immediately following our inspection.

Cleanliness and infection control

We saw that the practice was clean and well maintained. Patients we spoke with said they were happy with the standards of hygiene at the practice. We observed, and staff told us, that personal protective equipment was readily available and was in date. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. There were hand washing posters above wash hand basins throughout the practice including in the patients' toilet.

There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely.

There were infection control policies in place and all staff understood the importance of ensuring that the policies were always followed. The practice manager told us the infection control lead from the primary care trust had carried out an infection control check of the practice and supplied a report (this was not available at the time of our inspection). We were told no further infection control checks had been actioned since that time. We found the arrangements for infection control had been discussed at the August 2014 clinical meeting and a clinician had been appointed as the infection control lead. However infection control systems and practices were still being established. We saw draft plans of daily and weekly duties for infection control audits. The practice confirmed the arrangements for infection control would be improved following on our inspection.

Legionella was tested at the practice on the 06 August 2014 by a contractor with no concerns or requirements raised.

Staffing and recruitment

We looked at the staff rota and the practice appointments rota. We saw that staffing was monitored and reviewed daily by the practice and assistant practice manager. However, the practice manager told us there were no formal systems in place for this. We were told by the

practice manager, and staff confirmed that administrative and receptionist staff were knowledgeable of each other's roles and were therefore able to stand in for each other in times of absence or busy periods.

Staff we spoke with staff confirmed if they had daily concerns they would ask any of the GPs, the practice manager or the assistant practice manager for support and advice. Staff felt their concerns were listened to and acted on.

Dealing with Emergencies

The practice had a business continuity plan in place. This detailed the responsibilities of the partners and the practice manager in the event of the plan needing to be implemented. All senior staff retained a copy of the plan off site. We saw that the plan was reviewed and updated every year or when suppliers, contact numbers, doctors or staff changed.

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities or periodic incidents such as bad weather or illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis.

The plan covered incidents such as the loss of the computer system, loss of utilities such as the telephone, electricity or water or the incapacity of clinical or reception/ administration staff. The plan was clear and told staff what to do in an emergency. Staff we spoke with were aware of the plan and had access to a paper and online copy. The practice manager told us many of the non-clinical staff worked part time and would cover each other where possible when they were changes in demand or disruption to staffing. The practice used a named agency for locums GPs and had built a trust with locums that they would employ and wanted to work for them. This ensured continuity of care to patients.

Equipment

There were policies in place for the safe use and maintenance of equipment. We saw that portable appliance testing had been regularly carried out on electrical equipment throughout the surgery.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

All clinicians we interviewed were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence and from local health commissioners.

The clinicians we interviewed demonstrated evidence based practice. All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were reviewed and implications for patients and practice performance were discussed. These were implemented and the use of them was monitored. All the GPs we spoke with were aware of their professional responsibility to maintain their knowledge.

The GPs had access to online prescribing support systems. These systems ensured that the GPs were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments. A clinical pharmacist from the local Clinical Commissioning Group (CCG) visited the practice every three months to review prescribing habits at the practice and to offer advice.

We found that patients had their needs assessed and that their care was planned and delivered in line with guidance and best practice. Patients were referred in line with guidance and best practice to secondary and other community care services. We saw that care and treatment decisions were based on people's needs without unlawful discrimination. National data showed the practice was in line with national standards on referral rates for all conditions. We saw appropriate use of the Two Week wait referrals. We saw minutes of meetings where regular review of elective and urgent referrals were made and that improvement to practice were shared with all clinical staff.

We saw that the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose the typical range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated if necessary.

Management, monitoring and improving outcomes for people

The practice used The Quality and Outcome Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that they generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well? in comparison to other practices within their CCG area. Staff spoke positively about the culture in the practice around clinical audit and quality improvement. We saw that Milton Surgery had undertaken clinical audits on prescribing, as requested by the prescribing adviser of Cambridgeshire CCG, such as non-steroidal prescribing and the practice had used the CCG prescribing formulary. In addition, the practice undertook a steroid inhaler audit, to ascertain whether the inhalers prescribed to patients were necessary (i.e.: the disease was steroid responsive, such as some cases of COPD).

The practice participated in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess performance. The practice liaised closely with the local parish council community warden, district nurses, the multidisciplinary team coordinator, the Arthur Rank hospice charity and the out of hour's service to try and reduce unplanned admissions. The Arthur Rank Hospice provided specialist palliative care to adult patients and their friends, family and carers from the practice. The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep patients in their own homes.

Effective Staffing, equipment and facilities

All staff were appropriately qualified to carry out their roles safely and effectively in line with best practice. There were effective induction programmes. The learning needs of staff were identified and training put in place which had a positive impact on patient outcomes. Staff felt well supported in the training programme. We saw the staff training record which showed that all staff were up to date with mandatory training including basic life support, infection control, fire safety, equality and diversity and

Are services effective?

(for example, treatment is effective)

safeguarding of vulnerable adults and children. Staff told us that they could ask to attend any relevant external training to further their development. There were opportunities for professional development beyond mandatory training such as telephone technique training, apprentice schemes for the practice health care assistant, management development training for the assistant practice manager and a practice development course for the practice manager.

The practice manager told us that poor performance was identified during observation of staff performance and in the staff appraisal process, and addressed with staff as a training or development requirement.

The practice manager told us that local practice managers had an email link where they could email questions for support and advice. The practice manager attended local practice manager meetings which the local CCG facilitated. We were told these were useful for support and development.

During our inspection the practice manager was able to access access information electronically to check all GPs at the practice were up to date with revalidations.

The practice was accredited by the University of Cambridge as a suitable teaching centre for trainee GPs and medical students. However at the time of our inspection there were no students in place at the practice.

Working with other services

The practice held monthly palliative care meetings. Palliative care and treatment was offered to patients with cancer and other life limiting illnesses, who were identified as approaching the end of their lives. This was confirmed by the GPs who advised that all patients with palliative care needs were reviewed during these meetings. We looked at the meeting minutes and saw these were attended by GPs and representatives of the community care team. The practice shared information with the out-of-hours service, for example special patient notes about patients with complex health needs.

Information about patients who had contacted the out of hours service, had been admitted to hospital, were seen in hospital clinics or had been discharged from hospital were reviewed daily by GPs at the practice.

Results of tests received by the practice, such as blood or urine results were seen by the GPs. Patients enquiring about the results of their tests were able to contact a practice nurse to discuss the findings. This ensured that patients had the opportunity to ask questions about their results.

Health, promotion and prevention

New patients who registered at the practice were offered a consultation for a new patient registration health check with a nurse to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height, weight, BMI). Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications. Staff showed us and told us about the New Patient's Registration pack. The nurse told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, lifestyles and/or any risk factors.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation advice. In addition the practice offered a weigh-2-go (weight loss programme) for patients who were18 years old and over. Patients would undergo an initial assessment and then be referred to Addenbrooks hospital obesity services. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. We saw a clear process that was followed for patients who did not attend for cervical smears.

Flu vaccinations were offered to all patients over the age of 65, those in the identified at risks groups and pregnant women. A one off Pneumococcal vaccination was offered to patients over 65. The practice offered a travel vaccinations service to patients.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients, their relatives and carers to organisations such as: Crossroads, Village Benefits and

Are services effective?

(for example, treatment is effective)

Help the Aged. The patient participation group ran a drop in session in a local café to offer support to patients and assist them, their relatives or carers to make informed decisions about their care and support.

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards in the reception area.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients and those close to them being treated with respect and dignity throughout our time at the practice. Staff in all roles treated people with dignity. Patients who used the service told us they felt supported and well-cared for. We saw that staff responded compassionately to patients discomfort and emotional distress in a timely and appropriate manner. Patients we spoke with confirmed that they had not felt rushed during their consultation.

We noted that staff approached people in a person centred way; they respected people's individual preferences, habits, culture, faith and background.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We received two completed cards which contained detailed positive comments. Both comment cards stated that patients were grateful for the caring attitude of the staff and for the treatment they had received at the practice.

We saw that staff were careful to follow the practice confidentiality policy when discussing patients' treatment in order that confidential information was kept private. This was respected at all times when delivering care, in staff discussions with people and those close to them, and in any written records. However we saw that patients conversations at the reception window could be overheard by patients sitting in the waiting room area of the practice. Staff told us that patients were offered a private area or an alternative window to use should they wish to have a private conversation. However not all the patients we spoke with were aware of this.

There were systems in place to support patients and those close to them to receive emotional support from suitably trained staff when required (particularly near the end of a person's life and during bereavement). The practice contacted bereaved families by phone and invited them to visit the practice to talk. Bereaved family members were offered the opportunity to speak with the GP or nurse whenever they wanted.

There was information available at the practice to signpost the patient and those close to them to support groups. Patients we spoke with told us they felt supported by the practice.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour they would raise these with the practice manager or the GPs. The practice manager told us these would be investigated and any learning outcomes identified would be shared with staff. We saw examples of how incidents had been discussed at staff and partnership/management meetings.

Involvement in decisions and consent

Patients we spoke with told us they felt involved in decisions about their treatment, planning their care, choosing and making decisions about their care and treatment, and were supported to do so where necessary. We were told the GPs and nurses gave them time to ask questions. They were happy with the level of information available at the practice and the information they were given. Patients we spoke with told us they understood the next steps in their treatment.

Staff told us that the majority of patients who used the service spoke English. Staff informed us that they had access to interpreter services when required.

We saw that staff had effective communication skills. People were communicated with in a way that they understood and was appropriate and respectful.

Patients and relatives were able to contact the service when needed and speak to someone about their care. We saw that the practice understood issues relating to confidentiality which did not exclude carers from being given appropriate information.

We saw examples of how young patients, those with learning disabilities, those whose first language was not English, those with mental health problems and patients with dementia were supported to make informed decisions about their care and treatment. Where patients did not have capacity to consent to their treatment, staff were able to give us good examples of how patient's best interest had been taken into account.

The GPs we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care plans and their capacity to give their own informed consent to treatment.

The nurse told us they had an understanding from the safeguarding training about The Mental Capacity Act (MCA) (2005) and people's capacity to consent. Staff told us they always talked to the patients and involved them in their

Are services caring?

care, and those close to them (including carers) were supported to make informed choices and decisions. We were told if a patient had been unable to make a decision about their care, they would be given all the information available and encouraged to make another appointment, to give them time to think about the options available to them.

Patients told us that nothing was undertaken at the practice, without their agreement or consent. For patients whose first language was not English, the practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

Patients we spoke with told us they felt the practice was responsive to their individual needs. The practice did not look after any patients in a care home for the elderly and therefore all their elderly and a high proportion of palliative care patients lived within their own homes. There was an awareness amongst the staff team that the local population were striving to maintain independent living, either alone or with elderly partners. Patients we spoke with told us they had been visited at home when appropriate and felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were made by the GP who was most familiar with the patient where possible. This included vaccinations for the elderly and annual health checks for patients with learning disabilities.

There was a suggestions and comments box available for patients feedback in the waiting room area of the practice. We saw the practice had responded to patient feedback. For example in response to patient comments and requests the practice had been trialling a new appointment system from 1 April 2014. The new system allowed patients to book the next day routine GP appointment slots on line, by telephone or in person from 3pm on the previous working day. The practice manager told us this was under daily review. Patients and staff we spoke with told us they were happy with the new system and felt the changes had been effective.

The practice had an active patient participation group (PPG). (A PPG is made up of practice patients and staff that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about a range and quality of services provided by the practice.) The aim of the PPG was to help to the practice engage with a cross-section of the population and obtain patient views. There was evidence of quarterly meetings with the PPG throughout the year. The practice had worked with the PPG to implement changes. For example following patient feedback the practice was trailing a new appointment system. The PPG were preparing to undertake a six monthly patient audit of the pilot system. This would include both written and verbal patient feedback to the practice on the effectiveness of the appointment system.

Access to the service

The practice was all on one level with ample parking facilities which provided easy access. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users and parents with pushchairs or prams. However patients using wheelchairs told us they experienced problems opening the heavy front doors at the practice. Patients were not aware of any arrangements in place for asking reception staff for assistance to open these doors. The reception staff told us they were available to assist and support patients who required it appropriately. We discussed this with the GPs and practice manager. We were told the practice was aware of problems with the doors; staff were always available to help people. The practice manager confirmed the practice were investigating alternative entrance facilities.

Patients were able to access the service in a way that was convenient for them. Patients could make appointments on-line, by telephone or in person. Information about the appointment system was found on the practice website, front door and by reception desk. Patients were happy with getting an appointment. We were told they liked the on line booking system. Patients were able to request a telephone consultation. GPs and staff were able to give us clear examples of how vulnerable people had been able to access the practice's services without fear of prejudice.

Patients could order repeat prescriptions on-line, by post or in person at the surgery. The practice aimed to have the prescription ready for collection within 48 hours.

There were arrangement in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, there was an answerphone message giving advice on telephone numbers to ring depending on the circumstances. Information on the out-of–hours service was also available on the practice website.

Meeting people's needs

There were systems in place for managing blood and test results from investigations and information from other providers, such as hospital consultations and out of hours services. When GPs were on holiday the other GPs covered

Are services responsive to people's needs?

(for example, to feedback?)

for each other. Patients' test results were seen each working day and where concerns had been identified, had been either given immediately, phoned through by a GP, sent by letter or supplied when they phoned the surgery.

Patients requiring further specialist investigation or treatment were referred using the 'choose and book' system. This was organised by delegated members of staff. The GPs told us that they ensured that patients understood the choices they had and that they were happy they had made the right choice. We saw that systems were in place to ensure there was timely referral for patients to secondary care. Patients we spoke with told us their referrals had always been discussed with them and they were happy that these had been handled in a timely way.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information on how to raise a complaint or concern was displayed within the practice and information was also available on the website. The process included timescales in which the practice would respond and information of other regulatory bodies to whom patients could complain.

We saw the practice's log and annual review of complaints it had received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

Are services well-led?

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

Our findings

Leadership and culture

We spoke with GPs, nurses, health care assistants, reception and administration staff during the inspection. There were clear lines of accountability and staff were aware of each other's roles and responsibilities. They told us that the GP partners and practice managers were very approachable and there was a strong team ethos throughout the practice. All of the staff we spoke with made very positive references to the open culture within the practice.

Staff told us they felt well supported and motivated and said they were treated well. We were told the practice manager and GPs listened to them and were resourceful with information, support and advice. One staff member told us if they needed any training this request would be taken to practice meetings and training arranged. Staff we spoke with told us they felt supported and valued by the practice

Governance arrangements

There were systems in place to manage governance of the practice. The practice had structured meetings that ensured information was shared, for example, GPs held weekly meetings to discuss clinical issues. GP partners and the practice manager met to discuss matters relating to the running of the practice such as staffing, significant events and complaints. This ensured that matters that may have an impact on patient care and safety were discussed to ensure awareness and effective service delivery.

There were clearly identified lead roles for areas such as medicines management, complaints and safeguarding.

Systems to monitor and improve quality and improvement

There were systems to assess and monitor the quality of service provided to patients. We saw that the practice had completed a number of audits to assess the quality of its services. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice was able to demonstrate that it was meeting the required QOF targets and that its performance was regularly monitored. There was a QOF lead at the practice and all clinicians contributed to the practice performance.

In addition to monitoring and reporting its performance against the national quality requirements, the practice had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG monthly. This enabled the practice and the CCG to have an overview of the practice performance, and monitor any areas that were below expectation. The practice was then able to put plans in place to improve its performance.

The practice manager told us they perform daily 'spot checks' on the running of the service which involved the daily observation and review of the performance of each member of staff and included a review of the clinicians records and notes. Issues highlighted were discussed with staff at either staff appraisal or if they were of concern, they were addressed with the member of staff immediately. Staff and the practice manager were all very clear of their understanding and responsibility to report concerns or issues. Where necessary they were able to detail how they would report concerns or whistleblow beyond the partners and the practice manager.

Patient experience and involvement

The practice recognised the importance of patient feedback and ensured that there were appropriate facilities available and advertised for patients to see. Patients who used the service were asked for their views about their care and the service, and their comments were acted on. Records showed that the results of the annual satisfaction surveys were analysed and that an action plan was put in place to help improve the service.

There was a comments and suggestions box in the reception area and an active Participation Group (PPG). (A PPG is made up of practice patients and staff that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about a range and quality of services provided by the practice.) The PPG group had highlighted problems associated with the appointment booking system. A patient survey had been conducted in 2013 by the practice. Of the 150 questionnaires sent out to patients the practice had received 150 responses. The findings of this survey were positive with 72% of patients surveyed reporting their experience of their GP surgery as excellent. However, patients had reported they were unhappy with the appointment system and concerns were raised at the time

Are services well-led?

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

as patients had to wait on arrival at the practice for their appointment time. It was noted that the practice had responded to these comments and developed a pilot appointment system which was introduced in April 2014.

Practice seeks and acts on feedback from users, public and staff

The practice had a patient participation group (PPG). One GP told us there were approximately 12 members of the PPG, meetings were held every six months and the practice manager attended these. We were told the PPG provided the minutes to their meetings and we saw evidence of these minutes and actions discussed at meetings.

The practice manager told us that the PPG for Milton Surgery was not representative of all the practice population as it had been difficult to recruit from certain demographic groups such as the young and working age population. The PPG were actively involved in the local community and held a local drop in café where they encouraged the elderly patient population and younger members of the local population to meet together. We looked at minutes of PPG meetings and saw these referenced the importance of encouraging patients to 'pass on their comments and concerns' to the group, patient feedback received and informing patients of the existence of the PPG and encouraging patients to join the group. There was an action plan in place to liaise with local PPG representatives from other surgeries to investigate how they had developed patient interest in their surgeries. The PPG planned to advertise the Milton PPG locally and run a stall at a local summer fete to encourage awareness among the local patient population. Minutes of meetings were available on the practice website. However the most recent meeting minutes were not available.

We spoke with members of the PPG who told us that they were happy that they could challenge decisions at the practice. We were told the PPG had requested the practice introduce the diabetic education sessions which had been successful and the appointment prompt card. This card was developed following feedback from the patient questionnaire. This encouraged patients to write down the reasons for their appointment beforehand and enabled the GP and the patient to focus on the reason for the consultation which ensured the ten minute appointment time was optimised with their clinician.

The staff we spoke with told us that they felt able to express their views to the practice manager and that any suggestions they had for improving the service would be taken seriously.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training afternoons where training took place.

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

Identification and management of risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. We saw risk assessments had been completed for health and safety risks relating to the building.

We looked at the business continuity plan for the practice. We saw that this included agreement of arrangements with other services for example in response to a disaster situation where the premises were no longer usable. The practice ensured that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care. Risks were discussed at the monthly practice meeting and any action taken or necessary was documented and cascaded to all staff.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice actively targeted older people to attend surgery for 'flu vaccinations. Patients who attended for flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by a GP or nurse to administer their flu vaccine.

All patients over the age of 75 had been provided with a named GP to help achieve continuity of care and reduce risk to patients. Patients in this group had been informed by letter who their named GP was, but were advised they could see any other GP at the practice if they preferred.

The practice did not look after any patients in a care home for the elderly and therefore all their elderly patients lived within their own homes. There was an awareness amongst the staff team that the local elderly population were striving to maintain independent living, either alone or with elderly partners. The practice liaised closely with the local parish council community warden, the district nurses, the multidisciplinary team coordinator, the Arthur Rank hospice charity and the out of hours service to try and achieve this. The Arthur Rank Hospice provides specialist palliative care to adult patients and their friends, family and carers. The practice held monthly multi-disciplinary meetings to discuss the most vulnerable patients and to organise the care required to keep them in their own homes.

Milton Medical Centre was taking part in a pilot working with the Alzheimer's society. The practice advised patients and where appropriate their relatives of the monthly Alzheimer's Society sessions held at the practice and the opportunity for patients or their carers to attend these sessions either at the practice or to be visited by the society within their own homes.

The practice patient participation group held a local drop in café where they encouraged the elderly patient population and the younger members of the local population to meet together.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice ran regular clinics for patients with long-term conditions such as diabetes, cardiovascular disease and asthma. We saw the practice followed a call and recall protocol to ensure that as many patients as possible with long term conditions regularly attended for a review. Patients with multiple long term conditions, where appropriate, were offered one appointment for their multiple annual reviews, incorporating all the tests required in the one session. When required patients were offered the opportunity to see their usual GP during their long term condition review. The practice patient participation group held a diabetes educational open evening for diabetic patients at the practice to support the self-management of their condition.

The practice held specialist diabetic nurse surgeries at the practice for their patients with diabetes. This ensured patients who could not travel to the local hospital were provided with a local specialist service. Diabetic patients were given a personal plan of their condition before their GP review appointment. This ensured they could review the plan and prepare any questions they wished to ask their GP.

The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives. The practice clinicians attended regular local long term condition monitoring sessions to ensure they were up to date and involved with the latest ideas and projects.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice offered lifestyle advice to pregnant patients.

The GPs made the first antenatal booking for pregnant women and the midwives held a surgery at the practice every Friday. The GPs offered mothers and babies a postnatal examination and a six week check which could be pre booked. Parents arriving at the practice for their babies first vaccinations were offered the 'When should I worry' leaflet which provided new parents advice on the management of respiratory tract infections such as coughs, colds, sore throats and ear aches in children. The practice offered eight month checks for babies and delivered the full range of childhood immunisations.

Health and advice checks were available for 15 year old patients. The practice liaised regularly with local health visitors and the school nurse. There was awareness amongst the staff team that young people telephoning or attending the practice would be offered an appointment with a GP.

The practice offered Friday afternoon appointments for family planning, but would also offer other appointments which would fit in with mothers and their children.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered pre bookable appointments for patients who may have difficulty attending during the day. The practice offered early morning opening times from 8am Monday to Friday to provide easier access for patients who were at work during the day. Patients could also consult the doctors by telephone or email rather than visiting the surgery.

The practice offered a choose and book referral service when patients needed to be referred to other services. Information on other services was also available. Patients could choose to be referred for further treatment or investigation at a hospital closer to their place of work if required.

The practice provided well woman and well man health checks.

The practice offered regular cervical smear appointments with recall periods dependent on identified risks.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was accessible for any vulnerable group. The staff culture evidenced that patients could access the practice's services without fear of prejudice.

The practice had identified patients with learning disabilities. These patients had individual care plans and were offered an annual health check. The practice had identified problems with carers from local homes for people with learning disabilities attending with patients for appointments with little understanding of the patients appointment needs. The practice had therefore developed a questionnaire for the homes to complete prior to the patient's appointment. This was filled out in advance of the appointment giving information about the patient and their health care problem. People with learning disabilities were offered appointments that suited their working hours.

Staff were prepared to assist patients with visual impairment, or whose first language was not English in filling in any forms or accessing healthcare if necessary. GP names were displayed on consulting room doors along with a large coloured dot, (a different colour for each GP), to help patients who could not read, whose first language was not English or for some who had visual disturbance to identify their GPs room.

The practice offered telephone consultations and contact via email, for patients that found it difficult for whatever reason to attend the surgery.

There was a booking in touch screen in the reception area with a variety of languages available.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice held a register of its patients known to have poor mental health. The practice worked in conjunction with the local mental health team and the community psychiatric nurses. Patients with poor mental health were invited to attend an annual health review. The practice ensured that patients with poor mental health were able to access the practice at a time that was good for them. For example, at a quieter time of the day, when there were fewer people in the waiting room or at the same time and with the same GP or nurse they had previously seen. Appointments were often pre booked and allowed for extra time during the consultation.

GPs recognised and managed referrals of more complex mental health problems to the appropriate specialist services.

The practice held a register of patients with dementia. These patients were offered a full annual health review. Carers were involved in the reviews as necessary.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe management of medicines.