Trumpington Street Medical Practice

Quality Report

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

Contents

Summary of findings

Overall summary

Trumpington Street Medical Practice provides a primary health care service for approximately 12,500 patients rising to 13,500 in October when the university term time begins. At the time of our inspection, there were five GP partners, one salaried GP and one GP in training (GP registrar). Doctors at the practice are supported by a practice manager, four practice nurses, one health care assistant and a team of reception and clerical staff.

We checked to see if services were safe, effective, caring, responsive and well-led. We found that Trumpington Street Medical Practice met all of these criteria. We looked at how the practice provided services for patients who were aged over 75; for patients with long-term conditions; for mothers, babies, children and young people; for patients of working age and those recently retired; for patients in vulnerable circumstances who may have poor access to primary care and for patients experiencing poor mental health. We found evidence of positive care for patients in each of 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 was safe.

There was evidence of a safe track record and systems to report, analyse and learn from significant events. Complaints and other events were discussed with all staff so that everyone could learn and work together to improve safety within the practice.

There were systems in place to protect patients and staff against the risk of infections. The practice had suitable policies and procedures in place to ensure that the premises were clean. Staff were provided with suitable protective equipment and undertook training to minimise the risk of infections.

Medicines used in the treatment of patients, including those for use in the event of a medical emergency were available and checked to ensure that they were within date.

There were procedures in place to safeguard people against the risk of abuse and staff undertook training to help them recognise people who may be vulnerable, and to report any concerns appropriately.

People were treated and cared for in safe and suitable premises. There was suitable equipment for the treatment of patients and this was regularly checked, calibrated and serviced to ensure it was safe and suitable for use. The practice had a business contingency plan in place to deal with any unforeseen circumstances which may disrupt the day-to-day running of the practice.

Are services effective?

The practice was effective.

The practice ensured that important information from NHS England area team, the local Clinical Commissioning Group (CCG) and from the National Institute for Health and Care Excellence (NICE) was shared with staff and acted upon. Care and treatment was delivered in line with current best practice. There was an effective system in place to manage the health reviews of patients with long term conditions and appropriate referrals were made to specialist services as required.

All staff had training and development plans and were provided with training opportunities to enhance the level of care and treatment provided to patients. Staff performance was appraised and staff had suitable supervision.

Summary of findings

Information and advice was provided to patients around diet, exercise, smoking cessation and alcohol intake, to promote and encourage patients to choose healthy life-style options. The practice participated in national screening programmes to help identify and prevent conditions such as diabetes, cervical cancer and the other preventable conditions.

Improvements in patient care were achieved through audit processes. The practice team demonstrated their knowledge of local cultures, local services and legal principles to provide information for their patients and to enable them to give informed consent to treatment.

Are services caring?

The practice was caring.

Patients we spoke with, and those who completed our comment cards, told us that all staff at the practice including doctors, nurses and receptionist were kind, compassionate and understanding. Patients felt their views were listened to and were respected. They told us that they were involved in making decisions about their care and treatment and they were treated with dignity and respect by both the clinical and non-clinical staff.

Patients, including children and adolescents, had access to counselling and bereavement services where appropriate.

The practice had an established Patient Participation Group (PPG). The PPG is a forum made up of patient representatives and staff who met regularly to discuss changes within the practice and how services could be improved for patients.

Patients' consent to their care and treatment was sought and their wishes acted upon. Where patients did not have the capacity to consent, the practice acted in accordance with the legal requirements to ensure that decisions were made in people's best interests.

Are services responsive to people's needs?

The service was responsive to people's needs.

The practice worked hard to meet patients' needs. Staff at the practice understood the needs of the practice population and they were aware of the changes to the population profile and make upwithin the local area and the impact this had on the needs of patients.

Summary of findings

The appointments system was tailored to meet the needs of patients. Where patients required specialist services or treatments appropriate and timely referrals were made, and patients were involved in making decisions about their treatment.

Patients with reduced mobility were offered appointments at the branch surgery, where there were disabled access facilities and on-site parking. This was because Trumpington Street Medical Practice was not easily accessible to those with a physical disability or mobility problems. The majority of consultation rooms were situated on the first floor and there was no lift access

There was a clear complaints policy and complaints were well received, investigated and responded to promptly.

Are services well-led?

The service was well led.

There was a robust leadership structure and clear allocation of responsibilities. There was an open and supportive culture. Patients and staff told us that they were involved in influencing how the practice was managed.

There was a system of audits and risk management in place to ensure patient, staff and visitor safety. There was a governance strategy in place and the practice staff understood how they needed to take forward the practice in the future.

There was evidence of a commitment to learning from patient feedback, complaints and incidents.

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

or older had a named accountable GP who was responsible for overseeing their care and treatment, in line with recent GP contract changes for 2014 to 2015.

Regular health and medication reviews were conducted to ensure that patients received appropriate and safe treatment.

The practice had established links with other health and social care professionals, such as district nurse teams so as to ensure that older patients received safe, effective and co-ordinated care to meet their needs.

Unplanned hospital admissions, re-admissions and use of the out-of-hours services were monitored to help identify patients who may be at risk and those whose treatment required review.

There were arrangements for identifying older people who were at risk of neglect or abuse. The practice had a lead person who was responsible for overseeing safeguarding matters and liaising with external agencies such as the local safeguarding team.

People with long-term conditions

The practice had effective systems in place to monitor patients with one or more chronic conditions. Patients were provided with information to help them manage their conditions.

Patients had access to regular reviews through the various clinics to monitor treatments and make changes if appropriate. Patients with long term conditions were referred to specialist services when appropriate.

Patients use of out-of-hours services, unplanned and re-admissions to hospital were monitored and reviewed to help identify where additional support or changes to treatment was required.

Information was provided about a range of long term conditions and the local and national support services available. Patients were encouraged to make healthy lifestyle choices to promote good health and help manage their medical conditions.

Mothers, babies, children and young people

The practice had effective arrangements in place to offer access to co-ordinated care for mothers, babies and young children.

Information and advice was available to promote health to women before, during and after pregnancy.

Summary of findings

The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying children who were at risk of abuse or neglect and sharing information with other agencies such as health visitors and social services as appropriate.

Expectant mothers had access to midwife clinics every week, alternating between the main practice and the branch surgery.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies.

Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

The working-age population and those recently retired

The practice provided safe and effective services to patients of working age and those who were recently retired. The practice had taken all reasonable steps to provide accessible appointments.

Patients with long term or chronic illnesses were reviewed and appropriate referrals were made to specialist services in a timely way where required.

There was information and support available for patients around promoting healthy lifestyles and maintaining good health. Patents were encouraged to participate in health screening.

Patients who were responsible for caring for others were supported and provided with information about the various agencies that provided practical, emotional and financial assistance.

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

The practice had arrangements in place to ensure access to its services to patients who were vulnerable as a result of social or other circumstances. This included people with certain medical or mental health conditions, people who had learning disabilities and those who were homeless or from travelling communities or migrant populations.

The practice had systems for monitoring the health and attendance for patients who were vulnerable and those who had difficulty is accessing services. Patients who had learning disabilities were provided with an annual health check review.

Information was shared with appropriate community health and social care agencies to help ensure that patients received safe and coordinated care.

Summary of findings

People experiencing poor mental health

The practice had systems in place to offer support to people with mental health conditions. They recognised the pressures faced by students as they coped with being away from home and family; and the stresses of university life. One of the GPs had a special interest in mental health issues and acted as a lead within the practice.

Staff treated people sensitively and were aware of their responsibilities for raising concerns such as missed appointments. Counselling services were available on a weekly basis and patients who were suffering mental health problems were referred to specialist services.

Patients health needs were reviewed regularly and health screening and checks were provided. Patients' attendance for appointments was monitored and concerns were shared with other professionals as appropriate.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and we received feedback from eight representatives from the Patient's Participation Group (PPG). A PPG is a patient and staff forum who met to discuss ways in which the service could be improved for patients. We also spoke with three carers (patients who provided care to others such as family members) during our inspection. We reviewed comments made by 16 patients who completed our comment cards prior to our inspection. We also spoke with staff from two care homes to which the practice provided a service.

All patients we spoke with and those who completed our comment cards made positive comments about the service and treatment that they received. Patients told us that they could easily access appointments at times to suit them.

Patients said that their care and treatments were explained to them in a way that they could understand and that they were involved in making decisions.

Patients told us that they had no concerns or complaints about the practice and they felt confident that any concerns would be handled appropriately. They said that they were treated with respect and kindness by all staff.

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice treated a predominately student population. They recognised the issues faced by students such as isolation, living away from family and support networks and the pressures of student life. An in-house counselling service was provided with sessions available each week.

The practice scored higher than the national average for patients who would recommend the surgery. Patients expressed very high satisfaction with how they were treated and the medical care and treatment that they received.

Trumpington Street Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team included two CQC inspectors; a GP specialist advisor and a practice management specialist advisor.

Background to Trumpington Street Medical Practice

Trumpington Street Medical Practice is located in Cambridge City Centre. The practice provides a range of primary medical services to around 12,500 patients. This number rises to approximately 13,500 in October with the start of the new intake of students by the University of Cambridge.

Due to its location and proximity to the University of Cambridge, a high number of patients are students. Other population groups including mothers, babies and young children and working aged people numbers are increasing due to new residential housing developments.

The practice is managed by five GP partners, one salaried GP and one GP in training (GP registrar). Doctors at the practice are supported by a practice manager, four practice nurses, one health care assistant and a team of reception and clerical staff.

The main practice is located in Trumpington Street. There is a branch surgery located at 17 Beverley Way, Trumpington, Cambridge. The branch surgery was not visited as part of this inspection.

Trumpington Street Medical Practice has opted out of providing out-of-hours services to patients. These services are provided by a local out-of hours provider and details of how to access these services are available in the practice and on their website.

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

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced inspection of this practice on 4 September 2014. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. As part of our inspection we spoke with six patients and read comment cards left for us by a further 24 patients. We spoke with seven members of the practice team including doctors; practice nurses, managers, administrators, health care assistants and receptionists.

We read a range of documents produced by the practice, including policies, practice guidance, staff records, minutes of meetings and audits. We reviewed summaries of information based on statistics collected by the local Clinical Commissioning Group (CCG) and other parts of the NHS. We observed non-clinical activities throughout the day.

Are services safe?

Our findings

The services were safe

Safe patient care

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive care and to improve safety.

Complaints, accidents and other incidents such as significant events were reviewed and discussed regularly during practice meetings to monitor the practice's safety record and to take action to improve on this where appropriate.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events.

Staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

We looked at records and saw that accidents and any other safety incidents were fully investigated and a root cause analysis was carried out to help determine where improvements could be made to avoid recurrence. Ongoing complaints and significant events were discussed with staff at weekly practice meetings to promote learning and improvements where needed. Minutes from practice meetings seen confirmed this. Investigations into safety incidents were reviewed periodically to ensure that staff learning was embedded in practice and patient safety was improved.

Safeguarding

The practice had suitable procedures in place to help protect adults and children who may be vulnerable, against the risk of abuse or harm. There were guidelines for staff to follow when patients who had been identified as vulnerable, either due to social circumstances or as a result of a mental health condition or a learning disability, had failed to attend appointments. Staff were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns.

Staff undertook training in safeguarding children and vulnerable adults. One GP was nominated as the lead for safeguarding and had oversight for safeguarding procedures and practices. They showed us how information about vulnerable adults and children was shared between appropriate health care professionals such as social workers, community nurses and health visitors to help safeguard patients from harm, abuse (including domestic abuse) or neglect.

The patients we spoke with told us they felt safe at the practice. They told us that they felt they were well cared for, and that they had no concerns about the practice. There were leaflets available to patients about organisations that they could contact if they had concerns about their safety or that of someone close to them.

We saw that patients' personal information was kept securely. There were governance arrangements in place to ensure that only staff who required access to medical records had the means to see this part of the computer system. Paper records were kept in locked storage.

Monitoring safety and responding to risk

The practice had a staff rota that set minimum staffing levels and these were reviewed weekly or more frequently, if needed. Patients we spoke with and those who completed comment cards said that they had access to appointments to meet their needs. There were arrangements for increasing staffing levels to manage increased demand for services during busy periods as part of the business continuity plan.

There were arrangements in place for dealing with medical emergencies. Staff had undertaken training in basic first aid, cardio-pulmonary resuscitation (CPR) and treating anaphylaxis (potentially dangerous allergic reactions to medicines and vaccines). Staff were aware of the

procedures to follow in the event of a medical emergency. They could describe how they would summon assistance in the event of urgent or emergency situations such as physical health emergencies, mental health crises, or other incidents. The practice had suitable equipment and medicines to deal with medical emergencies. These were checked by the practice staff to ensure that they were in date and fit for use if required.

Medicines management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date.

Information about the arrangements for obtaining repeat prescriptions was made available to patients. This information was displayed in the practice and available on their website. The practice followed national guidelines around medicines prescribing and repeat prescriptions. Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully.

Cleanliness and infection control

The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. There were infection control policies and procedures for staff to follow. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments, needles and dealing with needle stick injuries.

Staff told us that they had undertaken infection control training. All staff were provided with suitable protective clothing and equipment such as aprons, gloves and protective eyewear. Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

We spoke with one nurse who was the infection control lead for the practice. They told us that they had oversight for infection control practices, including auditing the procedures to ensure that they were effective. We saw that regular infection control audits were carried out. The results of these audits demonstrated that there were suitable arrangements for minimising the risks of infection to both patients and staff.

All areas of the practice, including consultation and treatment rooms were visibly clean and tidy. The practice employed an external cleaner to carry out general cleaning tasks. The cleaners were provided with cleaning schedules and checklists. Some of these had not been completed. However the practice manager assured us that daily checks were carried out to ensure that all the required cleaning had been completed.

The practice had a service level agreement with the local hospital sterile services for cleaning and sterilising re-usable surgical instruments. There were arrangements in place for the storage and disposal of waste matter including clinical waste.

Staffing and recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. We checked staff files and found that employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. There were procedures in place for managing under-performance or any other disciplinary issues.

Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required

Are services safe?

to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures), or adverse weather conditions.

Dealing with Emergencies

The practice had clear procedures in place for dealing with emergency situations or events that may disrupt the delivery of service or impact upon the care and treatments provided to patients. There was a business continuity plan in place for staff to refer to in the event of disruption to the service. The plan included instructions on what to do if there was a failure in the supply of domestic utility services, a fire or a change in staffing numbers. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred. Staff were aware of the arrangements at the practice for identifying and responding to emergency situations.

Equipment

Staff had access to appropriate equipment to safely meet patients' needs. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment such as an automatic external defibrillator was periodically checked and calibrated to ensure accurate results for patients.

All equipment within the practice was regularly checked by staff and records were kept to show when these checks were carried out. Where appropriate equipment was serviced in line with the manufacturer's recommendations.

Are services effective?

(for example, treatment is effective)

Our findings

The services were effective

Promoting best practice

The practice actively participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local Clinical Commissioning Group (CCG) led enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care in general practice.

Information and alerts such as National Patient Safety Alerts (NPSA) and other guidance and patient safety information from organisations such as the National Institute for Health and Care and Excellence was reviewed by the GP partners. This information was made available to and shared with staff by email notifications and during staff meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments.

The practice ensured that patients had access to appropriate health checks and assessments. Patients who had learning disabilities were provided with an annual health check review. All new patients were assessed for mental health issues. Counselling services were available and patients were referred for specialist care and treatments as required.

There were consistent systems in place for monitoring and treating people with chronic long term conditions such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD). Regular clinics were held to monitor and review patients' treatment and progress. The practice is commissioned by NHS England to take an enhanced role in monitoring and reducing avoidable unscheduled hospital admissions. Monthly multi-disciplinary meetings were held with district and community nurses to ensure that services were planned and coordinated to meet the changing needs of patients. Up to date information was available via the SystemOne computerised records system so that all agencies involved in the treatment of patients including the out-of-hours services were aware of patients' needs.

Management, monitoring and improving outcomes for people

The practice participated in clinical audits and peer review, which led to improvements in clinical care. Clinical audits and peer review are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. We saw a number of clinical audits had recently been carried out. These included audits around medicines such as the use of antipsychotic medicines in treating patients with dementia to help identify risks and benefits. The results and any necessary actions were discussed at the weekly GPs meetings.

Doctors in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and NICE guidance. The staff were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

The GP partners showed us how the practice was making use of reference data collected by the NHS in order to gain an insight into the effectiveness of the practice. This included information taken from the Quality and Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was higher than the local and national average, demonstrating that they were providing effective assessments and treatments for patients.

Complete, accurate and timely performance information was published by the practice. This included the results of the patient survey and the action plan identifying areas for improvements and how these would be achieved.

Staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Robust checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for ten members of staff. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration.

All new staff underwent a period of induction to the practice. There were tailored induction packs to support

Are services effective?

(for example, treatment is effective)

new staff according to their role and job description. Support was available to all new staff to help them settle into their new role and to familiarise themselves with relevant policies, procedures and practices.

Training and development needs were identified through annual appraisal of staff performance. Staff had personal development plans, which were kept under review. We saw that where staff had identified training interests arrangements had been made to provide suitable courses and opportunities. Nursing staff told us that they received regular clinical supervision, support and advice from the GPs when needed. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had named GPs and nurses to act as leads for overseeing areas such as safeguarding, infection control, palliative care and treatment and staff training. One nurse had undertaken specialist training in the treatment of minor illness such as colds, flu, acute asthma, digestive complaints and urinary tract infections. This enabled the doctors to prioritise other problems and conditions.

There was appropriate equipment available for assessing patients' health and treating medical conditions. All equipment was regularly cleaned, checked and calibrated as needed. The practice had appropriate facilities for carrying out consultations and there was a dedicated treatment room for performing minor surgical procedures such as wart and mole removal. The premises were unsuitable for patients who have reduced mobility as there were no disabled access facilities and no passenger lift to access the consulting rooms on the first floor. Patients who could not access the premises were offered treatment at the practice's branch surgery which has parking and disabled access facilities.

Working with other services

Trumpington Street Medical Practice did not provide an out-of-hours services for its patients. This is a service which was contracted out to another provider. Information about patients who were receiving palliative care and those who had chronic long-term conditions was available via the computerised records so that patients who contacted the service could receive appropriate treatment. There were robust systems for ensuring that information about patients' needs was shared in a timely manner between all of the agencies involved in the person's care and treatment. There were arrangements in place for working with the local out-of-hours service to ensure that information about treatment and risks was handled appropriately. We saw that treatment records for patients who had used the out-of-hours service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

GPs and nurses at the practice worked closely with Macmillan nurses who support people with life limiting illnesses. They held a monthly palliative care meeting with other doctors, nurses, healthcare assistants and Macmillan nurses attending to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs. There were arrangements in place to inform the local out-of-hours service about any patients on a palliative care pathway.

The practice understood the specific needs of the student population in relation to mental health and the pressures of student life, and staff maintained strong links with local mental health services and support agencies.

Staff from two local care homes reported that doctors were proactive in reviewing and treating patients who lived at the homes. They said that weekly visits were made to review new and existing patients, and that visits were easy to arrange when a patient's health deteriorated.

Health, promotion and prevention

All newly registered patients were offered routine medical check-up appointments with a nurse, health care assistant or GP. Patients between 16 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months could book an appointment for a general health check-up.

There was a range of health promotion leaflets available in the waiting area with information to promote good physical and mental health and lifestyle choices. We saw information about mental health domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption, contraception. Sexual health and smoking cessation sessions were provided. There were also leaflets signposting patients to other local and national

Are services effective?

(for example, treatment is effective)

support and advice agencies. Information about health promotion was available on the practice website and patients were encouraged to access a local NHS supporting self-care booklet.

The practice had arrangements in place for supporting patients who were caring for others. Information about local support agencies was readily available in the waiting area. Where appropriate, referrals were made to health or social care services so that patients and their carers received additional support according to their needs.

There were arrangements for monitoring the health and reviewing treatments for patients with chronic or long term conditions such as such as diabetes, heart disease, respiratory problems, dementia and stroke. The practice held weekly clinics for patients with a range of chronic or long term health conditions such as diabetes, asthma and chronic obstructive airways disease (COPD). The practice's computerised records system was used to identify review dates, which enabled staff to schedule appointments. Well Person clinics were available and screening services were provided to deal with the four main risk factors for heart disease, high blood pressure, diabetes, smoking and high cholesterol level.

Are services caring?

Our findings

The services were caring

Respect, dignity, compassion and empathy

Before the inspection took place we had asked people who used the service to complete comment cards. We received 16 completed cards. The comments were all positive and patients who completed these praised the doctors, nurses and reception staff for their helpfulness and caring attitude.

The practice was located in an older style property, which was not easily accessible to patients with mobility issues. Patients with mobility difficulties were offered treatment at the branch surgery, which was located about one mile away from the main practice.

The practice treated a predominately student population. They recognised the issues faced by students such as isolation, living away from family and support networks and the pressures of student life. An in-house counselling service was provided with sessions available each week.

One of the GPs took the lead on reviewing patients who were receiving palliative care and treatment. Recently bereaved families and individual carers were offered referrals to local counselling and bereavement support services. There were a variety of information leaflets in the waiting area signposting patients and carers to local and national support agencies such as the British Red Cross, Mind and Macmillan counselling services.

The practice worked proactively to identify patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were invited to complete a 'carers form' so that they could be identified and provided with information and support to access local services and benefits designed to assist carers.

During our inspection we spoke with six patients who used the practice. They described the service provided as very good or excellent. Patients said that staff were caring and compassionate and they felt their views were listened to and respected. The practice scored higher than the average national scores for patients expressing satisfaction with how they were treated, cared for and respected by staff.

Staff were aware of the practices' policies for respecting patients' privacy and dignity. Records showed that relevant staff had undertaken training on how to chaperone a patient, and were aware of the procedure. There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

Involvement in decisions and consent

The practice had policies and procedures in place for obtaining patient's' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act 2005 and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

Patients told us that they were involved in making informed decisions about their treatment. They said that discussions about their health and treatment were appropriate and that information was provided in a way that they could understand.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon.

The practice had a virtual Patient Participation Group (PPG) made up of 40 patient representatives who were contacted regularly to discuss changes within the practice and how services could be improved for patients. The minutes from the group's meeting were available on the practice website, as was information inviting people to join the group. We contacted ten members of the group and they confirmed that staff were very receptive to suggestions and comments.

The practice had a variety of patient information leaflets and notices on display. Information about the practice was available in different languages, which represented the local population ethnicities. A variety of leaflets were available, which covered health conditions, health

Are services caring?

promotion and screening, and support groups. Patients told us they felt they had been involved in decisions about their care and treatment. They said they were given verbal and written information about their illness and the treatment they received. Patients told us that nursing and medical staff explained their care and treatments, and answered any questions they had in a way that they could understand.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The services were responsive.

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to plan and deliver services. Students and working aged people made up the majority of patients. Staff understood the needs of patients and in particular the issues faced by students due to isolation and pressures. There were in-house counselling services available on a weekly basis. The practice managing partners were aware of the changes to the population profile within the local area including an increase in patient population due to planned residential housing plans. They were aware of the impact this had on the needs of patients and there were plans in place to increase capacity to meet these needs.

We saw that the practice had high scores for services within the Quality and Outcomes Framework established by NHS to promote excellence in healthcare and managed locally by the Clinical Commissioning Group (CCG) and Local Area Team.

The practice engaged with local community nursing teams and the Macmillan service to ensure that patients' end of life care was monitored and adjusted to reflect changes in their needs over time.

A number of clinics such as antenatal and postnatal clinics, childhood immunisation and leg ulcer clinics were held. The practice provided minor surgery services including wart and mole removal. We were contacted by eight members of the Patient Participation Group (PPG). They told us that the practice was very responsive to patients' needs.

Access to the service

Staff at the practice understood the needs of the practice population and they were aware of the changes to the population profile within the local area and the impact this had on the needs of patients. The practice had developed an appointment system to meet the needs of patients. Details of the services available, how to book, change or cancel appointments were posted throughout the practice and displayed on the website.

The practice was open between 8.30am and 6pm and operated a 'duty doctor' system for same day morning and afternoon appointments. Pre-bookable appointments were also available. Due to the nature of the building access for patients who had reduced mobility was difficult as there were no parking facilities, passenger lift or disabled access. Patients who were unable to access services at the Trumpington Street practice were offered treatments at their branch surgery, which had parking and disabled access facilities.

Home visits were available to see patients who were frail or too unwell to attend the practice. These were usually carried out after surgery appointments or sooner if urgent.

The out of hours service was carried out by a local provider and information about how to access this service was found in the practice information leaflet and the practice website. The practice had a clear, easy to navigate website which contained detailed information to support patients including the arrangements for making and cancelling appointments, requesting and accessing repeat prescriptions and obtaining blood results.

Information about the practice, appointments system and the clinics available was provided in a variety of languages to assist patients whose first language was not English. A touch screen self-booking system was available to minimise delays during busy periods.

We spoke with six patients on the day of the inspection, contacted eight members of the patient group by email and we read 24 comment cards left for us. We received no complaints about accessing the services, choice or waiting times. People told us that they were always able to get appointments which suited them. Data from the NHS GP patient survey showed that Trumpington Street Medical Practice performed better than expected in patients' convenience and experience of making appointments.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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.

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for investigating and responding to complaints and concerns. Patients were advised what they could do if they remained

Are services responsive to people's needs?

(for example, to feedback?)

dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Staff were aware of these procedures and of the designated person who handled complaints. GPs, nurses and administrative staff told us that the practice had an open culture where they felt safe and able to raise concerns.

They told us learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise.

The complaints seen showed a caring and articulate response. Investigations into concerns were thorough and action for improvements were recorded acted upon. Ongoing and recent complaints or concerns were discussed at regular staff meetings to help ensure that staff were aware of any issues and learning from complaints and concerns. Patients we spoke with confirmed that when they had cause to complain or raise concerns that these were dealt with promptly and thoroughly.

Are services well-led?

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

Our findings

The services were well led

Leadership and culture

Trumpington Street Medical Practice had a clear vision and staff we spoke with were aware of the vision, values and future plans for the practice. The practice promoted an ethos by which patients received high quality care and where they were in charge of their healthcare. Patients we spoke with confirmed that they were encouraged and supported to do so.

The practice had clear leadership systems in place and a number of GPs and nurses took the lead in overseeing areas such as managing risks and improving quality and safety outcomes for patients. There were comprehensive risk assessments for clinical risks and other risks associated with the practice, including clinical practice, environment, equipment and staffing. We saw that all areas of risk were reviewed regularly.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, audits and listening to staff and patients.

Governance arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that there were clear leadership arrangements and everyone was aware of their roles and responsibilities within the team. A number of staff had lead roles, these included infection control, palliative care, safeguarding, and staff had oversight for procedures within the practice to help inform other staff and improve standards and safety.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. Roles and responsibilities were clearly defined and identified. We saw evidence that processes and procedures were working and in practice. The practice had robust systems for monitoring and reviewing the delivery of patient care and treatment. A range of audits and checks were regularly carried out to ensure that patients were treated in safe and appropriate premises and that they received safe and high quality care and treatments.

Monthly clinical governance meetings were held between the GPs and the practice manager. During these meetings decisions about clinical issues were discussed and any outstanding issues were reviewed and where appropriate resolved. We saw that the arrangements for patient appointments were regularly discussed to see if these could be improved. Other regular staff meetings were held where the day to day business of the practice such as skill mix, safety issues, new initiatives and clinical matters were discussed. Meetings were recorded and we were able to see that decisions had been made and communicated effectively. Any actions arising from these meetings were clearly documented, allocated to staff for completion, and followed up at subsequent meetings.

We saw the practice had achieved an overall achievement of level two with the 'information governance (IG) toolkit'. The IG toolkit is an online system which allows NHS organisations and partners to assess themselves against department of health IG policies and standards. It also allows members of the public to view participating organisations' IG toolkit evaluations. Level two is a satisfactory achievement for primary care services using this toolkit.

Systems to monitor and improve quality and improvement

We found the practice manager and partners held regular practice meetings and this included reviewing the register of all accidents/incidents and significant events which had taken place, including lessons learned from them. There were also ongoing checks of the safe running of the practice such as legionella testing, infection control monitoring and fire safety.

The practice manager and clinicians were aware of the needs of the practice population and tailored the service to meet the needs of the local population groups.

We were told the GPs received external peer reviews through their annual appraisals.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) The PPG is a forum made up of patient representatives and staff who discuss changes within the practice and how services could be improved for patients.

Are services well-led?

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

The practice has a high number of students and informed new patients about the group when they registered. There were posters and information on the practice website informing patients about the group and how to join.

The PPG conducted annual patient surveys. The results from the most recent survey, which was carried out in 2013 showed that the majority of patients were very happy with the care and treatments that they received. As part of the survey it was identified that many patients would like to use online services for booking / changing appointments and re-ordering repeat prescriptions but were unaware that they could do so. As a result of the survey an action plan was developed to improve patient awareness of the available online services.

Patients we spoke with told us that they were aware of the patient group. Those who were unable to be part of this group told us that they were always listened to by staff at the practice. Members of the patient group said that they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and nation GP surveys.

Learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality, safe and effective care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Identification and management of risk

The practice had systems in place for anticipating and assessing risks to the safety and welfare of patients and staff. This helped to ensure that any risks to the delivery of high quality care were identified and mitigated before they became issues which adversely impacted on the quality of care. Staff we spoke with were aware of their individual responsibilities around identifying and reporting areas of risk. Staff told us that they knew who to report any issues to within the team dependant on that individuals' responsibilities.

Risks were discussed at the regular weekly and monthly practice meetings; any actions taken if 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 provided individualised tailored care to meet the needs of patients who were 75 years or older. This was achieved by speaking with people and understanding their individual needs and supporting them with their choices. The practice identified people with caring responsibilities and those who required additional support and referrals were made to other support agencies as appropriate. Written information about a number of local support agencies who provided practical, social, emotional and financial assistance to older people.

We found that all unplanned hospital admissions or readmissions of older patients were reviewed to help identify patients changing needs and identify patients who may be vulnerable. The practice had established links with other health and social care professionals, such as district nurse teams to ensure that older patients received safe, effective and co-ordinated care to meet their needs. GPs at the practice were involved through multidisciplinary meetings in the planned discharges of older patients from hospital to help ensure these were arranged safely and to minimise preventable re-admissions.

Each patient who was 75 years or older had a named accountable GP who was responsible for the overview of their care and treatment. We found regular patient care reviews, including medicines reviews were conducted in consultation with patients and carers where appropriate to ensure that patients care and treatment continued to be safe and effective.

There were arrangements for identifying older people who were at risk of neglect or abuse. The practice had a lead person who was responsible for overseeing safeguarding matters and liaising with external agencies such as the local safeguarding team.

Home visits were provided for patients who could not attend the practice due to frailty or poor health. The practice provided a reliable service to patients who were living in local care homes. Staff we spoke with from two care homes told us that they could easily access assistance and advice over the telephone if a person's health deteriorated and that home visits were always carried out when requested.

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 provided individualised tailored care to meet the needs of patients who had one or more long term condition. This was achieved by speaking with people and understanding their individual needs and supporting them with their choices. The practice identified people with caring responsibilities and those who required additional support and referrals were made to other support agencies as appropriate. Written information about a number of long term conditions, such as diabetes, dementia and respiratory conditions was available, as was information on promoting healthier lifestyles. The practice had a recall system for people with long term conditions to ensure their health needs were being met. There were regular surgeries for people with diabetes, asthma and chronic obstructive airways disease. The doctors reviewed patients' medication; nurses and healthcare assistants were involved in health checks and patient support and education.

Regular multidisciplinary meetings were held and discussions were held about how patients with long term conditions were treated and cared for. Regular patient care reviews were conducted with patients and carers where appropriate to monitor each patient's progress with treatment and make any changes to the treatment offered. Patients were referred for specialist assessments and treatment as appropriate.

Patients access and use of out-of-hours services, unplanned and re-admissions to hospital were monitored and reviewed to help identify where additional support or changes to treatment was required.

The practice had considered the accessibility of the service for patients with long term conditions and offered flexibility in access to the service, so far as possible. Doctors told us that the duration of appointments were flexible so as to facilitate should longer time be required to address multiple issues or simply provide the required support to understand and meet the person's needs. One nurse had undertaken specialised training in dealing with minor conditions such as asthma, flu and colds. This helped to free up doctors to treat more complex conditions.

Staff had received specific training in identifying, understanding and facilitating the needs of people with long term conditions. Patients told us that staff understood their needs, their medical condition, any impact upon their daily lives, and that their medicines were explained to them fully in a way that they could understand.

The practice had arrangements for reviewing and auditing the care and treatment provided for patients with chronic or long-term conditions, such as, diabetes. Patient's attendance for medication reviews were monitored and followed up where patients failed to attend their appointments.

Ongoing clinical audits were used to improve outcomes for patients with long-term conditions.

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 had arrangements in place for the timely identification and management of children where there were safeguarding concerns. There were systems in place to identify looked after children or children living in vulnerable circumstance such as with parents or carers who may require additional support due to substance dependency.

All staff had received training in recognising and responding to an acutely ill child and staff we spoke with were able to demonstrate how they would deal with a baby or child who was acutely ill, or whose health deteriorated while they were at the practice.

Information on healthy lifestyle choices and how to access community services and support networks was available to expectant and new mothers. The practice monitored the child and mother's progress to ensure appropriate medical support was being provided and liaison between specialists where appropriate such as with consultants, midwives and health visitors. Expectant mothers had access to midwife clinics every week, alternating between the main practice and the branch surgery. There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies.

The practice conducted regular assessments of children's development and monitored the take up of primary and pre-school immunisation to identifying children potentially at risk. Where concerns were identified with regard to the physical and/or mental health of a child, appropriate and timely referrals to partner agencies were made and documented. These were discussed with the child and carers and provided with additional information or support as required.

Patients we spoke with told us that the doctors and nurses were very understanding of their needs and that it was always possible to get same day appointments when their children were unwell.

The clinical staff we spoke with had an awareness of principles of parental responsibility and consent for patients who were under 16 year years.

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 accessible appointments to working aged patients. The practice operated a 'duty doctor' system during the mornings and afternoons. Patients could book and change appointments online and pre-bookable appointments were available.

Patients told us that they could access appointments easily to fit in with their work and study schedules and that they were happy with the services and treatments that they received.Working aged patients and those who were recently retired were provided with information about choosing healthy lifestyles and promotion and maintenance of good overall health. Patients were encouraged to participate in health promotion activities such as breast screening, smoking cessation, and cytology screening. Details of relevant clinics and information were readily available on the practice website and within the practice waiting areas.

Working age and recently retired patients who had responsibilities for caring for others were provided with information about the various support agencies available locally and nationally to help with practical, emotional and financial matters.

Those patients with one or more chronic conditions were reviewed regularly and referred for specialist care and treatment as required. When patients required referral to specialist services they were offered a choice of services, locations and dates to suit their needs.

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 had arrangements in place to ensure access to its services to patients who were vulnerable as a result of social or other circumstances. This included people with, such as those with certain medical or mental health conditions, people who were homeless or from travelling communities or migrant populations.

The practice worked with other health and social care professionals such as community mental health teams and community nurses to ensure that patients who had learning disabilities received safe, effective and coordinated care. Patients were contacted to attend the practice for their annual health checks. Where patients were unable to attend the practice doctors carried out home visits.

The practice had systems for identifying and monitoring patients who may be vulnerable due to a number of circumstances. The practice's computerised records system had mechanisms for flagging the records for any patient who had been identified as being at risk of abuse, harm or neglect. This helped staff identify vulnerable patients and monitor their safety and welfare. There were guidelines for staff to follow when patients had been identified as vulnerable, either due to social circumstances or as a result of a mental health condition or learning disability had failed to attend appointments.

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 recognised the needs of people who were experiencing poor mental health, including patients from the student population. Staff told us that a number of students experienced mental health conditions including depression and eating disorders due to the pressures of student life and some due to being away from home and their support networks. Referrals for specialist treatments were made and patients were provided with information about local support agencies.

The practice had a dedicated appointed lead clinician responsible for overseeing the care provided and monitoring of the mental health needs of people within the practice to ensure they were supported throughout their care.

Regular patient care reviews were conducted with patients and carers where appropriate to ensure that care and treatment was appropriate and amended where required. Patients were invited to and received annual health checks. Where appropriate patients were referred appropriately to specialists in a timely way.

The practice had an effective system for identifying patients with mental health needs so that when they contacted the surgery for an appointment or when they attended for routine reviews they would be seen by the clinical staff best placed to support them.

Reception and administrative staff told us that where patients with mental health conditions failed to attend appointments that there were arrangements for raising concerns about non-attendance with the doctors and making second appointments, or arranging home visits if necessary.

The practice had a range of information leaflets available about local support agencies available to people who have mental health conditions.