

Staploe Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

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

We carried out an announced comprehensive inspection at Staploe Medical Centre on 28 April 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw the following areas of outstanding practice;

Summary of findings

- The Practice ran a GP team or 'squadron' system. GPs were grouped into permanent squadrons to maximise continuity during annual or sick leave. During leave all issues and results for a patient were handled by the same group of GPs with two or more GPs from the same squadron never on leave at the same time, thus maximising continuity of care for patients. The duty GP oversaw the daily triaging of calls, home visits, the agenda for the clinicians morning coffee break meeting and peer review of referrals. The duty team reviewed all out of hours contacts first thing to ensure an early review or visit and where required an early admission to secondary care.
- The practice research team had been recognised as an 'exemplary medical research team in primary care' by the National Institute for Health Research (NIHR) and as a consequence had secured two years of awards (research capability funding). The practice acted as a hub for other practices encouraging the Royal College

of General Practitioners (RCGP) research ready model and used funds raised by the research team to improve clinical resources and education throughout the practice teams.

The areas where the provider should make improvement are:

- Assess the suitability of the drop-off locations for the safe and appropriate storage of medicines.
- Improve the management of blank prescription forms and to ensure that an audit trail of usage was maintained.
- Ensure that all waiting areas of the practice can be clearly seen by reception staff to ensure the safety and security of vulnerable patients.

We carried out an announced comprehensive inspection at Staploe Medical Centre on 28 April 2016. Overall the practice is rated as good.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- The practice had effective recruitment procedures in place to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Risks to patients and the public were assessed and well managed, including procedures for infection control and other site related health and safety matters. Risks to vulnerable patients with complex needs were monitored by multidisciplinary team meetings to provide holistic care and regular review.
- The practice had effective systems in place to deal with medical emergencies.
- The practice ensured staffing levels were sufficient at all times to respond effectively to patients' needs.

Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. With the practice achieving 100% across each indicator, and exception reporting in line with CCG and national averages across all indicators.
- The Practice ran a GP team or 'squadron' system. GPs were grouped into permanent squadrons to maximise continuity during annual or sick leave. During leave all issues and results for a patient were handled by the same group of GPs with two or more GPs from the same squadron never on leave at the same time, thus maximising continuity of care for patients. A daily squadron duty GP led the GPs arranged into two squadrons and coordinated cover to ensure administration tasks such as results, tasks and correspondence were overseen

Summary of findings

should a clinician be absent. The duty GP also oversaw the daily triaging of calls, home visits, the agenda for the clinicians morning coffee break meeting and peer review of referrals. The duty team reviewed all out of hours contacts first thing to ensure an early review or visit and where required an early admission to secondary care. We were told this promoted continuity and ensured daily cover.

- The practice undertook weekly reviews of all patients who had an 'intention to refer' code entered onto their records, but had not had their referral completed. The practice then ensured actions were put in place to expedite a referral if still required. This system was put in place three years ago following a significant event where a referral had not been completed. The practice reported no such cases since the introduction of the audit, however the audit had highlighted occasions where intended referrals had not progressed as planned ensuring the practice could take action and which evidenced the effectiveness of continued audit in restricting delays to one week.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement. The practice participated in local audits, national benchmarking, accreditation, peer review and research. The practice research team had been recognised as an 'exemplary medical research team in primary care' by the National Institute for Health Research (NIHR) and as a consequence had secured two years of awards (research capability funding). The practice acted as a hub for other practices encouraging the Royal College of General Practitioners (RCGP) research ready model and used funds raised by the research team to improve clinical resources and education throughout the practice teams.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey published January 2016 showed patients rated the practice higher than others for several aspects of care. For example 91% said the last GP they

Good



Summary of findings

saw was good at listening to them compared to the CCG average of 87% and the national average of 86%. 94% said the last nurse they saw was good at listening to them compared to the CCG average of 92% and the national average of 91%.

- Feedback from patients we spoke with on the day of inspection, along with feedback received on our comment cards was positive. Patients recounted examples of care they had received, and recalled instances where the GP and nurses had ensured that patients were supported well to make informed choices.
- The practice had identified 224 patients as carers; this was 1% of its patient population.
- The practice continued to proactively identify carers and had systems in place to ensure their needs were met.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice adopted a flexible approach in dealing with vulnerable patients to ensure their individual needs were accounted for. This included allocating suitable appointment times.
- There were processes in place to provide support and guidance to bereaved patients and their families.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Comment cards and patients we spoke with during the inspection were positive about their experience in obtaining a routine appointment. This was reinforced by the national GP patient survey published in January 2016 which found that 84% of patients described their experience of making an appointment as good. This was above comparison to the CCG average of 77% and the national average of 73%. In addition 94% of patients said they were able to see or speak with

Good



Summary of findings

someone the last time they tried compared to the CCG average of 87% and the national average of 85%. 94% said the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.

- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders and displayed in the waiting area of the practice.
- If patients at reception wished to talk confidentially, or became distressed, they were offered a private room away from the waiting area. Baby clinics were scheduled at quieter times, usually during the lunch period when GP clinics were not busy to ensure parents with children plus other patients received a calmer and more sensitive approach to their appointment time.
- Translation services could be accessed to assist any patients whose first language was not English.

Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of, and complied with, the requirements of the duty of candour. The GPs encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The GPs reviewed comparative data and ensured actions were implemented to address any areas of outlying performance.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Good



Summary of findings

- There was a strong focus on continuous learning and improvement at all levels. The practice was a teaching and training practice for GP registrars and medical students and were overseen by the GP School, Health Education East of England. The practice showed us evidence of well-planned inductions for trainees which took account of their personal circumstances. The induction included a designated support for any new doctor in addition to attendance at the morning clinical coffee meeting where referral pathways, allocation of duty, home visits and discussion of patient case management was undertaken. The practice felt this was not only an invaluable resource for new doctors, students and GPs but also ensured an opportunity for continued professional development and learning for all GPs. In this way clinicians at the practice had a daily opportunity to reflect on patient treatment with the support of their peers and where relevant affect an improved referral pathway or outcome for patients, often on the same day.
- The practice was a research practice and the practice research team had been recognised as an 'exemplary medical research team in primary care' by the National Institute for Health Research (NIHR) and as a consequence had secured two years of awards (research capability funding).

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis and heart failure were above local and national averages.
- The practice ensured it prioritised care for their older patients and offered proactive, personalised care to meet the needs of older people. Care plans were in place for older patients with complex needs. All patients had a named GP.
- The practice had administered flu vaccination to 72% of patients who were on the practice register for over 65 years. Shingles and pneumococcal immunisations were also provided.
- The practice oversaw the care of patients in one nursing home and residential homes. There was a lead GP for the nursing home and another GP for the residential homes. The practice ensured there was weekly protected time for these GPs to provide support to these homes.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2014/2015 showed that performance for diabetes related indicators was 100%, which was above the CCG and the national averages by 11percentage points.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 72% to 98% and five year olds from 92% to 96%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered a 'Commuter's Clinic' from 6.30pm to 9pm Monday evenings and from 8.30am to 10.30 am every Saturday for pre-booked appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The bowel cancer screening rate for the past 30 months was 59% of the target population, which was in-line with the CCG

Good



Summary of findings

average of 59% and the national average of 58%. The breast cancer screening rate for the past 36 months was 62% of the target population, which was below the CCG average of 72% and above the national average of 72%.

- The practice offered NHS health checks for patients aged 40–74. The practice had undertaken in excess of 2,700 of these checks over the last four years.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had identified 49 patients with a learning disability on the practice register, 42 had received a health checks in the previous twelve months. All these patients had supporting care plans.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 82% compared to the national average of 84%. Overall performance for dementia indicators were above CCG and national average with the practice achieving 100%. The rate of exception reporting was in line with both the CCG and national averages.
- The percentage of patients experiencing poor mental health who had a comprehensive, agreed care plan documented in their records, in the preceding 12 months (01/04/2014 to 31/03/2015) was 98% compared to the national average of 88%.

Good



Summary of findings

Overall performance for mental health indicators were also above CCG and national average with the practice achieving 100%. The rate of exception reporting was in line with both the CCG and national averages.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Leaflets were available in the waiting area on a range of services available for patients and carers.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had all undergone mental capacity act training and had a very good understanding of how to support patients with additional mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing above local and national averages. 293 survey forms were distributed and 123 were returned. This represented a 42% response rate

- 94% of patients found it easy to get through to this practice by phone compared to the CCG average of 75% and national average of 73%.
- 94% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%.
- 92% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and national average of 85%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received ten comment cards. Nine of the ten patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One card raised concerns regarding the cost implications for referrals.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice placed 'Friends and Family' comments cards in the reception area and prompted patients to state whether they were likely to recommend the practice to their own friends and family. 91% of patients who provided a response stated that they were likely or extremely likely to recommend the practice in this way.

Areas for improvement

Action the service **SHOULD** take to improve

- Assess the suitability of the drop-off locations for the safe and appropriate storage of medicines.
- Improve the management of blank prescription forms and to ensure that an audit trail of usage was maintained.
- Ensure that all waiting areas of the practice can be clearly seen by reception staff to ensure the safety and security of vulnerable patients.

Outstanding practice

- The Practice ran a GP team or 'squadron' system. GPs were grouped into permanent squadrons to maximise continuity during annual or sick leave. During leave all issues and results for a patient were handled by the same group of GPs with two or more GPs from the same squadron never on leave at the same time, thus maximising continuity of care for patients. The duty GP oversaw the daily triaging of calls, home visits, the agenda for the clinicians morning coffee break meeting and peer review of referrals. The duty team reviewed all out of hours contacts first thing to ensure an early review or visit and where required an early admission to secondary care.
- The practice research team had been recognised as an 'exemplary medical research team in primary care' by the National Institute for Health Research (NIHR) and as a consequence had secured two years of awards (research capability funding). The practice acted as a hub for other practices encouraging the Royal College

Summary of findings

of General Practitioners (RCGP) research ready model and used funds raised by the research team to improve clinical resources and education throughout the practice teams.

Staploe Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice manager specialist adviser and a pharmacy specialist advisor.

Background to Staploe Medical Centre

Staploe medical centre provides general medical services to approximately 20,600 patients. The practice was formed in 1970 through the amalgamation of three single handed GP practices in Soham and Isleham. The practice grew over the years; with the village of Soham and local villages seeing a more rapid growth over the last five years. The practice moved to the current health centre location in 1990 with extensions to the site in 2001 following the growth of the practice patient list size. The building provides good access with accessible toilets and car parking facilities. The practice provides treatment and consultation rooms on the ground floor with ramp access and automatic doors. The practice is an accredited eastern region clinical research network practice and an accredited training practice. The practice provides services to a diverse population age group, is in a semi-rural location and is a dispensing practice, dispensing to approximately 8000 patients. A dispensing practice is where GPs dispense the medicines they prescribe for patients who live more than 1 mile (1.6km) from a community pharmacy.

There is a team of 58 clinical and non-clinical staff including 12 GPs. Six GPs are partners which means they hold managerial and financial responsibility for the

practice and there are six salaried GPs. The practice nursing team consists of the senior nurse/clinical manager, a lead nurse, one nurse practitioner, six practice nurses and five health care assistants (one of whom was currently undertaking training to become a nurse). The nursing team of nine run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager who is supported by a managerial assistant. In addition there is a team of dispensers and a team of non-clinical administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice is open between 8.30am and 6pm Monday to Friday. Appointments are from 8.40am to 10.30am every morning and 3.30pm to 5.30pm daily. Extended hours appointments are offered from 6.30pm to 9pm Monday evenings and from 8.30am to 10.30 am every Saturday for pre-booked appointments. In addition to pre-bookable appointments that can be booked up to three months in advance, urgent appointments are also available for people that need them. We were told GPs see their own patients where possible to provide continuity of care and all patients with urgent problems are seen on the same day, however not necessarily by their own GP. The practice runs a 'duty team' system each day. Where patients request an appointment on the day, contact details are transferred to the duty team consisting of a GP and a practice nurse. The patient is contacted within the hour and where required an appointment or home visit or telephone consultation is allocated with the most appropriate clinician.

The practice does not provide GP services to patients outside of normal working hours such as nights and weekends. During these times GP services are provided by Urgent Care Cambridge via the NHS 111 service.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 April 2016. During our visit we:

- Spoke with a range of staff including GPs, nurses, management, dispensing, administration and reception staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.

- Reviewed comment cards 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 and treatment, we always ask the following five questions:

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events with an annual review of all significant events to identify any trends and improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice and prevent further occurrences.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Safeguarding was a standing agenda for the weekly GPs meetings, and the practice provided reports where necessary for other agencies. In addition GPs met daily and reviewed any concerns, safeguarding, home visits and peer reviewed each

other's referrals. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to safeguarding level three (safeguarding children and young people).

- A notice in the waiting room advised patients that chaperones were available if required. Nursing staff acted as chaperones and were trained for the role. The practice was in the process of undertaking Disclosure and Barring Service (DBS) checks for all non-clinical staff in addition to the DBS checks already undertaken for clinical staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Medicines Management

The dispensary at Staploe Medical Centre was open Monday to Friday and on Saturday mornings for collection services and dispensing of urgent items. The dispensary was staffed by one senior dispenser and six dispensing staff. All staff members were qualified to national vocational qualification (NVQ) level two. The dispensary staff told us that they always had access to a GP for advice and guidance and that the GP's were always helpful and easy to approach.

Security systems were in place to secure the dispensary and the premises were shared between the practice dispensary staff and staff from the Staploe Pharmacy which operated independently from the same building. We noted that the dispensary and pharmacy staff had a close

Are services safe?

working relationship and co-operated to ensure that patients received a seamless service. Records showed that all members of dispensary staff had received annual appraisals and training appropriate to their role.

We noted that the practice had a robust and clear process for the management of information about changes to a patient's medication received from other services. All such changes were reviewed and authorised by a GP and communicated to dispensary staff as necessary. The practice had a prescribing policy which promoted prescribing of generic medicines wherever possible and limited the maximum quantity of medicines supplied to 28 days. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. We noted that a dispensing review on the use of medicines had been carried out on approximately 10% of patients in the last year in accordance with DSQS requirements.

We observed systems in place to ensure that repeat prescriptions were monitored effectively and that patients are able to request repeats by a number of means including on-line. Acute prescriptions and prescriptions for Controlled Drugs (CDs, medicines that require extra checks and special storage arrangements because of their potential for misuse) were always signed by the GP before being dispensed and given to patients. We were told by dispensary staff that they monitor prescriptions that have not been collected and inform GPs of this. Dispensary staff also informed GPs if they observed any deteriorating health problems which may prevent patients from taking their medicines safely. We also observed that dispensary staff counselled patients on possible side effects of medicine they receive and on whether medicines should be taken with or after food. We observed that the dispensing process was safe and a checking system was in place to ensure that medicines were correct before being handed to patients. We noted that the dispensary provided medicines in weekly blister packs for over 150 patients.

The practice held stocks of CDs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the dispensary staff. We noted that CDs were correctly stored in a locked cupboard and that

receipts and dispensing were recorded in a CD record book. We examined the CD record book and noted that it was comprehensively and accurately completed. We checked a sample of CD medicines against stock levels in the record book and found them to be correct apart from one entry for the supply of an emergency item to a GP which had taken place some weeks previously. We discussed this with the dispensary manager who confirmed they would be reviewing the procedures and protocols to ensure this type of incident could not occur again. We observed that CDs were checked at regular intervals as per policy and that staff were aware of how to report any concerns with CDs to the practice manager and lead GP. There were arrangements in place for the recording of stock and the destruction of CDs.

The practice had clear and comprehensive Standard Operating Procedures (SOPs) for their dispensary staff to follow and we saw evidence that each member of staff had signed that they had seen and understood each SOP and that SOPs were reviewed on an annual basis.

There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We checked medicines stored in the dispensary, medicine and vaccines refrigerators and found they were stored securely. There was a clear policy for ensuring that refrigerated medicines were kept at the required temperatures and described the action to take in the event of a potential failure. The practice staff followed the policy. We noted that thermometers used to record refrigerator and ambient room temperatures were validated and calibrated annually to ensure their accuracy. All the medicines we checked were within their expiry dates.

Blank prescription forms were handled by dispensary staff in accordance with national guidance and were tracked through the practice. We observed that blank prescription forms were kept in unlocked printers in the GP consulting rooms and were removed by them at the end of the

Are services safe?

working day and placed inside a locked drawer. However, we found there was scope to improve the security of these as serial numbers of blank forms given to GPs for use in their consulting rooms were not recorded.

We noted that dispensed medicines were transported to remote collection sites in surrounding villages for collection by patients living in those areas. We saw no evidence that the practice had risk-assessed this practice to ensure that medicines were correctly and securely stored and patient confidentiality was maintained at these remote sites, and of the arrangements to ensure that medicines were collected by the correct patients. We discussed this with the practice management team during our inspection. The practice manager confirmed following our inspection that a program of risk assessments for remote collection sites was being undertaken.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a term for a particular

bacterium which can contaminate water systems in buildings). However we noted that not all waiting areas of the practice could be clearly seen by reception staff to ensure the safety and security of vulnerable patients.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available with 8% exception reporting (compared to the CCG average of 10%). The exception reporting figure is the number of patients excluded from the overall calculation due to factors such as non-engagement. A lower figure demonstrates a proactive approach by the practice to engage their patients with regular monitoring to manage their conditions. QOF data from 2014-15 showed;

- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2014 to 31/03/2015) was 82% compared to the national average of 84%. Overall performance for dementia indicators were above CCG and national average with the practice achieving 100%. The rate of exception reporting was in line with both the CCG and national averages.
- The percentage of patients experiencing poor mental health who had a comprehensive, agreed care plan documented in their records, in the preceding 12 months (01/04/2014 to 31/03/2015) was 98% compared to the national average of 88%. Overall performance for mental health indicators were also above CCG and national average with the practice achieving 100%. The rate of exception reporting was in line with both the CCG and national averages.

- Performance for other indicators such as asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, depression, diabetes, epilepsy, heart failure, hypertension, learning disabilities, osteoporosis, palliative care, peripheral arterial disease, rheumatoid arthritis and secondary prevention of coronary heart disease were all above or in-line with CCG and national averages with the practice achieving 100% across each indicator. The rate of exception reporting was also consistently in-line with or lower than both the CCG and national averages.

There was evidence of quality improvement including clinical audit.

- The practice regularly monitored clinical data using a reflective review process and discussed and disseminated findings with clinical staff and relevant organisations. Daily coffee morning meetings with clinicians gave staff the opportunity to discuss and review daily referrals and clinical decisions with the duty GP.
- High risk medications were monitored regularly by doing a search on the clinical computer system. The practice described and showed us how their recall system worked for various drug monitoring. The recalls in place were robust and the practice regularly checked that patients had been in for their blood tests and monitoring. For example, we saw that of 100 patients prescribed methotrexate at the time of our inspection, 78 patients had received an up to date blood test. Other patients were scheduled for a blood test or were seen by other services such as the hospital for their blood tests. The practice system highlighted when a repeat prescription was due and flagged to the GP the most recent blood test results.
- We saw the practice identified and monitored those patients who were overdue for review and those patients whose blood tests were undertaken and monitored by secondary care services. We saw there was a clear process in place for review and patients were actively followed up by the administration and dispensing teams.
- We looked at two of the most recent clinical audits where the improvements made were implemented and monitored, including an audit of pain medication prescribing where the practice identified a trend of 77% for a named brand pain medication. When the audit was repeated the results demonstrated an improvement in



Are services effective?

(for example, treatment is effective)

prescribing from a named pain medication to a more cost effective brand by 100%. The practice had also undertaken an audit of patients with a diagnosis of atrial fibrillation (AF) who had been prescribed a novel anticoagulant drug (NOAC). Following NICE guidelines for the prevention of stroke in patients who have a diagnosis of AF the practice audit identified 67% of patients with a diagnosis of AF who had been prescribed NOAC. When the audit was repeated the results demonstrated an increase to 73%. An audit of patients with AF on 21 April 2016 showed that of the 341 patients with AF, 90% were receiving appropriate treatment.

- Other audits included read coding audits of patients experiencing poor mental health, a second audit evidenced more accurate identification of patients and ensured the practice were able to identify any disengaged patients. Nurse led audits included pre-consent form audits, swab taking prior to contraceptive coil implants and environmental audit of infection control in treatment rooms.
- The practice undertook weekly reviews of all patients who had an 'intention to refer' code entered onto their records, but had not had their referral completed. The practice then ensured actions were put in place to expedite a referral if still required. This system was put in place three years ago following a significant event where a referral had not been completed. The practice reported no such cases since the introduction of the audit, however the audit had highlighted occasions where intended referrals had not progressed as planned ensuring the practice could take action and which evidenced the effectiveness of continued audit in restricting delays to one week
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. The practice research team had been recognised as an 'exemplary medical research team in primary care' by the National Institute for Health Research (NIHR) and as a consequence had secured two years of awards (research capability funding). The practice acted as a hub for other practices encouraging the Royal College of General Practitioners (RCGP) research ready model and used funds raised by the research team to improve clinical resources and education throughout the practice teams.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at daily and weekly practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The Practice ran a GP team or 'squadron' system. GPs were grouped into permanent squadrons to maximise continuity during annual or sick leave. During leave all issues and results for a patient were handled by the same group of GPs with two or more GPs from the same squadron never on leave at the same time, thus



Are services effective?

(for example, treatment is effective)

maximising continuity of care for patients. A daily squadron duty GP led the GPs arranged into two squadrons and coordinated cover to ensure administration tasks such as results, tasks and correspondence were overseen should a clinician be absent. The duty GP also oversaw the daily triaging of calls, home visits, the agenda for the clinicians morning coffee break meeting and peer review of referrals. The duty team reviewed all out of hours contacts first thing to ensure an early review or visit and where required an early admission to secondary care. We were told this promoted continuity and ensured daily cover.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Gold Standard Framework (GSF) meetings took place on a monthly basis with other health care professionals when care plans were routinely reviewed and updated for patients with complex needs. Multidisciplinary team (MDT) meetings took place every two weeks with a GP and district nurse where the agenda for the MDT/GSF meeting was reviewed to ensure effective use of meeting time.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term

condition and those requiring advice on their diet, smoking and alcohol cessation and sexual health advice. Patients were then signposted to the relevant service either internally (with a GP or nurse) or an external provider.

- The practice undertook six monthly meetings at a local care home with a 'care of the elderly' consultant to review the care plans for patients who were residents.
- There were special notes and reminders for clinicians on staff on patient records to highlight personal needs and circumstances. For example, for clinicians undertaking a home visit there were indicators of personal circumstances to be aware of, such as ensuring there was water available for a pet or what room a patient prefers to sit in whilst in their home.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The bowel cancer screening rate for the past 30 months was 59% of the target population, which was in-line with the CCG average of 59% and the national average of 58%. The breast cancer screening rate for the past 36 months was 62% of the target population, which was below the CCG average of 72% and above the national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 72% to 98% and five year olds from 92% to 96%.

The practice had administered flu vaccination to 72% of patients who were on the practice register for over 65 years and 43% of patients on the practice at risk register.



Are services effective? (for example, treatment is effective)

The practice had identified 49 patients with a learning disability on the practice register, 42 had received a health check. The practice referred patients to various support services.

Patients had access to appropriate health assessments and checks. These included health checks for new patients

where appropriate and NHS health checks for patients aged 40–74. The practice had undertaken in excess of 2700 of these checks over the last four years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Nine of the 10 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One card raised concerns regarding the cost implications for referrals.

We spoke with five patients during our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice were generally above for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG and national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.

- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The GP patient survey data also included areas where the practice could improve. For example 49% of respondents usually got to see or speak to their preferred GP in comparison to the CCG average of 61% and the national average of 59%. The practice was aware of these figures and felt that these were due in part to a rapid growth of the practice patient population. It was noted that the survey also identified that 94% of respondents were able to get an appointment or see someone the last time they tried compared to the CCG average of 87% and national average of 85%. The provider told us they believed the good access the practice provided also fuelled demand. The practice continued to monitor this feedback.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. Staff told us translation

Are services caring?

services for patients were available. The self-check-in screen was available in English only. However the practice explained that they monitored the patient list regularly and would change it if they felt it required other languages. Information leaflets were available. In addition the practice provided information on support available for patients. The practice booklet available on the practice website and in the reception area of the practice provided contact information on a number of support organisations such as Child line, the Samaritans, AIDS hotline and the Rape Crisis Centre.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 224 patients as carers (1.08% of the practice list). Carers were referred to various support groups and charities. The practice actively encouraged carers to identify both carers and cared for patients. Information for carers such as The Carers Trust was available to all staff through the practice intranet. Patients we spoke with told us that if they didn't see the information they required they would ask the practice staff.

This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered a 'Commuter's Clinic' from 6.30pm to 9pm Monday evenings and from 8.30am to 10.30 am every Saturday for pre-booked appointments.
- There were longer appointments available for reviews of patients with a learning disability, long term conditions and for patients aged over 75.
- The practice offered online appointment booking for phlebotomy, healthcare assistant, nurses and GP appointments and online repeat prescription requests. Warfarin monitoring services were available at the practice.
- A telephone appointment was available to patients if required. Text appointment reminders were also available for patients who provided a mobile telephone number.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- The practice oversaw the care of patients in one nursing home and several residential homes. There was a lead GP for the nursing home and another GP for the residential homes. The practice ensured there was weekly protected time for these GPs to provide support to these homes.
- The practice provided a range of nurse-led services including minor illness clinics, leg ulcer treatment and dressings, phlebotomy services, audiology services, immunisations, shingles, flu and pneumococcal vaccinations and family planning.
- Baby clinics were scheduled at quieter times, usually during the lunch period when GP clinics were not busy to ensure parents with children plus other patients received a calmer and more sensitive approach to their appointment time.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

- There were call and recall systems in place for nurse led, GP supervised clinics such as chronic heart disease, hypertension, diabetes and ischaemic heart disease. In addition to respiratory clinics for asthma and chronic obstructive pulmonary disease. The practice had achieved 100% across each chronic disease indicator.
- There were disabled facilities and a hearing loop to assist patients with a hearing aid.
- There was a named GP for all patients including families.
- The practice could refer patients to a range of services including mental health support groups and charities, Improving Access to Psychological services and the Community Mental Health Team (CMHT).
- The practice provided rooms at the practice for specialist consultations where possible to prevent patients travelling to local hospitals and clinics. These included CMHT and Inclusion (an advocate's service for vulnerable patients).
- The practice provided access to condoms through the Cambridge C Card system, this provided free condoms for young people up to the age of 25 years who had signed up to the scheme.

Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were from 8.40am to 10.30am every morning and 3.30pm to 5.30pm daily. Extended hours appointments were offered from 6.30pm to 9pm Monday evenings and from 8.30am to 10.30 am every Saturday for pre-booked appointments. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for people that needed them. We were told GPs see their own patients where possible to provide continuity of care and all patients with urgent problems were seen on the same day, however not necessarily by their own GP. The practice ran a 'duty team' system each day. Where patients requested an appointment on the day, contact details were transferred to the duty team consisting of a GP and a practice nurse. The patient was contacted within the hour and where required an appointment was allocated with the most appropriate clinician. The duty team also oversaw all requests for home visits, the duty GP included these requests on the agenda for the daily clinicians' coffee meeting where visits were discussed and allocated. Urgent requests were triaged by the clinical duty team and actioned by the duty team appropriately.

Are services responsive to people's needs?

(for example, to feedback?)

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

- 74% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 75%.
- 94% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and the national average of 73%.
- 94% of respondents were able to get an appointment or see someone the last time they tried compared to the CCG average of 87% and national average of 85%.
- 94% say the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.
- 61% felt they did not have to wait too long to be seen compared to the CCG average of 59% and the national average of 58%.
-

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice. The practice manager was responsible for dealing with these.
- We saw that information was available to help patients understand the complaints system. There were leaflets and posters displayed in the waiting area and information was available on the practice web site.

The practice had received 40 complaints since March 2015. We noted the number of complaints received was indicative of a responsive attitude to recording and learning from complaints. We looked at three of these and found that these were satisfactorily handled, and dealt with in a timely way, with openness and transparency. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, where a breakdown in communications had occurred the practice sent a letter of apology to the patient and reviewed the systems in place, adjusting systems where appropriate.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice mission statement was to provide medical care for patients and their families in accordance with up to date, evidenced based good practice and to offer the very best employment conditions and support for all their staff.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. 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 through reviews and listening to staff and patients and had made changes accordingly.
- The practice had introduced a daily duty team which oversaw both morning and afternoon surgeries. The practice had an ethos of 'today's work today' which ensured unlimited access for patients to telephone and face to face appointments on the day.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. The practice intranet provided access to a wide range of information including website links, practice protocols and policies, safeguarding information, significant events database, referral information and clinical governance information.
- A comprehensive understanding of the performance of the practice was maintained. The practice undertook weekly clinical governance meetings for all clinicians with a rolling agenda and quarterly clinical governance meetings afternoons for all staff where in-house learning was undertaken in groups and outcomes were minuted.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. The practice undertook weekly audits of referrals to ensure all proposed referrals by GPs were reviewed and actioned.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of, and had systems in place to; ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There was a practice Executive Group. Two GP partners and two members of the management team met fortnightly to review practice systems, capacity and quality and in general review items that the whole management team did not need to be involved in. Outcomes and actions were then fed back to the remaining partners and GPs at clinical governance meetings
- Staff told us the practice held regular team meetings. Staff told us there was an open culture within the practice and they had the opportunity to raise any

Are services well-led?

Good 

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

issues at team meetings and felt confident and supported in doing so. In addition to the meetings previously referred to in this report, the practice held quarterly no-agenda lunches for all staff. Staff told us these were excellent team building sessions where lunch was provided by the provider and staff had the opportunity to relax, come together and communicate as a team. We were told no-one worked in isolation at the practice and from the senior partner to the medical students there was an ethos of support and development.

- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example we were told all staff were involved in the creation of the practice mission statement.

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

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

- The practice had gathered feedback from patients through the virtual Patient Participation Group (PPG) and through surveys and the GP patient survey. There were 192 members in the group who were regularly consulted by the practice.
- The practice collated feedback from patients from the 'NHS Friends and Family' test, which asked patients, 'Would you recommend this service to friends and family?' The friends and family feedback form was accessible in the waiting room for patients to complete and could also be completed via the practice's web site. As previously referred to in this report results showed that 91% of respondents would recommend the practice.
- The practice produced quarterly staff and patient newsletters. These included practice news, health education and current NHS matters.

- The practice had gathered feedback from staff through meetings, one to ones and appraisals. Practice staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. Four of the six partners had achieved a distinction in their Member of the Royal College of General Practitioners (MRCGP) qualification. MRCGP is an integrated assessment system, success in which confirms that a doctor has satisfactorily completed speciality training for general practice and is competent to enter independent practice in the United Kingdom. Satisfactory completion of the MRCGP is pre-requisite for the issue of a certificate of training and full membership of the RCGP.

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was in the process of developing a number of initiatives to improve the services and patient care. For example;

- The practice would be adopting the electronic prescription service in the summer of 2016, this provided patients with the option of having their repeat prescription sent electronically to the participating pharmacy of their choice
- The practice was developing a young persons'/teenagers page on the practice website to provide better access for health information and guidance.
- The practice was developing a one stop clinic service for patients with multiple long term conditions. It was expected these clinics would provide tailored long term condition reviews without the patient attending for multiple appointments.
- The practice was investigating staff development with the need for personalised plans, in addition to establishing an ethos of recruitment to retirement for staff to ensure retention development and performance.
- The practice was in the process of re-developing the 'on the day team'. Following increased pressure on appointments from the previous winter and in preparation for future winters the practice were working to improve;

Are services well-led?

Good 

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

i) closer team working to improve support, development and morale.

ii) improved skill mix, with more efficient demand management.

- The practice was in the process of piloting new initiatives to provide student nurse placements at the practice to provide training and encourage recruitment into primary care.

The practice was a teaching and training practice for GP registrars and medical students and were overseen by the GP School, Health Education East of England. The practice showed us evidence of well-planned inductions for trainees which took account of their personal circumstances. The induction included a designated support for any new doctor in addition to attendance at the morning clinical coffee meeting where referral pathways, allocation of duty, home visits and discussion of patient case management was undertaken. The practice felt this was not only an invaluable resource for new GPs, students and doctors, but also ensured an opportunity for continued professional development and learning for all GPs. In this way clinicians

at the practice had a daily opportunity to reflect on patient treatment with the support of their peers and where relevant affect an improved referral pathway or outcome for patients, often on the same day.

In addition the practice was an established research practice and had a long track record in clinical studies. The practice was invited to perform studies from several large pharmaceutical organisations and over the previous five years had conducted 46 clinical studies. The practice was currently active in several studies involving the practice and other institutions worldwide. The practice won a research capability award in 2015/2016 from the National Institute of Health Research and was affiliated to the United Kingdom Clinical Research Network (UKCRN), which was established to support clinical research and to facilitate the conduct of trials and studies across the United Kingdom. As part of the UKCRN the practice worked towards the development of an infrastructure to support clinical research within the UK. Local funding had also been received from the local Primary Care Research network which supported some of the non-commercial trials as well as the commercial trials the practice undertook.